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Sickness absence and health in the workplace: Understanding employer behaviour and practice

Trinh Tu, Kelly Maguire and Theebika Shanmugarasa, Ipsos MORI

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A report of research carried out by Ipsos MORI on behalf of the Employers, Health and Inclusive Employment (EHIE) team.

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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

- The research provides a description of the health and wellbeing initiatives used by employers and contributes to the growing evidence base.
- Findings from this report have informed the ongoing development of policy decisions relating to employers and ill-health related job loss.

Trustworthiness

- This research was conducted, delivered and analysed impartially by Ipsos MORI, working to the Government Social Research code of practice.

Quality

- The survey was carried out using established statistical methods.
- The research has been quality assured using Ipsos MORI's internal quality checking processes.
- The report has been checked thoroughly by Employers, Health and Inclusive Employment (EHIE) analysts to ensure it meets the highest standards of analysis and drafting.

Executive Summary

This summary presents the key findings from a survey of 2,564 employers (with at least two employees) across Great Britain and follow-up qualitative research with 30 of these employers, conducted by Ipsos MORI. The research looked at employer attitudes, behaviours, support and provisions around employee health, sickness and disability in the workplace. This research was carried out prior to the COVID-19 pandemic.

Employer attitudes towards health and wellbeing were generally positive. The majority of employers recognised the link between work and the health and wellbeing of employees.

Organisation size had a direct bearing on employer health and wellbeing provision. Large and medium employers were more likely to provide a wider range of formal support to prevent employee ill-health or improve general health and wellbeing. Small employers took a more informal approach which they saw as more appropriate for their size and culture.

Large and medium employers were more likely to **experience long-term sickness absence (LTSA)** than small employers. Measures to manage returns to work after LTSA were adopted by the majority of employers, regardless of size, but large employers were more likely to provide support that incurred an additional cost.

Across each of the topic areas covered by the research (managing sickness absence, retaining employees with health conditions, managing return to work, sick pay, and occupational health provision), employers' decisions were driven by **their legal obligations, a duty of care to their employees, employee demand for support** and **cost-benefit analysis** (for example, to retain employees that were critical to the organisation).

This meant that employers sometimes made **discretionary decisions on a case-by-case basis**, considering what they needed to do to support or retain a given employee. For example, some employers who paid Statutory Sick Pay (SSP) only, would choose to pay above SSP depending on the employee and their needs.

Four in five employers **paid some form of sick pay** to their employees. Specifically, around half paid SSP only and three in ten paid above SSP. The main reason employers paid above SSP was to attract and retain the best employees. Not offering sick pay at all was more common amongst micro employers.[1]

One in five employers **offered Occupational Health (OH) services to their employees**, and this was more common among large organisations than medium-sized or small employers. Perceptions of need (shaped by the level of employee demand or volume of cases to justify the expense of purchasing OH services) were a key factor as to whether employers offered OH services or not.

[1] Not all employees are entitled to SSP (see Section 6.1). Additionally, interviews with employers who stated they did not pay sick pay indicate that, in reality, the proportion of employers not providing statutory sick pay may be slightly lower than the 13% reported, and the proportion paying SSP only, slightly higher.

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The Authors

This report was authored by researchers at Ipsos MORI:

- **Trinh Tu** (Research Director);
- **Kelly Maguire** (Research Manager); and
- **Theebika Shanmugarasa** (Senior Research Executive).

Glossary and Abbreviations

General terms

Above Statutory Sick Pay (SSP)	Throughout the report, we refer to employers paying 'above SSP'. This refers to any employer who pays either: • Both SSP and occupational sick pay (OSP) – please see below for a definition; or • OSP only.
Employee Assistance Programme (EAP)	Designed to support employees with personal or work-related problems that adversely impact their ability to do their job, or their general health and wellbeing.
Fit note	Fit notes are issued by GPs or hospital doctors when an individual's health condition has impacted on their fitness for work. The provision of a fit note involves an assessment of an individual's fitness for work by either a GP or hospital doctor. Assessments determine whether an individual is either 'not fit for any work' or 'maybe fit for work' if certain workplace adjustments are in place. If an individual is found 'not fit for work' a fit note details how long the medical professional recommends they take off work. Fit notes can be used as medical evidence for the payment of sick pay.
Human Resources (HR)	Describes the management and development of employees. This includes: recruitment, benefits, training, and employment law.
Long-term sickness absence (LTSA)	An instance of sickness absence from work lasting four or more weeks.
Occupational Health (OH)	For this research, the definition used with employers was: "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."
Occupational Sick Pay (OSP)	Where an organisation chooses to provide a contractual sick pay that is more generous than the statutory minimum (i.e. Statutory Sick Pay).
Presenteeism	Where employees work while they are sick.

Reasonable (or workplace) adjustments	Steps taken by employers to ensure disabled workers or workers with health conditions are not substantially disadvantaged when doing their jobs. Examples include installing a ramp for a wheelchair user or allowing someone with social anxiety to work from home[2].
Statutory Sick Pay (SSP)	The minimum amount an employer must pay employees who are too ill to work. At the time of the survey (2018), SSP was set at £92.05 per week for up to 28 weeks and at the time of publication (2020) is £95.85 per week[3].
Working environment	These categories were derived for analytical purposes post-survey, and do not reflect how individual employers defined the nature of their working environment: • Mostly manual or hazardous work environment – Agriculture, Forestry and Fishing; Mining and Quarrying; Utilities, Waste Management and Remediation Activities.; Manufacturing; Construction; Accommodation and Food Service Activities; Human Health and Social Work Activities. • Mostly office-based work environment – Information and Communications; Financial and Insurance Activities; Real Estate Activities; Professional, Scientific and Technical Activities; Administrative and Support Services; Public Administration, Defence and Compulsory Social Security. • Mixed work environments – Wholesale and Retail Trade; Repair of Motor Vehicles and Motorcycles; Transportation and Storage; Education; Arts, Entertainment and Recreation; and Other Service Activities.

[2] For more information, please see: https://www.gov.uk/reasonable-adjustments-for-disabled-workers

[3] For more information, please see: https://www.gov.uk/statutory-sick-pay

Sector definitions

Several smaller sectors were combined to allow for analysis by sector. The groupings used throughout the report are as follows:

Agriculture and Energy	Includes: Agriculture, Forestry and Fishing; and Mining and Quarrying; Utilities, Waste Management and Remediation Activities.
Financial, Professional and Administrative Services	Includes: Financial and Insurance Activities; Real Estate Activities; Professional, Scientific and Technical Activities; and Administrative and Support Service Activities.
Distribution, Hotels and Restaurants	Includes: Wholesale and Retail Trade; Repair of Motor Vehicles and Motorcycles; and Accommodation and Food Service Activities.
Other Services	Includes: Arts, Entertainment and Recreation; and Other Service Activities.
Public Administration, Education and Health	Includes: Public Administration, Defence and Compulsory Social Security; Education; and Human Health and Social Work Activities.
Transport and Communications	Includes: Transportation and Storage; and Information and Communications.

Size definitions

Employers are referred to by size (number of employees) throughout the report. These definitions are as follows:

Micro employers	‘Micro’ employers are those with one to nine employees. However, only employers with at least two employees were included in the research. Throughout the report, we report on ‘small employers’ (combining those with 2-49 employees) but draw out findings relating to micro employers (2-9) included in the research where their behaviours are substantially different to small employers (with 10-49 employees).
Small employers	‘Small’ employers are those with 10-49 employees. As noted above, we have combined micro and small employers together for analytical purposes, unless the experiences of micro employers are notably different.
Medium employers	Employers that have 50-249 employees.
Large employers	Employers that have more than 250 employees.

1. Summary

1.1 Introduction

This summary presents the key findings of a telephone survey with 2,564 employers and follow-up qualitative interviews with 30 employers across Great Britain with at least two employees, undertaken during 2018-19. The research was commissioned by the Employers, Health and Inclusive Employment (EHIE) team, part of 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). EHIE leads the government's strategy to support working-age disabled people and people with long-term health conditions to enter, and stay in, employment.

Please note, this research was carried out prior to the outbreak of coronavirus (also known as 'COVID-19').

1.2 Background and objectives

'Improving Lives: The Future of Work, Health and Disability'[4] outlined the role of employers in helping disabled people or people with health conditions stay, and thrive, in work, as well as to prevent unnecessary sickness absence, presenteeism and health-related job loss. Disabled people and people with long-term health conditions are at greater risk of falling out of work[5], and in 2019, Government launched a consultation seeking views on the different ways in which government and employers could take action to reduce ill-health-related job loss[6].

Ipsos MORI were commissioned to conduct a survey and follow-up qualitative interviews that would contribute to the current evidence base surrounding employer attitudes and behaviours around disability and health in the workplace. The aim of the research was to provide a greater understanding of employers in regard to health and wellbeing – what drives their decisions, what support they put in place for their employees, and why – as they play a key role in preventing unnecessary sickness absence, presenteeism and health-related job loss.

[4] DWP and DHSC, 'Improving Lives: The Future of Work, Health and Disability', 2017, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/663399/improving-lives-the-future-of-work-health-and-disability.PDF

[5] DWP and DHSC, 'Health in the workplace – patterns of sickness absence, employer support and employment retention', 2019, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/817124/health-in-the-workplace-statistics.pdf

[6] DWP and DHSC, 'Health is everyone's business: proposals to reduce ill health-related job loss', 2019, https://www.gov.uk/government/consultations/health-is-everyones-business-proposals-to-reduce-ill-health-related-job-loss

This report builds on the 2011 'Health and well-being survey of employers'[7] which was commissioned to provide evidence into a range of measures, including employers' perceptions of the importance of work to health and health to work, the provision of health and wellbeing initiatives, and employers' occupational sick pay (OSP) policies.

1.3 Summary of methodology

A random probability telephone survey was undertaken with 2,564 employers in Great Britain (GB), between June and August 2018. The sampling frame was sourced from the Office for National Statistics (ONS) Inter-Departmental Business Register (IDBR)[8] and the survey included GB employers with at least two employees. The data in this report have been weighted by size and sector to be representative of the GB employer population.

The survey data was supplemented by qualitative research with 30 employers who took part in the survey. Interviews were carried out by telephone between July and August 2019. Quotas were set to ensure a good representation of employers in terms of characteristics and health and wellbeing practices. This report brings together findings from both quantitative and qualitative research. More detail on the methodology is provided in the Technical Report and survey data has also been published in an interim report to support the Health is Everyone's Business consultation.

1.4 Key findings

1.4.1 Understanding employer behaviour: Chapter 3

Employer attitudes towards health and wellbeing were generally positive, with the majority acknowledging a link between work and the health and wellbeing of their employees. The health conditions that employers reported amongst staff generally reflected their working environment. The majority of employers agreed that there was a link between work and employee health and wellbeing (91%) and that it was an employer's responsibility to encourage employees to be healthy (90%).

Concerns about musculoskeletal conditions and workplace injuries were more common in mainly manual or hazardous working environments, whereas predominantly office-based employers were more likely to report stress as the main health concern amongst staff.

When deciding whether or not to invest in employee health and wellbeing, employers cited maintaining the organisation's reputation (79%) and satisfying legal obligations (69%) as the most important motivations.

[7] GfK NOP Social Research, 'Health and well-being at work: a survey of employers', 2011, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/214525/rrep750.pdf

[8] Please see: https://www.gov.uk/government/statistics/business-population-estimates-2018

Employers reported that they knew what to do to improve employee health and wellbeing (83%) and that, by and large, they understood their legal responsibilities in this space (45% said they understood 'very well' and 48% 'fairly well').

Employers who had no disabled employees or employees with health conditions had mixed interpretations of the meaning of the Equality Act 2010, and the duty to provide reasonable adjustments. At a basic level, they understood that the Act was designed to ensure that all employees were treated equally.

In large organisations, dedicated Human Resource (HR) functions planned and implemented policies and processes in relation to sickness absence and employee health. Small organisations lacked dedicated support to develop policies in advance, but sometimes used HR consultants to advise on complex areas.

Employers most commonly used the internet for information on how to retain employees with long-term health conditions (47%). This source was more commonly used by small than large employers (47% and 25% respectively). A greater number of large employers than small employers accessed formal, paid-for sources of advice, such as an occupational health provider (49% and 7% respectively), or legal sources (31% and 9% respectively).

1.4.2 Employer behaviours in relation to health and wellbeing: Chapter 4

Organisation size had a direct bearing on employer health and wellbeing provision. Larger employers were more likely to provide a wider range of formal support to help prevent employee ill-health or improve general health and wellbeing. Small employers who did not provide these measures described taking a more informal approach, which they viewed as more appropriate and cost-effective for their size and culture. These employers reported insufficient demand from employees to justify the investment in formal and preventative schemes.

To prevent employee ill-health, over three quarters (77%) of employers invested in health and safety training or guidance; for a third (32%) this was all they provided. One in six (16%) did not provide anything, nearly exclusively small employers.

Larger employers provided a greater range of formal support than small employers. This included health and wellbeing promotion programmes to improve physical activity or lifestyle (70% of large compared to 20% of small employers) and Employee Assistance Programmes (EAPs) or staff welfare/counselling programmes (76% of large compared to 14% of small employers). Employers who offered comprehensive health and wellbeing provisions also offered occupational health services, generous sick pay and other employee benefits and perks.

More than half of employers (55%) described their approach to managing employee health and wellbeing as reactive. A proactive approach was more common amongst large (72%) than small employers (44%), partly because large employers were more likely to have experienced long-term sickness absence (LTSA) than small employers (86% compared to 15% of small employers).

1.4.3 Employer behaviours in managing sickness absence: Chapter 5

Employers took a flexible approach to sickness absence management; recognising the importance of line manager discretion in the application of policies, whilst treating employees equally and fairly. Three in five employers (61%) adapted their policies depending on the employee.

Employers reported that the most common business risks relating to LTSA were covering work within the organisation (57%) and arranging cover or recruiting new staff (41%). This was followed by paying sick pay (28%) and the uncertainty of when employees would return to work and planning for this (25%).

Two in five employers (41%) had a specific policy in place to manage sickness absence (85% of large and 37% of small employers). Slightly more employers used a dedicated sickness absence management policy (29%) than a disciplinary policy (20%). Small employers used more informal approaches.

Organisations adopted different approaches to the management of sickness absence. The majority (61%) delegated responsibility to line managers, but only 44% of these employers provided their line managers with training to perform this role. Findings from the qualitative interviews indicated that some employers, usually in large organisations, had centralised processes and structures to manage sickness absence, involving HR and occupational health (OH) specialists where necessary.

Short-term sickness absence for minor ailments typically involved minimal contact between employer and employee. In contrast, employers had more structures in place for longer absences, including agreeing mode and frequency of contact and likely recovery times early on in the process, where possible.

1.4.4 Supporting retention and return to work: Chapter 6

Meetings with employees and phased or flexible returns to work (involving reduced hours or duties) were central to how employers supported employees with health conditions to remain in work, and/or return to work following a sickness absence.

Employers used a range of mechanisms to identify employees who needed support to manage their health and wellbeing at work. For example, through conversations or questionnaires with new employees, through employee requests, ongoing monitoring, OH recommendations, or recommendations on a fit note (where an employee had taken a period of sickness absence).

When providing reasonable adjustments, employers focused foremost on their legal duties as well as a duty of care to support their employees. However, some employers exercised discretion if they believed the adjustments were unreasonable or too costly.

One in five employers believed that employees on LTSA should only return when they could do all of their work (21%). Employers operating in manual or hazardous environments were more likely to hold this view than those in office-based occupations (25% compared to 15%).

Three in five employers (61%) reported facing barriers in supporting employees to return to work following a LTSA. Small employers reported a lack of time or staff resources (64%) and a lack of capital to invest in support (51%). In contrast, a greater

number of large employers encountered structural challenges such as a lack of flexibility in how work was organised (67%) and difficulty engaging employees in the process (61%). The latter included staff wanting to return prematurely or not wanting to return at all, staff refusing to disclose their condition and staff refusing support.

Some employers lacked confidence in managing returns to work, particularly in more complex cases. These employers reported not knowing how to instigate or conduct a return-to-work conversation. These concerns were more common among employers without prior experience of LTSA and those without clear policies, dedicated personnel, or external support.

1.4.5 Sick pay provision: Chapter 7

The majority of employers paid some form of sick pay to their employees (82%). A greater number of large employers paid *above* Statutory Sick Pay (SSP) than smaller ones. Where employers have a sick pay (occupational) scheme, this offers employees more than SSP.

Half of employers paid SSP only (54%), 28% paid above SSP, 13% did not provide any form of sick pay and 5% did not know. Micro employers were more likely than other employers to not offer sick pay (17%). Employers also explained in the qualitative interviews that they did not pay sick pay to employees on certain types of contracts, including those on zero hours or temporary contracts.[9]

Paying only SSP was more common amongst small (55%) than large employers (16%), those in Distribution, Hotels and Restaurants (62%), as well as among employers who did not provide OH services (58%). Employers cited cost as the main reason for paying only SSP in the qualitative interviews.

Employers paid *above* SSP to attract and retain the best employees and enhance employee engagement and productivity. The majority (78%) offered it to all their employees and one in five offered it to some of their employees (20%). The most common criteria for paying above SSP to only some was length of service (59%). Large employers had different employment contracts for employees eligible for above SSP. In contrast, small employers tended to use their discretion.

The average duration for occupational sick pay was 53 days. However, one in six employers reported that they paid OSP indefinitely (17%). Among employers that offered OSP, three in ten (29%) reduced the rate paid over time, of these four in ten employers (37%) reduced it to between 81% and 100% of employees' usual wage.

1.4.6 Employers' provision of occupational health services: Chapter 8

One in five employers offered OH services to their employees (21%) and this was more common amongst large (92%) than medium (49%) or small employers (18%). Employers most commonly used OH services to help minimise sickness absence and improve employee health and wellbeing. Those not offering OH services tended to cite a lack of employee demand (37%).

[9] Legally, all employees are eligible for sick pay, regardless of their contract type, provided they earn more than the Lower Earnings Limit. As of 2020 this was £120 per week.

Overall, a third of employers cited cost as the main barrier (too expensive, 16%; or too few cases to justify the expense, 22%) but knowledge of actual costs amongst small employers was limited. Smaller employers only sought OH advice when they felt out of their depth or had experienced multiple cases of ill-health to warrant longer-term investment in external, formalised support.

The most common reason why employers used OH services was to help minimise sickness absence and improve employee health and wellbeing (57%). Employers also cited the influence of legal obligations on their decision to use OH services. This may explain why riskier, or more physical, workplaces had higher levels of OH provision on average.

OH provision tended to be part of a wider package of health-related support aimed at keeping employees healthy and in work, such as health and safety training, Employee Assistant Programmes (EAPs), or other measures to support staff with health conditions to remain in work or return to work following a sickness absence.

Regardless of size, employers offering OH services indicated they would pay for follow-up treatments recommended by OH professionals but would make decisions on a case-by-case basis considering the importance of the individual for the organisation.

Of those employers that provided access to OH, large employers were more likely to purchase long-term contracts (48%) compared to small and medium employers (24% and 26% respectively). Instead small and medium employers were more likely to provide OH on an ad-hoc basis (43% and 63% respectively), reflecting perceptions of both employee need and cost effectiveness.

1.4.7 Segmenting the employer population: Chapter 9

A segmentation analysis on the survey data was undertaken to categorise employers into distinct groups based on their health and wellbeing provision. The analysis identified seven different groups.[10] The segments ranged from employers whose workplace support was largely focused on meeting health and safety requirements (the ‘Minimal Support’ and ‘Reluctant Support’ groups), to employers who offered more comprehensive, low-cost provisions such as return to work meetings, and amends to job role (the ‘Informal’, ‘Pragmatic’ and ‘Reactive Support’ groups), to employers who invested in a comprehensive and proactive package of health and wellbeing support, including workplace health promotion, OH services, and OSP (the ‘Intensive’ and ‘Structured Support’ groups).

The analysis found that greater levels of health-related support tended to be provided alongside more generous wider employee benefits, such as enhanced maternity pay or pensions contributions.

Three in ten employers were in the ‘Minimal Support’ group (29%). Micro employers were overrepresented, making up 82% of this segment compared to 67% of the overall employer population. Preventative measures were focused predominantly on providing health and safety training. Access to OH services was rare, and employers were less likely to offer sick pay compared to other segments.

[10] For more detail on the approach, please see the Technical Report.

One in twenty employers (6%) were in the ‘Intensive Support’ group. Large employers were overrepresented in this segment (9% of the group compared to 2% of employers overall). This segment had the most extensive and established provisions. They provided multiple measures to prevent employee ill-health, including Employee Assistance Programmes (EAPs), and were the most likely of the segments to offer OH services (99%) and above SSP (63%).

Larger organisations tended to provide more generous and more varied health and wellbeing support to their employees, but organisation size did not always predetermine generous health and wellbeing provisions. One in seven (15%) small employers were in the two most comprehensive segments (‘Structured’ or ‘Intensive Support’), whilst half of medium-sized (52%) and 14% of large employers were not.

2. Introduction

2.1 Policy background and research objectives

The 'Sickness absence and health in the workplace' survey and follow-up qualitative research was commissioned by the Employers, Health and Inclusive Employment (EHIE) team, 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). The EHIE team leads the government's strategy to support working-age disabled people and people with long-term health conditions to enter, and stay in, employment.

'Improving Lives: The Future of Work, Health and Disability'[11] outlined the role of employers in helping disabled people or people with health conditions stay, and thrive, in work, as well as to prevent unnecessary sickness absence, presenteeism and health-related job loss. Disabled people and people with long-term health conditions are at greater risk of falling out of work,[12] and in 2019, the EHIE team launched a consultation seeking views on the different ways in which government and employers could take action to reduce ill-health-related job loss.[13] This report builds on the 2011 'Health and well-being survey of employers'[14] which was commissioned to provide evidence into a range of measures, including employers' perceptions of the importance of work to health and health to work, the provision of health and wellbeing initiatives, and employers' occupational sick pay (OSP) policies.

Research aims

Ipsos MORI were commissioned to conduct a survey and follow-up qualitative interviews that would contribute to the current evidence base surrounding employer attitudes and behaviours around disability and health in the workplace. The aim of the research was to provide a greater understanding of employers in regard to health and wellbeing – what drives their decisions, what support they put in place for their employees, and why – as they play a key role in preventing unnecessary sickness absence, presenteeism and health-related job loss.

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[11] DWP and DHSC, 'Improving Lives: The Future of Work, Health and Disability', 2017, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/663399/improving-lives-the-future-of-work-health-and-disability.PDF

[12] DWP and DHSC, 'Health in the workplace – patterns of sickness absence, employer support and employment retention', 2019, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/817124/health-in-the-workplace-statistics.pdf

[13] DWP and DHSC, 'Health is everyone's business: proposals to reduce ill health-related job loss', 2019, https://www.gov.uk/government/consultations/health-is-everyones-business-proposals-to-reduce-ill-health-related-job-loss

[14] GfK NOP Social Research, 'Health and well-being at work: a survey of employers', 2011, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/214525/rrep750.pdf

The research was designed to help answer the following research questions:

- What is the relationship between the nature of employers' work, their attitudes toward employee health and wellbeing, perceived health risks and provision of support? And what is the impact of the employers' proactivity on this?
- How does the number of part-time, low skilled, high-turnover employees, or temporary staff, impact the support that employers put in place?
- How do employer attitudes relate to their motivation to provide support to employees? And what are their motivations to invest in supporting staff?
- What is the totality of employers' provision, in terms of health and wellbeing support? And how does an employer's size impact this provision?
- Are larger employers better equipped to support the health of their staff and manage sickness absence in a flexible way?
- What are the impacts and challenges that employers face in terms of sickness absence management and returns to work?
- How do employers understand their legal responsibilities and perceive their ease of compliance?
- What processes and considerations do employers have regarding adjustments?
- Are there any perceived barriers, challenges or risks associated with retaining staff with health conditions or disabilities?
- How do employers use sick pay regimes? And what is the rationale behind them?
- Where employers have Occupational Health (OH), what form does it take and how is it used? Where they don't have OH, what are the barriers to purchase?

Following the completion of the survey, Ipsos MORI were commissioned to design additional qualitative work to explore some of the survey findings in greater depth.[15]

2.2 Method

The research comprised two strands, summarised below. For more detail on all aspects of the research design mentioned below, please refer to the Technical Report. Please note, this research was carried out in 2018, prior to the COVID-19 pandemic.

Telephone survey

This report presents key findings from this survey, which comprised 2,564 telephone interviews with employers in Great Britain (GB) with at least two employees. Employers were sampled from the Office for National Statistics (ONS) Inter-Departmental Business Register (IDBR).[16] The findings are weighted by size and sector to be representative of GB employers, according to 2018 figures. In the GB employer population, 92% of employers are small (2-49 employees), 6% medium (50 to 249) and 2% large (250+). Large employers were oversampled, making

[15] A more detailed explanation of the qualitative aims and method is included in the Technical Report.

[16] Please see: https://www.gov.uk/government/statistics/business-population-estimates-2018

up 20% of the unweighted sample to allow for analysis within the size category (see Table 2.1 below). Although such organisations are relatively few in number, they employ a large proportion (45%) of the total GB workforce and are therefore important to capture in terms of their impact on employee health and wellbeing. In comparison, 37% of GB employees work for small employers, and 18% of employees work for medium employers. The sample covered public, private and third sector organisations.

Employers were sampled at head office level, and the survey was conducted with the most senior person with responsibility for personnel issues across the whole organisation in GB (where the organisation spanned multiple sites). Amongst smaller employers, this was usually the owner of the business or an office manager and in larger settings, this was usually a staff member with a dedicated human resources (HR) role. Fieldwork took place between June and August 2018, with a response rate of 43.7%.[17]

Table 2.1: Sample profile weighted by employer unit and employee volume

Variable	Categories	Unweighted	Weighted by employer unit	Weighted by employee volume
Size	Small	1,457	92%	37%
	Medium	584	6%	18%
	Large	523	2%	45%
Sector	Agriculture and Energy	107	4%	4%
	Manufacturing	351	8%	12%
	Construction	225	13%	7%
	Distribution, Hotels and Restaurants	572	26%	30%
	Transport and Communications	220	11%	10%
	Financial, Professional and Administrative Services	657	26%	24%
	Public Administration, Education and Health	283	6%	8%
	Other Services	149	7%	5%
Ease of recruiting staff	Easy	733	27%	30%
	Difficult	1,346	53%	50%
Ease of retaining staff	Easy	1,565	68%	55%
	Difficult	479	15%	22%
Employee representation or trade union	Yes	355	5%	21%
	No	2,169	94%	77%
Decisions on daily work tasks	Employees	208	12%	7%
	Managers or supervisors	898	33%	35%
	Both employees and managers	1,443	55%	57%

[17] For an explanation of how this response rate was calculated, please see the Technical Report.

In-depth interviews

The survey data was supplemented by qualitative research with employers who had consented to be re-contacted following their participation in the survey. Ipsos MORI conducted follow-up depth interviews with 30 employers over the telephone, between July and August 2019. A range of quotas were set to ensure the employers broadly reflected the employer population and had characteristics of interest to explore in more depth in the qualitative interviews:

Table 2.2: Qualitative sampling matrix

Description	Characteristics	Quota	Total
Size	Micro (2-9)	Min. 12	3
	Small (10-49)		13
	Medium (50-249)	Min. 12	8
	Large (250+)		6
Organisation type	Private sector	Mix and monitor	26
	Charity or voluntary sector		2
	Government financed body		2
HR	Internal HR	Mix and monitor	24
	External HR (consultancy)		4
	None		2
Sickness absence	Long-term sickness absence in the last year	Min. 10	23
	Instances of recurring sickness absences	Min. 6	19
Employment type	Mainly 0hrs contracts or casual employment	Min. 10	7
	Mix of casual/permanent contracts	Min. 10	11
	No 0hrs contracts or casual employment	Min. 10	12
Use of occupational health services	Yes	Min. 8	20
	No	Min. 8	10
Sick Pay	SSP only	Min. 8	11
	SSP and OSP	Min. 8	16
	Neither	-	3
Employees with a disability or long-term health problem	Yes	Min.15	17

2.3 Analysis and interpretation of the data

Survey data

All tables and charts report weighted data but include the unweighted base. Where findings have only been reported descriptively, fully referenced supporting tables have been included in the Technical Report.

The survey results are subject to margins of error, which vary depending on the number of respondents answering each question and pattern of responses. The report only comments on differences that are statistically significant (at the 95 per cent level of confidence). Where figures do not add to 100 per cent, this is due to rounding or because the question allows for more than one response.

Several advanced techniques have been used to further explore the survey data. We have briefly explained the purpose of these techniques in footnotes throughout the report and have included a more detailed method section in the Technical Report.

Qualitative interviews

Qualitative approaches are used to explore the nuances and diversity of views, the factors which shape or underlie them, and the ideas and situations in which views can change. The results are intended to be illustrative, not statistically representative.

Verbatim comments have been included in this report to illustrate and highlight key points and common themes. Where verbatim quotes are used, they have been anonymised and attributed with employer size, sector, and relevant behaviours (e.g. whether or not they use occupational health (OH) services, in the OH chapter).

Throughout the report, we also draw on two additional qualitative studies, conducted by Ipsos MORI, to support the evidence around the consultation. Both reports are referenced fully throughout:

- Ipsos MORI (2019) Employers' motivations and practices: A study of the use of occupational health services.
- Ipsos MORI (2020) Exploring perceptions and attitudes towards the extension of fit note certification.

The following section summarises the main influential factors identified in the analysis along with insight from the follow-up qualitative research with employers.

2.4 Employer and workforce characteristics

Many of the factors that had a bearing on employer behaviour in relation to health and wellbeing were related to, or could be explained by, size, sector and workforce skills.

Organisation type, size[18] and sector

The vast majority of employers were small in size (92%). Medium (50 to 249 employees) and large employers (250+ employees) made up 6% and 2% respectively.

Sectors with a high representation of small employers included Distribution, Hotels and Restaurants; and Financial, Professional and Administrative Services. Both sectors also had a high proportion of large employers, meaning that they are good

[18] This report focuses on employee size rather than financial turnover because the two are highly correlated and data on employee size is more complete (and accurate) than turnover.

sectors to observe differences in behaviour explained by size. The differences in some sectors are driven by the size representation within the sector (as shown in the table below).

Table 2.3: Organisation size by industry sector

	Column Percentages			
	Size of Employer			
	Total	**Small**	**Medium**	**Large**
Agriculture and Energy	4%	4%	3%	3%
Manufacturing	8%	8%	12%	16%
Construction	13%	14%	7%	2%
Distribution, Hotels and Restaurants	26%	26%	19%	28%
Transport and Communications	11%	10%	17%	3%
Financial, Professional and Administrative Services	26%	26%	26%	20%
Public Administration, Education and Health	6%	5%	10%	17%
Other Services	7%	7%	6%	11%
Base	*2,564*	*1,457*	*584*	*523*

Base: All employers (unweighted)

Organisation size had a direct bearing on employer health and wellbeing provision; large organisations had a greater need for and were better equipped than smaller ones to offer employees more comprehensive provisions and other perks. They tended to have more employees with a health condition or disability, more instances of long-term sickness absences, and more requests for support to accommodate health conditions or disabilities from employees. This was evident in both the survey findings and qualitative follow-up interviews with employers.[19]

Workforce composition

Based on their knowledge, small employers dominated the two extremes in terms of **age of the workforce**, as would be expected due to their size. For example, they were 19 times more likely than medium and large employers to have **no employees** over the age of 50 (19% compared to 1% and 0% respectively). At the opposite end of the scale, 28% of small employers reported that **more than half** of their workforce was aged over 50, compared with 11% of medium and 6% of large employers. Large and medium employers were more likely to be somewhere between these two ranges.

Table 2.4: Proportion of employees aged 50+ by organisation size

	Column Percentages			
	Size of Employer			
	Total	**Small**	**Medium**	**Large**
None	17%	19%	1%	0%
Less than a quarter	20%	19%	41%	28%
A quarter to a half	36%	34%	44%	59%

[19] See Chapter 3 and Chapter 5 for more detail.

	Column Percentages			
	Size of Employer			
	Total	**Small**	**Medium**	**Large**
More than half	26%	28%	11%	6%
Don't know/Refused	1%	1%	3%	7%
Base	*2,564*	*1,457*	*584*	*523*
Base: All employers (unweighted)				

Seven in ten employers (68%) stated that **none** of their employees had a disability or long-term health condition; these employers were predominantly small in size (73% compared to 22% of medium and 1% of large employers). In contrast, medium and large employers most commonly reported that less than 10% of their employees had a disability or long-term health condition (62% and 63% respectively). Having employees with a disability or long-term health condition was more common in Public Administration, Education and Health, where 50% of employers had workers with these conditions, compared to 31% overall.

Table 2.5: Proportion of employees with a disability by organisation size

	Column Percentages			
	Size of Employer			
	Total	**Small**	**Medium**	**Large**
None	68%	73%	22%	1%
Less than 10%	16%	12%	62%	63%
11% to 50%	13%	14%	7%	19%
51% or higher	1%	1%	*	0
Don't know the proportion	1%	1%	5%	14%
None to employer's knowledge	1%	*	3%	2%
Base	*2,564*	*1,457*	*584*	*523*
Base: All employers (unweighted)[20]				

Employee skills

Organisations were grouped into one of the following categories based on the skills and occupations of their employees[21] (as reported in the survey):

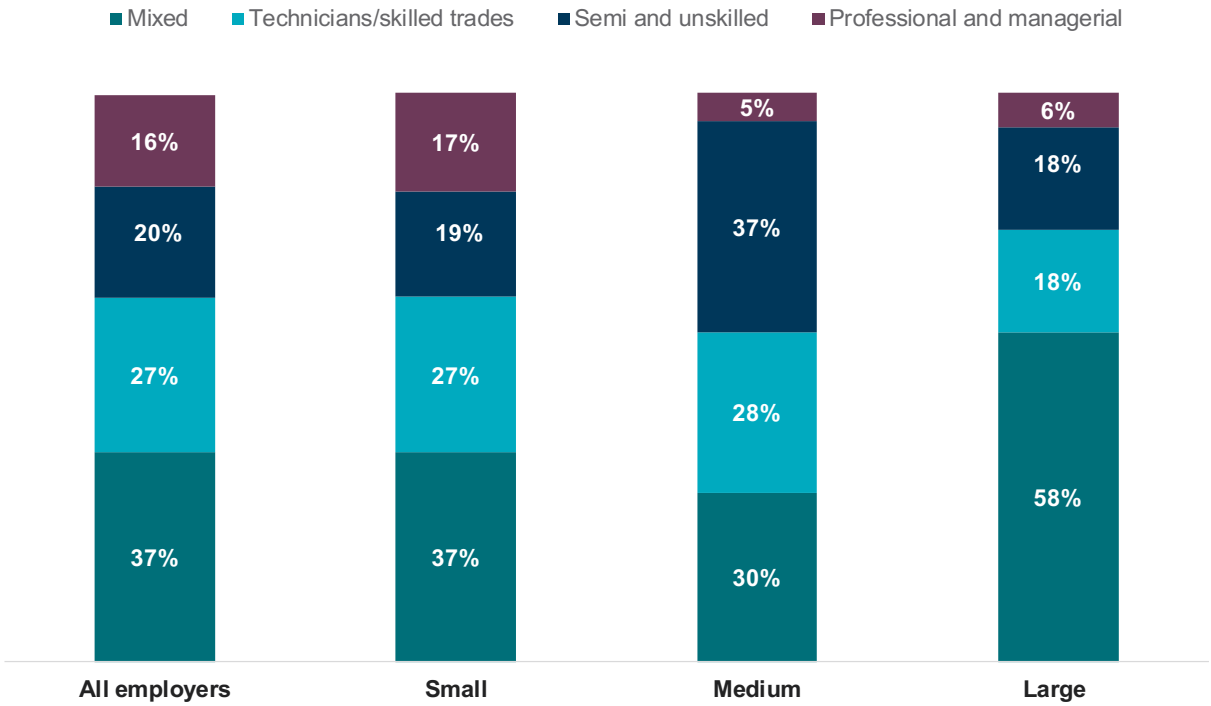
- Predominantly technicians and skilled trades – occupations requiring a substantial period of full-time training or further study (27% of employers);
- Predominantly semi- and unskilled occupations – occupations involving mostly routine tasks, with most not requiring formal educational qualifications (20% of employers);

[20] The following conventions are used in tables throughout the report: less than 0.5 per cent (*), no observations (0), and results based on fewer than 50 observations, which should be interpreted as indicative rather than statistically robust ([x]).

[21] Please refer to the Technical Report for a more detailed explanation of how these groups were calculated.

- Predominantly professional and managerial occupations – 'managers' include directors and managers of internal departments or sections, and 'professional occupations' usually require a degree-level qualification (16% of employers); and
- Mixed workforce; a balance of the above three categories (37% of employers).

Figure 2.1: Employee skill level by employer size



Base (unweighted): All employers included in the analysis (2,445), small employers (1,427), medium employers (562), large employers (456). The analysis excluded employers who could not give complete information on the skill level of their workforce.

A **mixed** workforce was more common amongst large organisations (58%), and in Construction (45%) and Financial, Professional and Administrative Services (44%).

Employers with predominantly **technicians and skilled trades** were in Manufacturing (41%), Public Administration, Education and Health (40%) and Construction (39%).

Semi- and unskilled occupations were more common in medium-sized organisations (37%), and among employers in Agriculture and Energy (27%); and Distribution, Hotels and Restaurants (37%).

Lastly, having a high proportion of **professional or managerial occupations** was more common amongst small employers (17%), which is to be expected as all organisations usually require at least one staff member at this level. These occupations were also more common than average in Financial, Professional and Administrative Services (27%), and Transport and Communications (20%), as small employers were well represented in both of these sectors.

The qualitative interviews indicated that employee skill was important when looking at health and wellbeing provision, because employers treated employees differently according to their perceived 'value' to the business, irrespective of the policies they had in place – that is they would tailor their policies to retain employees that were

valuable to the organisation. This applies to a range of provisions, for instance access to employee health and well-being provisions and employee perks and benefits. Value was assessed subjectively based on:

- the skills of the employee and the ease of sourcing similar skills;
- length of service or loyalty to the organisation; or
- dedication to their work.

2.5 Report structure

The remainder of this report is divided into seven further chapters combining the relevant evidence from the survey and qualitative interviews:

- Chapter 3: Understanding employer behaviour – exploring employers' main health concerns amongst their employees; employer attitudes and motivations towards health and wellbeing in the workplace; employers' understanding of their legal responsibilities; and where employers go for more information or advice to support disabled employees or employees with long-term health conditions.
- Chapter 4: Employer behaviours in relation to health and wellbeing – looking at the measures employers put in place to prevent ill-health and enhance wellbeing in their workforce; and organisational approaches to health and wellbeing.
- Chapter 5: Employer behaviours in managing sickness absence – covering employers' experience of sickness absence; the costs and risks associated with long-term sickness absence; and the policies, procedures and practical steps employers use for managing sickness absence.
- Chapter 6: Supporting retention and return to work – exploring the measures used to help retention and reintegration; the use of workplace adjustments and how employers manage a return to work following long-term sickness absence.
- Chapter 7: Sick pay provision – detailing the types of sick pay employers offer; which employers do not offer sick pay and why; which employers pay more than statutory sick pay and why; the ways in which employers provide sick pay provision for different employees; and details about the lengths and rates of occupational sick pay.
- Chapter 8: Employers' provision of occupational health services – looking into employers' provision of occupational health (OH); the reasons why some employers don't provide OH; why and how employers use OH services; and the types of OH contracts employers use and their payment structures.
- Chapter 9: Segmenting the employer population – exploring how specific employer behaviours around employee health and wellbeing group together.

3. Understanding employer behaviour

This chapter explores the health concerns that employers most commonly reported amongst their staff, and their attitudes and motivations to invest in employees' health and wellbeing. It also looks at employers' understanding of their legal responsibilities and use of information and advice, to provide context for interpreting the findings in later chapters.

Key findings

Employer attitudes towards health and wellbeing were generally positive, with the majority acknowledging a link between work and the health and wellbeing of their employees. The health conditions that employers reported amongst staff generally reflected their working environment.

- The majority of employers agreed that there was a link between work and employee health and wellbeing (91%) and that it was an employer's responsibility to encourage employees to be healthy (90%).
- Concerns about musculoskeletal conditions and workplace injuries were more common in mainly manual or hazardous working environments, whereas predominantly office-based employers were more likely to report stress as the main health concern amongst staff.
- When deciding whether or not to invest in employee health and wellbeing, employers cited maintaining the organisation's reputation (79%) and satisfying legal obligations (69%) as the most important motivations.
- Employers felt that they knew what to do to improve employee health and wellbeing (83%) and that they understood their legal responsibilities in this space (45% said they understood 'very well' and 48% 'fairly well').
- Employers who had no employees with disabilities or health conditions had mixed interpretations of the meaning of the Equality Act 2010, and the duty to provide reasonable adjustments. At a basic level, they understood that the Act was designed to ensure that all employees were treated equally.
- In large organisations, dedicated Human Resource (HR) teams planned and implemented policies and processes on sickness absence and employee health. Small organisations lacked dedicated support to develop policies in advance, but sometimes used HR consultants to advise on complex areas.
- Employers mostly used the internet for information on retaining staff with long-term health conditions (47%). This was more commonly used by small (47%) than large employers (25%). A greater proportion of large than small employers accessed formal, paid-for sources of advice, such as an occupational health provider (49% and 7% respectively), or legal sources (31% and 9% respectively).

3.1 Health concerns and the prevalence affecting staff

Over half of employers (53%) said they encountered health concerns that affected their staff, ranging from 52% of small employers to 66% of medium-sized employers and 88% of large employers. Correspondingly, small employers were more likely than larger ones to report that they did *not* have any health concerns (Table 3.1).

Health concerns were more common among employers in Public Administration, Health and Education (68% expressed health concerns compared to 53% overall). In contrast, 53% of employers in Distribution, Hotels and Restaurants expressed no health concerns compared to 45% overall.[22]

The three most commonly reported health conditions, irrespective of organisation size, were musculoskeletal conditions, repetitive strains or injuries (19%); stress (18%); and anxiety, depression or other common mental ill-health conditions (11%).[23]

Employers in the follow-up qualitative research observed that disclosures of mental ill-health had been increasing amongst their employees in recent years. Chiming with other employer research conducted in this area,[24] employers attributed this increase to greater social acceptance and lessening of stigma attached to mental ill-health.

> *'We've certainly seen incidents of mental health increasing significantly over the years. I think I read somewhere that it affects one in three people, or something. I'm not sure it's possible to prevent mental health issues, but we do a risk assessment when we take on someone new, which covers all aspects of their health, and if we identify a mental health issue, we've got guidelines on how to support them, and we can draw on our OH provider, too.'*
>
> (Medium, Distribution, Hotels and Restaurants)

Employers most commonly reported being affected by a single health condition only: 41% compared with 12% who cited more than one. Large employers were more likely to cite multiple health conditions than smaller ones due to their greater size and workforce diversity (Table 3.1).

[22] A full table of statistics can be found in Table 11.3 in the Appendix.

[23] This is broadly in line with ONS statistics. Please see: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/articles/sicknessabsenceinthelabourmarket/2018#what-are-the-reasons-for-sickness-absence

[24] Ipsos MORI (2019) Employers' motivations and practices: A study of the use of occupational health services, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/789894/employers-motivations-and-practices-a-study-of-the-use-of-occupational-health-services.pdf

Table 3.1: Types of health concerns affecting the most number of staff, by size of organisation (multicode)

		Size of Employer		
	*** Total**	**Small**	**Medium**	**Large**
Musculoskeletal conditions, repetitive strains or injuries	19%	18%	24%	46%
Stress	18%	18%	22%	40%
Anxiety, Depression or other common mental ill-health conditions	11%	10%	21%	49%
Physical injuries caused by workplace incident	7%	7%	6%	7%
Other[25]	15%	15%	17%	13%
None	45%	47%	32%	9%
Don't know	2%	2%	3%	3%
Additional analysis				
1 heath concern	*41%*	*40%*	50%	49%
2 health concerns	8%	7%	10%	21%
3+ health concerns	4%	4%	6%	19%
Base	*2,564*	*1,457*	*584*	*523*

Base: All respondents (unweighted)

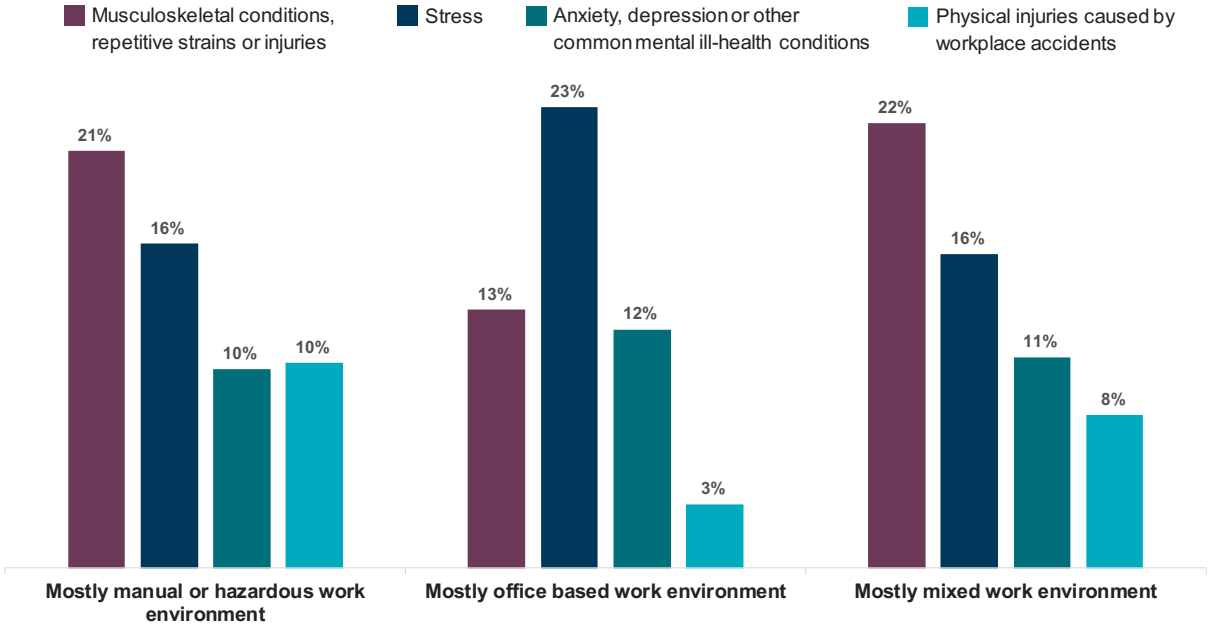
** Employers could select more than one response, therefore column percentages do not add to 100%*

Types of health concerns by nature of work

The health concerns reported by employers reflected the nature of their work (Figure 3.1). Organisations that performed mainly manual or hazardous work such as those in Agriculture and Energy, Manufacturing, and Construction reported higher instances of musculoskeletal conditions and workplace injuries compared to predominantly office-based organisations such as those in Information and Communications, and Financial and Insurance Activities. Office-based organisations were more likely to report stress among their workforce, whilst anxiety, depression or other common mental ill health conditions were most common in Public Administration, Education and Health (24% compared to 11% overall).

[25] 'Other' includes health concerns whose total mentions amounted to less than 6% and have been combined into one category for presentational purposes.

Figure 3.1: Types of health concerns by nature of work



Base (unweighted): Employers in a mostly manual or hazardous environment (1,111), employers in a mostly office-based environment (793), employers in a mixed environment (660).[26]

Prevalence of long-term sickness absence and requests for support

There is no official definition of what constitutes a long-term sickness absence (LTSA), but a period of four weeks has been commonly used.[27] As part of this survey, employers were asked whether they had experienced sickness absences lasting four or more weeks in the last 12 months (see Chapter 5 for more detail).

As with health concerns, (Table 3.2 below) large employers reported a greater prevalence of LTSA (86%) than small employers (15%).[28] Subsequently, whilst almost one in five (18%) employers overall indicated they had received requests to provide

[26] These categories were derived for analytical purposes post-survey, and do not reflect how individual employers defined the nature of their working environment:

- **Mostly manual or hazardous work environment** – Agriculture, Forestry and Fishing; Mining and Quarrying; Utilities, Waste Management and Remediation Activities.; Manufacturing; Construction; Accommodation and Food Service Activities; Human Health and Social Work Activities.
- **Mostly office-based work environment** – Information and Communications; Financial and Insurance Activities; Real Estate Activities; Professional, Scientific and Technical Activities; Administrative and Support Services; Public Administration, Defence and Compulsory Social Security.
- **Mixed work environments** – Wholesale and Retail Trade; Repair of Motor Vehicles and Motorcycles; Transportation and Storage; Education; Arts, Entertainment and Recreation; and Other Service Activities.

[27] Black, C. and Frost, D. 'Health at work – an independent review of sickness absence', 2011, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/181060/health-at-work.pdf

[28] Explored further in Section 4.1.

support for an employee's health condition or disability, more large employers had received requests for support (79%) than medium or small employers (40% and 16% respectively).[29]

Table 3.2: Factors explaining variations in employers' approaches to employee health and wellbeing (multicode)

	Size of Employer		
	*** Small**	**Medium**	**Large**
Expressed health concerns for staff	52%	66%	88%
Have employees with a disability or long-term health condition	27%	75%	96%
Experienced LTSA in the last 12 months	15%	54%	86%
Received request for support from employees to accommodate their health condition or disability in the last 12 months	16%	40%	79%
Base	*1,457*	*584*	*523*

Base: All respondents (unweighted)

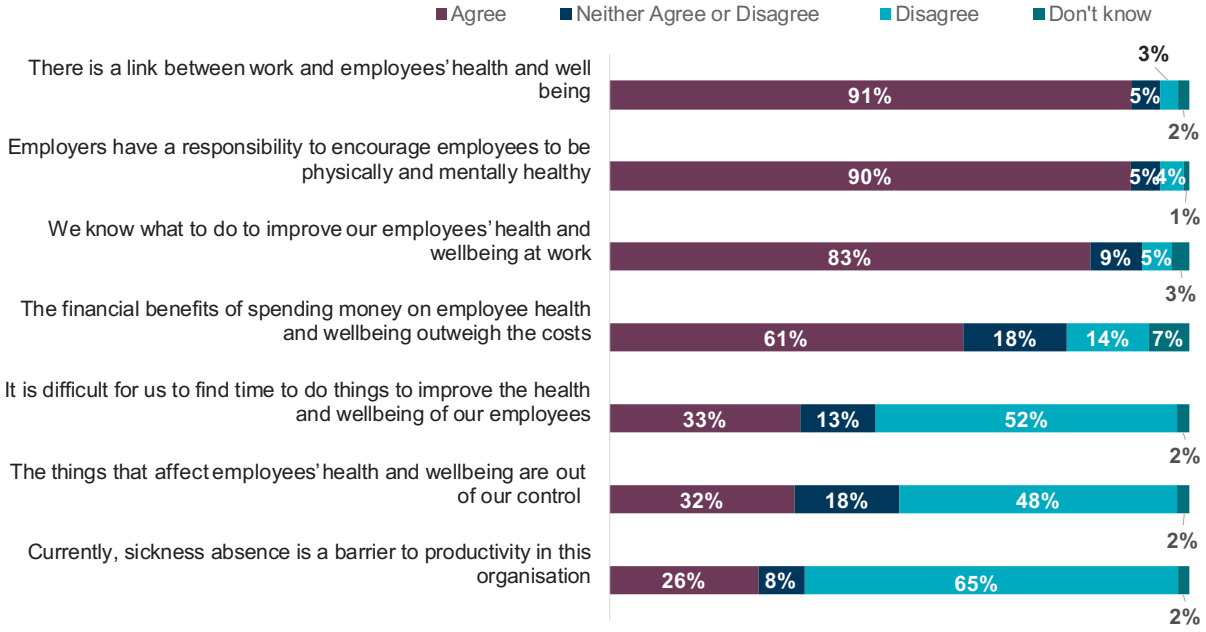
** Employers could select more than one response, therefore column percentages do not add to 100%*

3.2 Employer attitudes, motivations and spending priorities

The overwhelming majority of employers recognised their role in supporting employee health and wellbeing, with nine in ten acknowledging the link between work and health and wellbeing (91%), and recognising they had a responsibility to encourage their employees to be healthy (90%) (Figure 3.2). The large majority of employers (83%) also reported knowing what to do to improve employees' health and wellbeing. The fact that employers answered similarly across these measures suggests that employers' decisions to offer health and wellbeing provisions were ultimately not influenced by their attitudes or self-declared knowledge.

[29] See Chapter 5 for more detail.

Figure 3.2: Employer attitudes relating to employee health and wellbeing



Base (unweighted): All employers (2,564)

Employers' views were more varied on whether the financial benefits of spending money on employee health and wellbeing outweighed the costs, with a greater proportion of large employers recognising positive net benefits than small employers (77% vs. 61%).[30] There were also some variations in views by sector: around two-thirds of employers in Public Administration, Education and Health (65%); Financial, Professional and Administrative Services (66%); and Transport and Communications (64%) believed in the benefits of investing in employee health and wellbeing compared to half of employers in Distribution, Hotels and Restaurants (52%).[31]

A third of employers also reported that the things that affect employees' health and wellbeing were outside their control (32%), and a similar proportion reported that they lacked the time to do things to improve the health and wellbeing of their employees (33%). Both barriers were reported by a greater proportion of smaller employers than medium or large ones.

A quarter of employers (26%) agreed that sickness absence was currently a barrier to productivity in their organisation. This problem was more common for large employers (33%), and employers in Manufacturing (39%) and Construction (30%).

Employer motivations to invest in health and wellbeing

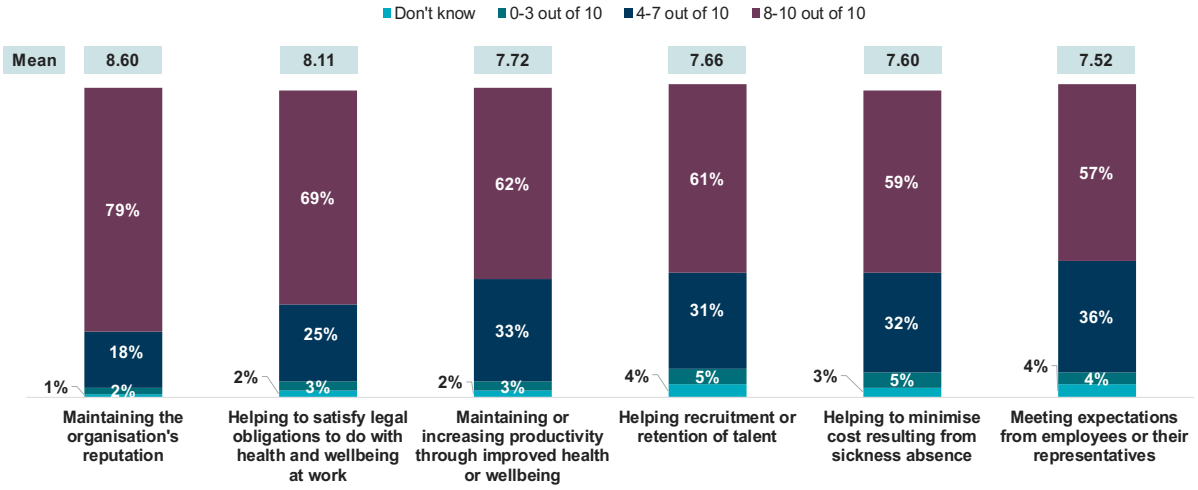
Employers invested in employee health and wellbeing to meet a range of organisational objectives. When asked to rate the importance of these factors, maintaining the organisation's reputation was the most important factor, with employers giving this a mean score of 8.60 out of 10, followed closely by helping to satisfy legal obligations to do with health and wellbeing at work (a mean score of 8.11). Other considerations, such as maintaining or increasing productivity, helping recruitment or retention, helping to minimise cost, and meeting expectations from

[30] A full table of statistics can be found in Table 11.4 in the Appendix.

[31] A full table of statistics can be found in Table 11.5 in the Appendix.

employees or their representatives, were less important, though not substantially so (the difference in mean scores were modest). There was no difference in employers' objectives by size or sector with the exception of Construction employers being more focused on minimising cost resulting from sickness absence. Employers in Construction were especially sensitive to costs as they generally only wanted their employees to return to work when they were certified as fit to complete their job role fully, due to the physical and hazardous nature of many of the tasks workers were required to perform.[32]

Figure 3.3: Factors influencing investment in health and wellbeing



Base (unweighted): All employers (2,564).

The follow-up qualitative research with employers showed that employers invested in health and wellbeing because they felt it was the 'right thing to do' for *both* their employees and for their organisation. These employers made links between investment in employee health and wellbeing and other key business objectives such as increased employer commitments and productivity, and reducing potential costs from sickness absence and recruitment difficulties. The importance that employers attached to these objectives explain why there are only modest differences between the mean scores in Figure 3.3.

For example, employers requiring more specialist skills and those that were unable to offer competitive salaries used their health and wellbeing offer to help retain and attract staff as this was considered more cost-effective (and appealing to employees) than an equivalent increase in salary.

> *'A few years ago we had a problem with staff retention, and we had a certain amount of money to try and improve it. Do we give them an extra 50p an hour – which I thought was kind of pointless – or a private healthcare package which would be something I thought might entice people to hang on.'*
>
> (Large, Distribution, Hotels and Restaurants)

Employers also cited examples of investing in health and wellbeing to reduce sickness absence, increase employee loyalty and commitment, and ultimately deliver increased productivity.

[32] See Chapter 6 (when employers felt employees should return to work).

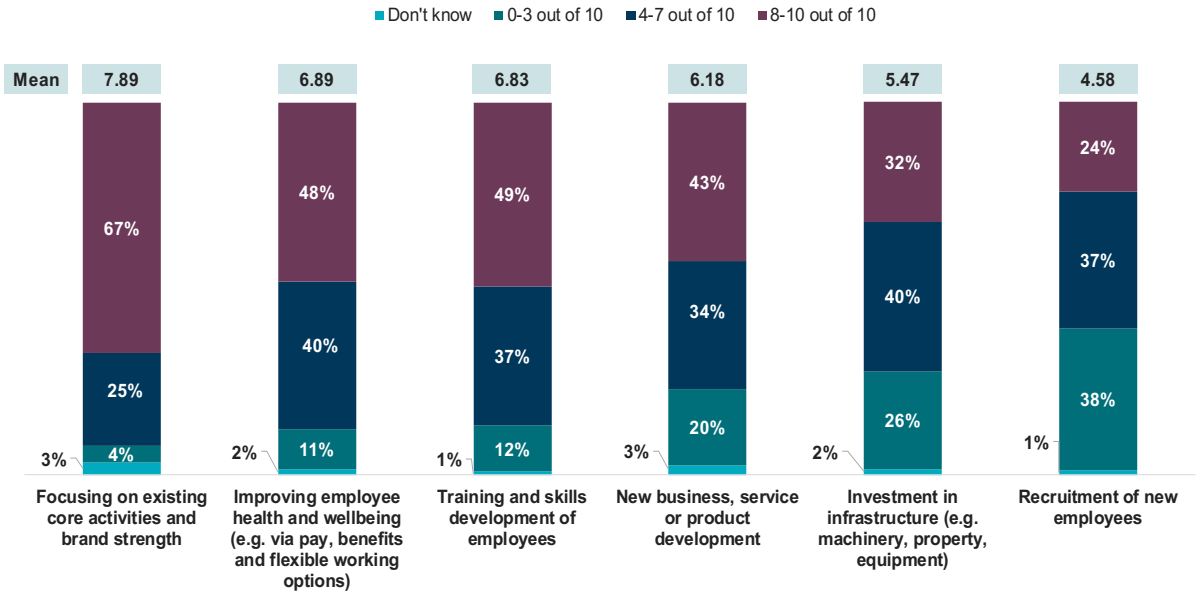
> *'Somebody who is fit, healthy, and wants to be at work actually makes me more money. Part of it is social, but ultimately, it's a good business decision. I'm good to my employees so that they'll be good to me.'*
>
> (Medium, Construction)

Improving employee health and wellbeing as a spending priority

Employers were asked to rate the importance they attached to a range of spending priorities (Figure 3.4). Employers attached great importance to improving employee health and wellbeing (second only to focusing on their existing core activities and brand strength) – mean scores of 6.89 and 7.89 respectively out of 10, where 10 was most important).

Other areas of slightly less importance were training and skills development, and new business, service or product development (mean scores of 6.83 and 6.18 out of 10 respectively). Areas considered to be substantially less of a priority included investment in infrastructure and recruitment of new employees (5.47 and 4.58 respectively).

Figure 3.4: Employers' spending or investment priorities



Base (unweighted): All employers (2,564) except *'Focusing on existing core activities and brand strength' which was only asked of those mainly seeking to make a profit (2,445)*

There were subtle differences in employers' spending priorities by size, though focusing on existing core activities and brand strength was employers' top priority. Improving employee health and wellbeing was the second highest priority for small and large employers but was less of a priority for medium employers (behind recruitment and new service or product development). Recruitment of new staff was also more of a priority for large than small employers. Training and skills development

were relatively high priorities for employers of all sizes (second or third in ranking), whilst investment in infrastructure was a relatively low priority for all employers (fifth and sixth in ranking).[33]

Overall, large employers tended to have a greater number of spending priorities compared to smaller ones and they tended to view many of them as equally important. There were limited differences by sector: employers in Public Administration, Education and Health attached greater importance to training and skills development than other employers, whilst employers in Manufacturing; and Transport and Communications placed greater importance on new business, service or product development than other employers.[34]

3.3 Meeting legal responsibilities

In the area of health and disability, employers face a set of legal responsibilities including their responsibility regarding employee health and safety, and the need to provide reasonable adjustments under the Equality Act (2010).

Health and Safety Responsibilities

All employers have a common-law duty of care to their employees. In addition, under the Health and Safety at Work Act (1974), every employer has a duty to ensure that, so far as is reasonably practicable, the health, safety and welfare of employees are protected. They must conduct a risk assessment to identify the measures necessary to comply with the Act and other regulations.

All employers with five or more employees must have a written health and safety policy, which must be brought to the notice of all employees.

Some sectors have additional, specific risk-based regulations they must adhere to, beyond the Health and Safety at Work Act. These include workplaces who handle asbestos, lead, construction and chemicals.

What is the Equality Act?

The Equality Act (2010) is a UK law that legally protects people from discrimination in the workplace and in wider society. It replaced previous anti-discrimination laws with a single Act and sets out the different ways in which it is unlawful to treat someone, based on the following protected characteristics:

- Age;
- Gender reassignment;
- Being married or in a civil partnership;
- Being pregnant or on maternity leave;
- Disability;
- Race (including colour, nationality, ethnic or national origin);
- Religion or belief;
- Sex; and
- Sexual orientation.

The overwhelming majority of employers (93%) reported that they understood well their legal responsibilities in relation to health and safety, disability and sick leave, but small employers were less likely than large and medium-sized employers to say

[33] A full table of statistics can be found in Table 11.6 in the Appendix.

[34] A full table of statistics can be found in Table 11.7 in the Appendix.

that they understood their responsibilities very well (43% compared to 66% and 77% respectively).[35] Two in three (67%) found it easy to meet these legal responsibilities; 11% found it difficult. More employers in Construction; Manufacturing; and Distribution, Hotels and Restaurants found meeting their legal responsibilities difficult (19%, 14% and 12% respectively), compared to employers in Financial, Professional and Administrative Services (6%).[36]

Figure 3.5: Employers' understanding and ability to meet their legal responsibilities

Base (unweighted): All employers (2,564)

Employers' understanding of the Equality Act 2010

The Equality Act, specifically in relation to the duty to make reasonable adjustments, is particularly important for disabled employees. Employers in the qualitative interviews were asked what they thought the Equality Act (EA2010) included, what they thought their responsibilities were as an employer, and what the Act meant for them in practice, focusing on their responsibilities towards disabled employees or employees with long-term health problems.

Overall, those who employed disabled staff or staff with health conditions, or those who had legal backgrounds (e.g. HR professionals) were more familiar with the detail of the Act, and could more clearly articulate what their responsibilities were, and what measures they had put in place for their employees. These employers explained that the Act required them to ensure their workplace was accessible, spanning recruitment and employment, and to ensure employees with protected characteristics had the support they needed to carry out their duties (see Chapter 6 for more detail).

[35] A full table of statistics can be found in Table 11.8 in the Appendix.

[36] A full table of statistics can be found in Table 11.9 in the Appendix.

Case study: Making adjustments for disabled staff

One small family-run agricultural business employed two people with autism and explained that they had a responsibility as an employer to make their working environment safe and accessible. They ensured their staff members had the support they needed to manage their work and their condition, including allowing them space for time-out during busier periods, and trusting them to return when they felt ready.

Employers without this experience had mixed interpretations on the meaning of the Act. At a basic level, employers felt the Act was designed to ensure all employees were treated equally, without discrimination, typically referring to age, sex, race, and disability.

> *'I employ young people, old people, females, males. I've never employed anyone from an ethnic minority background, but that's because the town is predominantly white and no-one has ever asked me for a job. I like to think I'm a fair-minded person and a fair-minded employer.'*
>
> (Small, Distribution, Hotels and Restaurants)

Beyond this, other employers expressed concerns around hiring disabled staff or staff with long-term health conditions. These concerns centred around employers feeling they would not have the skills or expertise to properly support someone with a disability or long-term health condition at work or feeling that someone with a disability or health-condition would not be suited to their working environment. As shown in the two examples below, underlying both concerns were attitudinal barriers and a sense that employers would be taking on an unnecessary level of risk by hiring someone with a disability or long-term health condition.[37, 38]

> *'I wouldn't take on someone with depression. They're going to be working at heights, working on machinery, driving machines… Also if they've got depression that means they're going to have random time off from work… Also, they're dealing with the public every day and they've got my name on the side of the lorry.'*
>
> (Small, Construction)

> *'I wouldn't take on somebody who looked unfit. If they became unfit while they were with us, then I would probably suggest that the job was no longer suitable for them. It's a straightforward situation of either you can do the job, or you can't. We've had one or two people who apply who are mentally a little bit, is the word 'challenged'? I'm not sure. You know, they struggle a bit mentally and definitely physically as well, and it's just not possible for us … If that person isn't able to*

[37] We see similar concerns from employers when facilitating an employee's return to work following sickness absence, particularly where adjustments are recommended. See Chapter 4, for more detail.

[38] The Department for Work and Pensions (DWP) launched the Disability Confident scheme in November 2016. The scheme aims to give employers the techniques, skills and confidence they need to recruit, retain and develop disabled people and people with long-term health conditions. For more information, please see: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/755667/disability-confident-scheme-summary-findings-from-a-survey-of-participating-employers.pdf

do the job in time, then there's no space for another person to come in and help out, so it's not even a monetary thing, it's all about the safety and wellbeing of my customers. We just can't take the risk.'

(Small, Distribution, Hotels and Restaurants)

3.4 Seeking information and advice

Employers used a range of sources for information and advice on how to support disabled employees and employees with health conditions. Employers most commonly used internet searches (47%), followed by professional or personal contacts (26%). Small employers primarily drew on free advice and were most likely to use the internet. Meanwhile, large employers were more likely than small employers to use expert-led paid-for-advice, such as an occupational health provider, or legal sources. Overall the majority of employers (77%) used only one source.

Table 3.3: Sources of information on how to retain an employee with a long-term health condition (multicode)

		Size of Employer		
	*** Total**	**Small**	**Medium**	**Large**
Internet search (e.g. government or ACAS website, Occupational Health specialists)	47%	47%	40%	25%
Professional/ Personal networks or contacts (e.g. Trade body)	26%	27%	22%	20%
Legal sources	10%	9%	18%	31%
Occupational Health/Professional Health provider	9%	7%	25%	49%
HR Team	6%	5%	9%	20%
Don't know	12%	13%	10%	7%
Base	*2,564*	*1,457*	*584*	*523*

Base: All employers (unweighted). Only responses cited by at least 5% are shown

** Employers could select more than one response, therefore column percentages do not add to 100%*

Use of expert advice, such as an occupational health or professional health provider, increased with the size of organisation in line with greater availability of OH and an increase in prevalence of permanent OH contracts (see Chapter 8): 7% of small employers; 25% of medium and 49% of large. Use was higher in Public Administration, Education and Health (20%) compared to other sectors.[39] As would be expected, employers with OH provisions were more likely to approach occupational health or professional health providers (21%) for information or advice than those without (6%).

Employers in the follow-up qualitative research provided some examples of the freely available and trusted sources they used:

- Newsletters or online resources from professional bodies including the Chartered Institute of Personnel and Development (CIPD) or the Federation of Small Businesses (FSB);

[39] A full table of statistics can be found in Table 11.10 in the Appendix.

- Searching for practical advice to manage health conditions from the NHS website (to give employers a better understanding of their employees' conditions);
- Articles shared by their peers or competitors on LinkedIn; and
- Using 'Mind' for support on managing employees reporting mental ill-health.

Employers in the follow-up qualitative research who had experience of managing employees with more complex health conditions also expressed a desire for more information from GPs or other healthcare professionals to support them to manage these employees' conditions in work. Employers wanted more information about:

- The nature of the condition and the impact it had on their work, and specific examples of the types of activities they could and could not do;
- More information about how they could amend their role of duties to support them to remain in-work with their condition; and
- Where the condition was undiagnosed, an indication of how long they might have to wait to run further tests, to help employers to plan for their sickness absence (in terms of covering work).

These employers were referring specifically to advice contained in fit notes issued by either a GP or hospital doctor when an individual's health condition impacted on their fitness for work. This finding is supported by recent research conducted by Ipsos MORI on employers', employees' and healthcare professionals' experiences of the fit note.[40]

Employers with more experience managing employees with long-term health conditions were confident in their ability to manage these employees successfully, either with their own internal resources, or drawing upon external expertise, advice or guidance. Amongst employers with less experience, or those handling what they felt were more straightforward cases, employers were satisfied with the level of free support available, such as the employees' GPs, and guidance from the NHS and other organisations. One small employer suggested that it would be helpful if DWP could keep businesses up to date about changes in policy affecting employers directly, via email.

Using Human Resource functions

Large employers had dedicated Human Resource (HR) functions with the knowledge and resources (time and money) to put in place policies and provisions to address a range of people issues, including: improving health and wellbeing, reducing sickness absence, and avoiding recruitment and retention difficulties.

In contrast, in smaller organisations without a dedicated HR function, people issues were often the responsibility of the business owner or another employee such as the office manager or company secretary. These employees had additional responsibilities such as ensuring the smooth day-to-day running of the organisation, meaning they did not always have the time, knowledge or dedicated budget of a HR department to plan and implement a proactive approach to employee health and wellbeing.

[40] Ipsos MORI (2019) Exploring perceptions and attitudes towards the extension of fit note certification, available at: https://www.gov.uk/government/publications/exploring-perceptions-and-attitudes-towards-the-extension-of-fit-note-certification

Some small organisations had sought to address these constraints by using external HR consultants for support with recruitment, payroll and employee health and wellbeing. An important motivation for these employers was ensuring that they were compliant with new legislation or requirements.

> *'*[The office manager] *has a full-time job handling payroll and the office and everything else, so we can't be learning about these things all the time. The government are bringing out new things all the time, and without this company* [HR consultant]*, we might make mistakes. They take care of everything.'*
>
> (Medium, Distribution, Hotels and Restaurants)

4. Employer behaviours in relation to health and wellbeing

This chapter covers the measures employers took to improve the health and wellbeing of their workforce. It also looks at the links between health and wellbeing provisions and other perks and benefits that employers provided (such as enhanced annual leave, maternity/paternity pay, pensions contributions, occupational health and sick pay).

Key findings

Organisation size had a direct bearing on health and wellbeing provision. Larger employers were more likely to provide a wider range of formal support to help prevent employee ill-health or improve general health and wellbeing. Small employers who did not provide these measures described taking a more informal approach, which they viewed as more appropriate and cost-effective for their size and culture. These employers reported insufficient demand from employees to justify the investment in formal and preventative schemes.

- To prevent employee ill-health, over three quarters (77%) of employers invested in health and safety training or guidance; for a third (32%) this was all they provided. One in six (16%) did not provide anything, nearly all were small employers.
- Larger employers provided a greater range of formal support than small employers. This included health and wellbeing promotion programmes to improve physical activity or lifestyle (70% of large compared to 20% of small employers) and Employee Assistance Programmes (EAPs) or welfare/ counselling programmes (76% of large compared to 14% of small employers).
- Employers who offered comprehensive health and wellbeing provisions also offered occupational health services, generous sick pay and other employee benefits and perks.
- More than half of employers (55%) described their approach to managing employee health and wellbeing as reactive. A proactive approach was more common amongst large (72%) than small employers (44%), partly because large employers were more likely to have experienced long-term sickness absence (LTSA) than small employers (86% compared to 15% of small employers).

4.1 Measures to prevent ill-health and improve wellbeing

All employers have a common-law duty of care to their employees. This includes carrying out risk assessments and taking steps to eliminate or control risks and informing workers fully about all potential hazards associated with any work process, chemical substance or activity, including providing instruction, training and supervision.

Beyond their health and safety duty, employers may also choose to play a role in helping employees to improve their health or prevent or mitigate non-work related health risks, such as through employer-funded interventions to prevent common health conditions becoming a problem, e.g. free health checks, or through Employee Assistance Programmes (EAPs).

Workplace health and wellbeing provisions

Half of employers (51%) reported that they provided a range of interventions ("a more comprehensive offer") to prevent employee ill-health or improve the general health and wellbeing of their workforce (Table 4.1). One in six employers (16%) reported not providing anything, nearly exclusively small employers, and a third (32%) provided health and safety training or guidance only, mainly small and medium employers. Likelihood of provision increased with employer size.

Table 4.1: Health and wellbeing provisions by organisation size (multicode)

		Size of Employer		
	* Total	Small	Medium	Large
Health and safety training or guidance	77%	76%	92%	99%
Interventions to prevent common health conditions becoming a problem[41]	29%	26%	46%	77%
Training for line managers on ways to improve employee health and wellbeing	26%	25%	42%	58%
Health and wellbeing promotion programmes to improve employees' physical activity or lifestyle[42]	23%	20%	40%	70%
An Employee Assistance Programme (EAP), or staff welfare/counselling programme provided by an external organisation	16%	14%	39%	76%
Activities to encourage supportive culture[43]	2%	2%	3%	*
Other	1%	1%	1%	*
We don't currently provide anything	16%	17%	1%	*

[41] For example: free health checks, free vaccinations, smoking or weight loss support.

[42] For example: health food choices, health advice or events, dedicated health and wellbeing section on the intranet, loans or discounts on bicycles, free or subsidised gym membership.

[43] For example: staff meetings, team bonding and social events.

	Size of Employer			
	* Total	Small	Medium	Large
Don't know[44]	*	*	*	*
Additional analysis				
Only provide health and safety training or guidance	32%	33%	23%	4%
Provide more comprehensive offer[45]	*51%*	*49%*	*75%*	*95%*
Base	*2,564*	*1,457*	*584*	*523*

Base: All employers (unweighted)

** Employers could select more than one response, therefore column percentages do not add to 100%*

The most common preventative measure was health and safety training or guidance (provided by 77% of employers). This was provided by the vast majority of medium and large employers (92% and 99% respectively), and by three in four small employers (76%). Small employers were more likely than larger ones to make this provision only (33% compared to 23% of medium and 4% of large employers), as were employers operating in hazardous or manual working environments who had a legal requirement to provide health and safety training. For example, 47% of employers in Agriculture and Energy and 42% of employers in Manufacturing provided health and safety training or guidance only compared with 32% of all employers.[46]

In contrast, medium and large employers were more likely to provide preventative measures such as free health checks, free vaccinations, smoking or weight loss support, Employee Assistance Programmes (EAPs) and health and wellbeing promotion programmes. Large employers were four times more likely than small employers to provide EAPs.

The standard practice among large employers was to have in place a range of measures to prevent employee ill-health or to improve the health and wellbeing of their workforce: 82% provided at least three measures compared with 49% of medium employers and 22% of small employers.

Among employers providing more than one, the most common combinations were health and safety training with interventions to prevent common health problems becoming a concern (e.g. free health checks, free vaccinations, smoking or weight loss support) and/or line manager training.

[44] The following conventions are used in tables throughout the report: less than 0.5 per cent (*) and no observations (0).

[45] Includes employers who offered some or all of the following measures: Health and safety training or guidance, health and wellbeing promotion programmes, interventions to prevent common health conditions from becoming a problem, and/or EAPs.

[46] A full table of statistics can be found in Table 11.11 in the Appendix.

Linking health concerns and provision

Employers who reported health concerns (see Chapter 3) provided more comprehensive support than those without any health concerns: 49% of employers with health concerns provided at least two types of support, compared with 43% of employers with no health concerns. These findings indicate that there are other factors besides health concerns that influence employers' decisions on what health and wellbeing support to offer to employees.

More extensive provisions were offered by medium and large employers (Table 4.1), especially in Public Administration, Education and Health where employee representative groups/trade unions were more common. There are a number of possible reasons for why these larger employers provided more extensive provisions than smaller ones:

- First, as highlighted in Chapter 3, larger employers had greater resources and the know-how, often in the form of a dedicated HR function, to respond to health concerns. HR departments are also responsible for a host of people issues such as recruitment and retention and this likely influenced their decisions to offer more extensive provisions (i.e. to meet their wider remit and objectives). For example, large employers were more likely than smaller ones to provide a generous package of benefits to their employees that include health and well-being provisions, employee perks, sick pay and occupational health (see Section 4.3).
- Second, larger employers experienced more instances of long-term sickness absence and received more requests for support from employees with health conditions or disabilities (see Chapter 5).
- Third, the repercussions from not taking appropriate action such as increased sickness absence, inability to meet deadlines and loss of productivity, are likely to be greater for large employers than smaller ones. On the other hand, any measures they put in place would benefit from greater economies of scale compared to smaller organisations.

The qualitative follow-up interviews provided insight into why small employers were less likely to offer formal health and wellbeing support to employees as standard. The primary reason was proportionality: it was not deemed financially viable or cost-effective to formalise provisions when demand for services was likely to be low. Employers in very small, tightly-knit organisations also expressed a preference for using more informal approaches; for example, informally checking in on the wellbeing of their employees rather than instigating formal procedures (such as meetings with HR representatives). Employers in these organisations described themselves as being friends as well as colleagues.

> *'Everyone keeps an eye on each other, and if we see that someone doesn't look themselves, we'd ask them if they were all right and, if they weren't, tell them to go home. We're all in a WhatsApp group and we see each other every day, so it's easy to keep in touch with people if they're off and see how they're doing.'*
>
> (Small, Distribution, Hotels and Restaurants)

'The conversation is basically to see if there's anything I can do to help her, as an employer. And whilst it's me with my 'employer hat' on, the conversation is more like two friends, to be honest. It's not that formal.'

(Small, Distribution, Hotels and Restaurants)

Variation in provision, within size bands

Employers who did nothing to improve their employees' health and wellbeing were virtually all small in size. Focusing specifically on small employers, the data shows that there were many factors that could explain why some small employers made provisions whilst others did not.

Table 4.2: Key differences between different small employers

Small employers who did not provide anything or provided health and safety training or guidance only were…	
Firmographics 	• More likely to be micro in size • More likely to be operating in Financial, Professional and Administrative Services.
Workforce composition 	• More likely to employ part-time employees. • Less likely to have disabled employees who may require or request support or adjustments. • Less likely to have a workforce that is predominantly technicians and skilled trades, and therefore less likely to encounter recruitment difficulties. • Less likely to report difficulties recruiting and retaining staff, hence less impetus to offer staff support.
Attitudes 	• Less positive about their role in supporting employee health and wellbeing.
Demand for support 	• Less likely to have received requests from employees for support to accommodate their health condition and disability. • Less likely to have experienced instances of long-term sickness absence of four weeks or more.
Provision of other benefits and perks 	• Less likely to offer any sick pay.[47] • Less likely to offer employee benefits and perks. • Less likely to offer Occupational Health and more likely to cite "Too few cases to justify it" as the main barrier for not providing it due to their small workforce.

[47] See Chapter 7.

Variation in provision explained by skills and size differences

The provision of health and safety training and guidance was common regardless of size or skills mix (77% of employers provided this regardless of their size or employee skillset). The data also showed that regardless of size, employers with a predominately semi- or unskilled workforce offered less comprehensive provision than employers with a mixed, or more skilled workforce (see Table 4.3). Employers with a semi- or unskilled workforce were more likely to use health and safety training or guidance as the sole measure to prevent employee ill-health or improve the general health and wellbeing of their workforce – 39%, compared to 32% of employers overall.

Table 4.3: Employers' provision by workforce occupation and size

	Column Percentages			
	Workforce skill mix of the employer[48]			
	Professional and managerial	**Semi- and unskilled**	**Technicians / skilled trades**	**Mixed workforce**
Amongst small employers				
Health and safety training or guidance only	25%	40%	35%	33%
Preventative action[49]	46%	42%	54%	50%
Provide nothing	28%	17%	12%	17%
Don't know	1%	1%	0	1%
Base	*208*	*304*	*439*	*476*
Amongst medium employers				
Health and safety training or guidance only	5%	30%	13%	30%
Preventative action	95%	67%	86%	69%
Provide nothing	0	2%	1%	1%
Don't know	0	*	0	0
Base	*29*[50]	*215*	*160*	*158*
Amongst large employers				
Health and safety training or guidance only	4%	17%	1%	2%
Preventative action	96%	83%	99%	98%
Provide nothing	0	0	*	0
Don't know	0	0	0	0
Base	*25*[51]	*181*	*87*	*163*
Base: All employers (unweighted)[52]				

[48] Please see Section 3.2 of the Technical Report for a full explanation of how these categories were derived.

[49] Includes employers who offered some or all of the following measures: Health and safety training or guidance, health and wellbeing promotion programmes, interventions to prevent common health conditions from becoming a problem, and/or EAPs.

[50] Small base size. Breakdown should be treated as indicative and not statistically robust.

[51] Small base size. Breakdown should be treated as indicative and not statistically robust.

[52] The following conventions are used in tables throughout the report: less than 0.5 per cent (*), no observations (0), and results based on fewer than 50 observations, which should be interpreted as indicative rather than statistically robust ([x]).

Links between health and wellbeing provisions and perks and benefits

The survey showed a positive link between health and wellbeing provisions and health-related benefits such as sick pay and occupational health.[53] As can be seen in Table 4.4, employers who offered generous benefits also offered a range of health and wellbeing measures.[54] These employers also provided more generous sick pay and offered occupational health as part of their package. This suggests that, in the main, employers treat health-related benefits as a wider package, rather than in isolation to attract and retain staff.

Table 4.4: Relationship between health and wellbeing provisions and other employee benefits or perks

	Column Percentages			
	Health and wellbeing provisions			
	None	**Health and safety training or guidance only**	**Preventative action[55]**	**Don't know**
Number of benefits[56]				
None	13%	7%	3%	20%
One benefit	29%	20%	13%	47%
Two or three benefits	51%	63%	63%	10%
Four benefits	7%	9%	21%	23%
Don't know	0	1%	*	*
Type of sick pay offered				
None	23%	13%	9%	44%
SSP only	49%	63%	50%	23%
Above SSP	20%	20%	36%	23%
Don't know	7%	5%	4%	10%
Use of OH services				
OH-user	3%	10%	33%	22%
Non-user	96%	85%	64%	77%
Don't know	2%	5%	3%	1%
Base	*214*	*612*	*1,729*	*9*[57]

Base: All employers (unweighted)

[53] The following conventions are used in tables throughout the report: less than 0.5 per cent (*), no observations (0), and results based on fewer than 50 observations, which should be interpreted as indicative rather than statistically robust.

[54] See Chapter 9 for more detail.

[55] Includes employers who offered some or all of the following measures: Health and safety training or guidance, health and wellbeing promotion programmes, interventions to prevent common health conditions from becoming a problem, and/or EAPs.

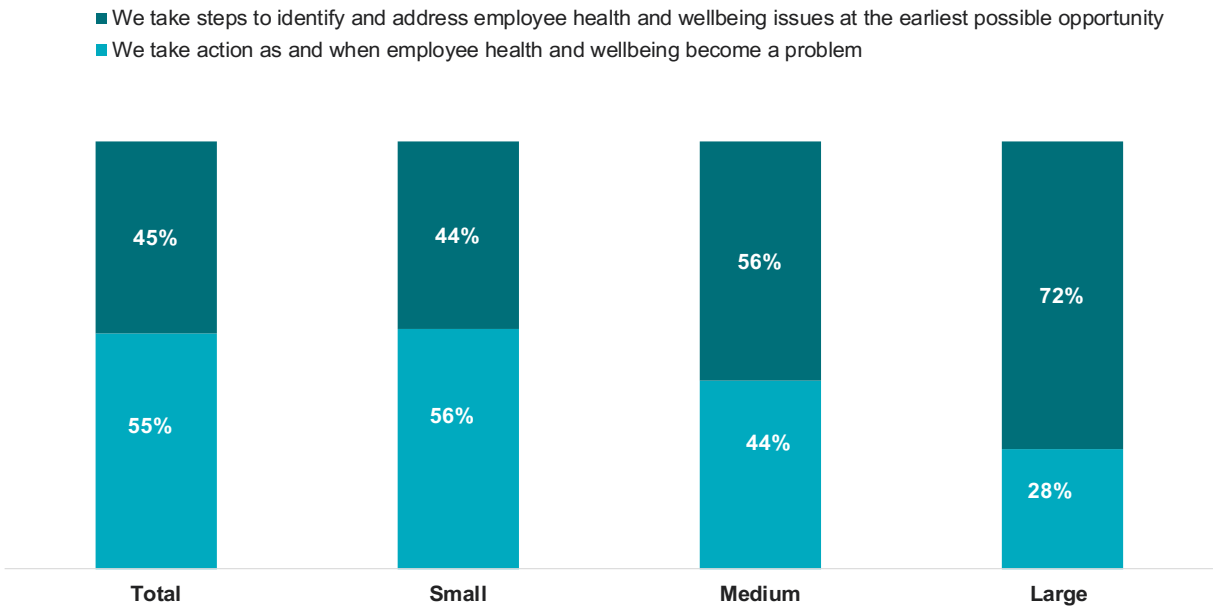
[56] Benefits include: More than 20 days paid annual leave (in addition to bank holidays); flexible working regularly used by employees; employer contribution to employee pensions (above statutory requirements); and enhanced maternity and paternity pay (above statutory levels).

[57] Small base size. Breakdown should be treated as indicative and not statistically robust.

4.2 Organisational approaches to health and wellbeing

Employers can be classified as taking a reactive or proactive approach to managing employee health and wellbeing. More than half (55%) described their approach as reactive, taking action as and when employee health and wellbeing became a problem. The remaining employers (45%) described their approach as proactive, identifying and addressing health and wellbeing issues at the earliest possible opportunity.

Figure 4.1: Approaches to managing employee health and wellbeing



Base (unweighted): All employers (2,564), small employers (1,457), medium employers (584), large employers (523)

Large employers were nearly twice as likely to state taking a proactive approach than smaller ones (Figure 4.1). This was also evident in the range of health and wellbeing support offered by large employers which was substantially more comprehensive than smaller employers (Section 4.2). Employers in Public Administration, Education and Health (56%) were the most likely to take a proactive approach, reflecting the greater number of large employers in this sector, whilst being proactive was far less commonplace in Distribution, Hotels and Restaurants (42%).[58]

This difference in approach by organisation size is likely to be the result of a number of factors such as the prevalence of health concerns, volume of long-term sickness absences (LTSA) among employees, presence of employees with a disability or long-term health condition, and incidence of employees requesting support to accommodate their health condition or disability (as detailed in Table 3.2 in Section 3.1). These factors were more commonplace in larger organisations.

In contrast, small employers in the qualitative follow-up research explained that it was not necessary or cost-effective for them to offer preventative health and wellbeing support because it was rare for them to experience LTSAs. However, among small employers who had adopted preventative measures, the trigger was when incidences

[58] A full table of statistics can be found in Table 11.12 in the Appendix.

of employee ill-health became more common within their organisation, for example, due to an increase in mental health disclosure among staff. It was at this point that these employers felt compelled to take action to minimise the detrimental impact to both their business and employees.

A number of employers in the follow-up qualitative research had experienced an increase in mental health disclosures within their organisation, which had prompted them to adopt a a more proactive stance to managing employee health and wellbeing. The act of having to react to this increase in mentail ill-health had given some employers the confidence to put in place more permanent support for their employees.

These findings illustrate the importance volume and severity of ill-health incidences in prompting employers to adopt formalised health and wellbeing support for employees.

5. Employer behaviours in managing sickness absence

This chapter explores how employers managed sickness absence, covering employer perceptions of the difference between short and long-term sickness absences, the prevalence of and risks associated with long-term sickness absence (LTSA), use of policies, and practical steps for monitoring sickness absences.

Key findings

Employers took a flexible approach to sickness absence management, recognising the importance of line manager discretion in the application of policies, whilst treating employees equally and fairly. Three in five employers (61%) adapted their policies depending on the employee.

- Employers reported that the most common business risks relating to LTSA were covering work within the organisation (57%) and arranging cover or recruiting new staff (41%). This was followed by paying sick pay (28%) and the uncertainty of when employees would return to work and planning for this (25%).
- Two in five employers (41%) had a specific policy in place to manage sickness absence (85% of large and 37% of small employers). Slightly more employers used a dedicated sickness absence management policy (29%) than a disciplinary policy (20%). Small employers used more informal approaches.
- Organisations adopted different approaches for managing sickness absence. The majority (61%) delegated responsibility to line managers, but only 44% of these employers provided their line managers with training to perform this role.
- The qualitative interviews indicated that some employers, usually large organisations, had centralised processes and structures to manage sickness absence, involving HR and occupational health (OH) specialists where needed.
- Short-term sickness absence for minor ailments typically involved minimal contact between employer and employee. In contrast, employers had more structures in place for longer absences, including agreeing mode and frequency of contact and likely recovery times early on in the process, where possible.

5.1 Experience of sickness absence

Employers' experience of long-term sickness absence (LTSA)[59] increased with size: 86% of large employers reported that they had experienced it in the last 12 months, compared to 54% of medium-sized employers and 15% of small employers. Sectors

[59] There is no official definition of LTSA. In this survey, we asked employers about absences (including recurring LTSA) lasting four or more weeks in the last 12 months.

with a high proportion of large employers reported higher than average LTSAs, such as Manufacturing (35% compared to 19% overall) and Public Administration, Education and Health (38%).[60]

Employers in the qualitative research defined long-term sickness absence in terms of *when* the absence triggered formal processes. The point at which these formal processes kicked in varied. The types of triggers that employers associated with LTSA were:

- **An impact on the way work was organised**, for example, when it was no longer feasible to cover work within the organisation and new staff (either temporary or permanent) were required;

  'If an absence went on for longer than two weeks, you might start to see tensions in terms of how work was being covered. It's easy for us to ask for help covering work with our staff … people here will roll their sleeves up and pitch in. But after two weeks, it would start to become an issue.'

  (Small, Other Services)

- **When the organisation had to instigate formal processes relating to sickness absence management**, for example if policies recommended bringing in other services such as HR or OH providers to support the main person managing the absence. This was usually specific to larger employers;

  'I'd say a short-term absence is anything up to two weeks, because our policy states that OH should be consulted for any absences longer than a fortnight.'

  (Medium, Financial, Professional and Administration Services)

- **When formal documentation was required**, usually in the form of a fit note from a GP or hospital doctor, detailing for how long the employee will be off work;

  'A short-term sickness absence would be anything less than five days, as they can self-certify during that time. Long-term would be more than five days, and we'd require them to have a doctor's note[61] *after this point.'*

  (Medium, Construction)

- **When the rate at which employers paid sick pay reduced** (in organisations where variable rates were offered). As shown in the example below, this was the point at which employees on sickness absence moved from OSP to SSP.

  'At the minute, we don't have formal policies in place, but we are looking to. I believe a long-term sickness absence is four weeks or more, and a short-term would be less than four weeks. I suppose that's because once you've been here a year, you get four weeks on full pay if you go off sick, before it drops down to SSP.'

  (Small, Manufacturing)

[60] A full table of statistics can be found in Table 11.13 in the Appendix.

[61] Employees can self-certify for a total of seven consecutive days (including non-working days). After this, some employers may require them to get a fit note from their GP or hospital doctor. Some employers refer to fit notes as 'doctor's notes'.

5.2 Costs and risks associated with LTSA

Employers who had experienced LTSA reported a range of business risks and costs associated with it. The most common ones included covering work among existing staff (57%) and arranging temporary cover or recruiting new staff (41%). For all employers, this was followed by paying sick pay (28%), and the uncertainty of when employees would return to work and planning around it (25%).

Table 5.1: The main business risks or costs associated with LTSA (multicode)

		Size of employer		
	*** All**	**Small**	**Medium**	**Large**
Covering work within the organisation (additional pressure, readjusting work processes)	57%	59%	52%	47%
Additional cost/time arranging temporary cover/ recruiting and training new staff	41%	40%	38%	53%
Having to pay sick pay	28%	30%	19%	21%
Uncertainty of return to work and planning around it (including reintegrating employees back into the business, time involved)	25%	27%	20%	19%
Impact on productivity or quality of work	21%	20%	26%	22%
Keeping job open	17%	19%	12%	12%
Low morale among rest of staff	15%	14%	16%	21%
Missing client deadlines/dissatisfied clients	12%	12%	12%	11%
Legal risk resulting from employees who do not feel they have had appropriate support	6%	6%	5%	6%
Reputational risk resulting from employees who do not feel they have had appropriate support	6%	6%	5%	5%
General impact on costs	1%	1%	1%	5%
Costs associated with OH	1%	-	*	5%
Other	*	*	*	1%
Don't know	12%	11%	11%	13%
No risks reported	2%	2%	2%	*
Additional analysis				
One risk reported	38%	37%	44%	37%
Two risks reported	18%	17%	17%	21%
Three or more risks reported	30%	32%	26%	28%
Base	*1,188*	*318*	*388*	*482*

Base: All employers with a long-term sickness absence in the last 12 months (unweighted).[62]

** Employers could select more than one response, therefore column percentages do not add to 100%*

Small employers were more sensitive to having to pay sick pay (30%) and to keeping the employee's job open (19%), whilst large employers were more likely to cite the additional cost/time of having to arrange cover (53%). These differences are reflected

[62] The following conventions are used in tables throughout the report: less than 0.5 per cent (*) and no observations (0).

within certain sectors. For example, employers in Construction (who tended to be small in size) were more likely to cite the costs of paying sick pay (46% compared to 28% of employers overall). Employers in this sector tended to want employees to return to work only once they could perform all of their role, meaning they were more likely to be at risk of paying sick pay for longer than other employers.[63]

Employers in Public Administration, Health and Education (who tended to be large) were more likely than average to report incidences of LTSA among staff and thus arranging temporary or permanent cover was the main cost for the majority of these employers (70% versus 41% of the average).[64] Over three-quarters of large employers (78%) used temporary staff to cover irregular demands for intense resources, in addition to cover for sickness absences, compared to 25% of small employers and 43% of medium-sized employers.

Employers experienced multiple risks or costs as a result of LTSAs within their workforce, irrespective of organisation size – just two per cent of employers who had experienced LTSAs reported no risks or costs as a result. However, employers in small and medium-sized organisations appeared to feel the impact of these costs more deeply than large employers because of their more finite resources. For example, small and medium-sized employers who took part in the follow-up qualitative research reported that it was often not affordable for them to bring in temporary staff to cover sickness absences. In these situations, work had to be covered within the organisation which placed strain and potential risks on existing staff members.

> *'The strain on other people is the worst, really. The rest of the team tries to rally round and pick up the slack, but they'll be working overtime. Everybody can work a bit of overtime, but if you start doing it week in and out, you burn people out, then they go off sick, and your machine breaks.'*
>
> (Medium, Distribution, Hotels and Restaurants)

Whilst large organisations had the financial resources to bring in cover for employees on LTSA, it was not always possible in practice to find cover for niche roles. Organisations of all sizes struggled to cope with LTSA where staff members with specific skillsets or established relationships with their clients were absent from work, as cover fell to employees with existing workloads and responsibilities.

5.3 Approaches, policies and procedures for managing sickness absence

Collecting sickness absence data

The majority of large and medium-sized employers (98% and 90% respectively) collected sickness absence data compared to half of small employers (54%). Among small employers, it was micro employers (with between 2-9 employees) that were the least likely to collect sickness absence data (45% of micro employers collected

[63] See Chapter 6 for more detail.

[64] A full table of statistics can be found in Table 11.14 in the Appendix.

sickness absence data, compared to 78% of employers with 10-49 employees). Again, this was because micro employers rarely experienced LTSA: eight per cent had experienced LTSA in the last 12 months, compared to 34% of employers with 10-49 employees.

Small employers in the follow-up qualitative interviews explained that it was not necessary for them to collect sickness absence data because these cases were rare and mostly short-term (lasting one or two days). They did not require data to monitor employees because more serious cases would become apparent quickly due to their small size and close proximity to one another. Additionally, they did not see the need to collect sickness absence data to track overall levels of sickness absence.

> *'We're in an open-plan office, and there's only 11 of us so it's obvious when someone is unwell. We only really have colds, or there's been the occasional bout of stress due to workload. If I don't notice, then someone else will and will tell me. I wouldn't be a very good manager if I wasn't on good terms with the staff and took the time to talk with them all individually.'*
>
> (Small, Other Services)

Policies guiding sickness absence management

Two in five employers (41%) had a specific policy in place to manage sickness absence; 58% did not (Table 5.2). Those **without** a dedicated policy were mainly small employers (62%), rather than medium or large (19% and 14% respectively), and in Agriculture and Energy (73%).

Employers in Public Administration, Education or Health were most likely to have dedicated policies (79% compared to 41% of employers overall).[65] This reflects the high proportion of public sector organisations, as well as organisations such as hospitals and schools in this sector. Other qualitative research with employers suggested that these types of organisations have detailed policies in place relating to a variety of health and safety, and health and wellbeing issues.[66]

Small employers who took part in the follow-up qualitative research explained that they used other vehicles to guide their management of sickness absence, including employment contracts and staff handbooks. These employers had no need for formal policies because instances of serious sickness absences were rare, and when they did occur, organisations dealt with them on a case-by-case basis, tailoring the support they offered to the needs of the employee. Indeed, small employers in the qualitative follow-up research expressed a strong preference for informal approaches which were more in keeping with the close personal relationships they had with their employees. In contrast, medium and large employers stressed that policies performed an important function in helping to ensure that employees were treated fairly, in line with legal requirements.

[65] A full table of statistics can be found in Table 11.15 in the Appendix.

[66] Ipsos MORI (2019) 'Employers' motivations and practices: A study of the use of occupational health services', available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/789894/employers-motivations-and-practices-a-study-of-the-use-of-occupational-health-services.pdf

Case study: Lack of need for policies in micro organisations

An online retailer had been operating for two and a half years and employed one other member of staff. The business did not have any formal policies relating to health and wellbeing, beyond what was in the employee's contract.

> *'The contract is very basic and just says, 'if you're sick for more than X days, you'll get SSP and then it will run out at this point'. I can't remember the exact details off the top of my head – I just told the accountant when she was off sick and they handled it all in the pay.'*

The employer explained that her employee had a pre-existing health condition that she was aware of when she was hired, and that affected her energy levels and mood. Whenever her employee suffered from an episode, they would discuss how long she would need off and how often they would stay in touch during the absence to make sure the employee did not feel too estranged from the workplace. The employer explained that she took an informal approach, not guided by formal policies, and was not completely certain of any legal requirements, but thought that both parties were satisfied with the way the sickness absences were handled.

> *'I just try to be as human as possible, try to be as supportive as I can. It's about making sure she has the time she needs to recover, and being clear about how taking time off sick will affect her pay … I'm not 100% on what the legal requirements are as an employer. I suppose if I'm being honest, we've sort of brushed that under the carpet, because we're so small, and we both agreed how we wanted to handle her sick leave. She got SSP and I sorted all that out, but anything beyond that I haven't really considered seriously at all.'*

(Micro, Distribution, Hotels and Restaurants)

However, there were examples of small employers putting policies in place as they grew in size and experienced more instances of ill-health among employees. As shown in the example below, not having a dedicated policy in place *until* prompted by certain events also applied to other policies besides sickness absence management.

> *'We don't have any specific sickness absence policies in place, we deal with it on a case-by-case basis when we need to. The team is fairly small, though we've been growing for the last eight years, and we've just not had that much experience with long-term sick. Permanent employees are covered in terms of long-term sickness in their contracts … there is no hierarchy, we regularly have catch-ups together and will decide the best way forward. We only had a maternity leave policy in place a few years ago as we'd never needed one before. We had to deal with this and generate a policy when it happened.'*

(Small, Other Services).

Types of policies used to manage sickness absence

Employers used a range of policies to manage employees' sickness absence (Table 5.2). The most common was a dedicated sickness absence management policy but use of disciplinary and capability policies were also common, particularly in medium and large organisations due to the volume and diversity of LTSAs

experienced by these organisations compared to smaller ones. The majority of small employers (62%) did not use any policy to guide their management of sickness absence.

Table 5.2: Policies used to manage employees' sickness absences from work (multicode)

		Size of Employer		
	*** All**	**Small**	**Medium**	**Large**
We do not have a specific policy	58%	62%	19%	14%
Sickness absence management policy	29%	25%	72%	69%
Disciplinary policy	20%	17%	47%	38%
Wellbeing at work policy	15%	14%	22%	26%
Capability policy	10%	8%	29%	36%
Other	1%	1%	4%	3%
Don't know	1%	1%	2%	1%
Base	*2,564*	*1,457*	*584*	*523*

Base: All employers (unweighted)

** Employers could select more than one response, therefore column percentages do not add to 100%*

A handful of medium-sized employers in the follow-up qualitative research reported using the 'Bradford Factor' score to manage sickness absences.[67] Participants who used the Bradford Factor score found it useful for managing repeated sickness absence, in the absence of formal advice.

What is the 'Bradford Factor' score?

This is a formula used by some employers to work out the level of recurring sickness absence amongst employees. It works on the premise that repeated absences (even shorter ones) have a greater impact on organisations than LTSAs. Employers input the total number of separate absences by an employee and the total number of days the employee was absent to obtain their 'Bradford score', which guides employers as to the appropriate action to take. The Bradford factor does not take account of medical conditions such as cancer that may cause irregular absence patterns because of hospital appointments. It also does not account for cases where disability is involved. Instead it relies on the employer to recognise that they need to take account of these conditions in how they use the tool, otherwise they risk discriminating against an employee if their absence is connected to a disability.

[67] See, for example: https://www.bradfordfactorcalculator.com/

Case study: Using the Bradford Factor to support sickness absence management

One financial services organisation explained that the Bradford Factor meant that an employee taking five individual days off over a year would yield a higher score (meriting greater concern or action needed) than an employee who had one sickness absence of five days in the same period. They explained that they excluded anyone with a recognised condition from being scored.

> *'If someone's got a medical condition, we don't include that because that's not fair. It's more for the headaches, the 'I'm sick', the stomach bugs, flu, colds, sore throats … that's the kind of thing we'd include.'*

The participant explained that if an employee scored above a certain number, they would be flagged to the team leader, who would issue a verbal warning. If the problem persisted, they would begin a disciplinary process, with a number of formal warnings and meetings, ultimately culminating in dismissal in the absence of improvement.

> *'It's incredibly rare for people to get as far as that, as they realise they need to stop taking so much time off. But we've had occasions where people haven't been kept on after their probationary period ends, because they've taken too much sick leave.'*

(Medium, Financial, Professional and Administrative Services)

Flexibility in how employers apply sickness absence management policies

Policies perform an important function in helping to ensure that employees are treated fairly, in line with legal requirements, whilst also allowing line managers some discretionary power.

> *'We have formal policies covering sickness absence, sick pay and return to work and the guidelines are available on the intranet for staff to access. I think by having these formal policies in place it's more likely to make employees trust and respect the company. It's about transparency and it's a legal requirement; the most important thing in any business, whether you've got five people or 5,000 people is that you have to have strategic guidelines for all employees, so that you don't fall foul of treating one person different to another.'*

(Medium, Distribution, Hotels and Restaurants)

Some employers used their discretion in applying the different sickness absence management policies at their disposal. Three in five employers with a named policy (61%) adapted their policies for managing sickness depending on the employee. In the qualitative interviews, one large employer explained that their sickness absence management policy specified that employees had to complete a short health questionnaire with their line manager whenever they had been off work due to ill-health. The participant explained that the policy was designed to ensure that line managers were having return to work conversations with staff and checking to see if they required any additional support to prevent further sickness absence.

The participant was aware that the policy was applied more flexibly in practice, depending on the preferences of the individual and their line manager, and the nature of the sickness absence, as well as its length. Employers who had more experience managing employees with long-term sickness absences or recurring conditions explained that flexibility was particularly important to ensure that decisions were made with the individual at the forefront.

A third of employers with a named policy (34%) did not adapt their policies depending on the situation. In order to provide a level of flexibility to their sickness absence management policies, employers combined and used relevant parts of different other policies. For example, the follow-up qualitative research showed that, where employers had multiple policies in place, it was usually up to the discretion of the individual with primary responsibility for managing sickness absence to decide how to proceed in the first instance.

Participants in organisations with multiple policies tended to also have an HR professional that could provide guidance. Line managers would approach this individual for support in managing more complex cases, or to discuss how to tailor the policies to individual circumstances. Employers explained that policies were a reference point, rather than a 'step-by-step guide' to managing sickness absence. Line managers relied on their awareness of the policies, any training they had received, HR personnel (where applicable), and their own discretion to decide how to handle an absence. The steps they took also depended on the situation, for example, they might take the necessary steps outlined in the disciplinary policy (such as raising with HR, or issuing a formal warning), if they felt that employees were not being open or honest or showed a lack of willingness to being supported to address their condition.

> *'All the policies are used, really. They all interact and overlap – which part of the policy you use very much depends on the employee in terms of the length of their sickness absence, the issue or condition, their job role, level, and their receptiveness to support. That is – their willingness to talk to us and share information so we can work together to provide the support they need.'*
>
> (Medium, Construction)

Medium and large employers in the qualitative interviews stressed that whilst it was important to have discretion to tailor policies to the employee, it was also important to have policies to guide line managers with responsibility for managing sickness absence.

Responsibility and training for managing sickness absence

Three in five organisations (61%) delegated responsibility for managing sickness absence to line managers. This was more common in medium and large organisations than small since line management structures are linked to size (83% and 77% respectively versus 59%, in Table 5.3). However, less than half (44%) provided line managers with training to equip them to manage sickness absence. Training was more common in large (87%) and medium (72%) organisations than in small ones (40%). The follow-up interviews found that training included both wider health and wellbeing topics (see Chapter 4), and specific training on how to implement the organisational policy on sickness absence.

Table 5.3: Employer practices in managing sickness absence, by size

	Column Percentages			
	Size of Employer			
	All	**Small**	**Medium**	**Large**
Line manager (LM) responsible for managing absences and receives training	27%	24%	60%	67%
LM responsible but not trained	34%	35%	23%	10%
LM does not take responsibility	39%	41%	17%	23%
Base	*2,564*	*1,457*	*584*	*523*

Base: All employers (unweighted).

Employers who had experienced sickness absence tended to recognise that some level of training was required. However, the levels varied substantially depending on the organisation, their experience and individual line managers. The qualitative research identified the following training approaches to support line managers:

- **How to implement the organisation's policy on sickness absence.** This outlined the process line managers should take including the roles and responsibilities of the line manager and employee, what they should do in the first instance, and when to bring in additional support (such as HR or OH services).
- **Training on mental ill-health.** As noted (Chapter 4), employers pointed to an increase in sickness absence as a result of mental ill-health. Subsequently, there were examples of employers putting dedicated training in place to support line managers to spot signs of ill-health and to support employees disclosing mental ill-health. Training delivered by 'Mind' was commonly mentioned.

A third of employers (34%) delegated responsibility for managing sickness absence to line managers but did not provide them with training. Cases in the follow-up qualitative research suggested that line manager training was less common where there was a lack of formal processes for managing sickness absence, illustrated by the quotes below. Some employers also believed that the sickness absence management policy was sufficient and training for line managers was unnecessary.

> *'I handle everything with some involvement from the line manager … because I want to make sure everyone is treated the same, and the tone and pitch of the conversations is framed in a positive light. There's no official training as we're such a small company, but I provide support and guidance informally. Though, we are growing, which is another reason why we're looking to formalise the process.'*
>
> (Small, Manufacturing)

> *'It's not a big issue for my business. It's not a physically demanding job, there's a bit of light lifting, stocking shelves, standing on your feet at the till ... We don't have anything formal telling us how to do these things, if someone's ill, they'll ring me in the morning, and beyond that they all talk to my manager, and she keeps an eye on them. She acts as a conduit and keeps me updated if there's anything happening with the staff that I need to be aware of.'*
>
> (Small, Distribution, Hotels and Restaurants)

Managing short-term, long-term and recurring sickness absences

The follow-up qualitative research explored how employers managed short-term, long-term and recurring sickness absences. In all cases, there was an obligation on the employee to let their employer know that they would be absent (and ideally for how long) so that the employer could make alternative arrangements if required. Employers' responses varied depending on the nature of the sickness absence.

Where employees had minor ailments lasting a few days (such as a cold), employers and employees tended to have minimal contact. Employers typically allowed employees to self-certify and manage their own conditions in these instances. Some employers had very informal conversations to 'check in' with employees returning from short-term sickness absece. It was rare for employers to conduct formal return to work interviews.

Other employers had experienced instances of suspect short-term sickness absences. These employers monitored sickness absence data and had noticed certain employees taking a series of short-term sickness absences. This monitoring had led some employers to request meetings with employees to discuss their attendance, performance, and overall health and wellbeing. Other research conducted by Ipsos MORI with employers on their use of OH services also showed that some employers used OH referrals to confirm cases where they did not believe the employee's sickness absence was genuine.[68]

For more serious health conditions, where it was clear that the employee would be off work for a longer time, approaches varied depending on the experience and resources available to the organisation.

Employers who had experienced multiple instances of LTSA or had employees with complex health conditions were more likely to invest in OH provision. These employers had established practices, including agreeing the frequency and mode of contact with the employee up front, taking into consideration what would work best for the employee. The employee's line manager was usually the first port of call. Where LTSA cases were sufficiently serious, line managers would bring in HR representatives who would, in turn, bring in OH support as required. By contrast, employers with less experience of LTSA, were more reliant on the employee's GP (via the fit note) and the employee themselves.

Employers' managed employees with recurring conditions depending on their relationship with the employee, the length of the sickness absence and, ultimately, the level of trust they placed in them. Where employees took recurring, short-term sickness absences for the same, or similar reasons, this may trigger attendance review procedures. Where the employer believed the condition was genuine, the employer and employee established routines for managing the absence; for example, agreeing frequency and mode of contact and cover for the employee's work. Employers described building trust and confidence over time. In a sense, they 'took

[68] Ipsos MORI (2019) 'Employers' motivations and practices: A study of the use of occupational health services', available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/789894/employers-motivations-and-practices-a-study-of-the-use-of-occupational-health-services.pdf

a step back' and trusted that the employee was managing their condition, seeking medical support (if required), engaging with their OH provider (if applicable), and keeping them updated with their progress.

6. Supporting retention and return to work

This chapter explores how employers supported employees with health problems to remain in work and help with reintegration following long-term sickness absence.

Key findings

Meetings with employees and flexible returns to work (involving reduced hours or duties) were central to how employers supported employees with health conditions to remain in work, and/or return to work following a sickness absence.

- Employers used a range of mechanisms to identify employees who needed support to manage their health and wellbeing at work. For example, through conversations or questionnaires with new employees, through employee requests, ongoing monitoring, OH recommendations, or recommendations on a fit note (where employees took sickness absence).
- When providing reasonable adjustments, employers focused foremost on their legal duties as well as a duty of care to support their employees. However, some employers exercised discretion if they believed the adjustments were unreasonable or too costly.
- One in five employers believed that employees on LTSA should only return when they could do all of their work (21%). Employers operating in manual or hazardous environments were more likely to hold this view than those in office-based occupations (25% compared to 15%).
- Three in five employers (61%) reported facing barriers in supporting employees to return to work following a LTSA. Small employers reported a lack of time or staff resources (64%) and a lack of capital to invest in support (51%). In contrast, a greater number of large employers encountered structural challenges such as a lack of flexibility in how work was organised (67%) and difficulty engaging employees in the process (61%). The latter included staff wanting to return prematurely or not wanting to return at all, staff refusing to disclose their condition and staff refusing extra support to return to work.
- Some employers lacked confidence in managing returns to work, particularly in more complex cases. These employers reported not knowing how to instigate or conduct a return-to-work conversation. These concerns were more common among employers without prior experience of LTSA and those without clear policies, dedicated personnel, or external support.

6.1 Adjustments and support for employees with health conditions

Patterns of adjustments and support for employees with health conditions in work

Half of employers (51%) had put measures in place to support employees with health problems to remain in-work or to support them to return to work following a period of sickness absence, in the last 12 months. The measures included both work-related adjustments, as well as physical adjustments to the workplace itself, and wider specialist support.

The most common types of support used by employers, irrespective of size, were meetings with employees, amending an employee's workload or job role, and phased returns to work (Table 6.1). Resource-intensive or specialist support or adjustments, such as adjustments to the workplace, additional external support or advice (e.g. clinical support), or the use of job coaches or personal assistants, were less common overall, but more prevalent amongst larger employers.

Table 6.1: Measures to support employees with health problems to remain in-work or return to work (multicode)

		Size of employer		
	*** All**	**Small**	**Medium**	**Large**
Meetings with employees	40%	36%	75%	97%
Amending employee workload or job role	35%	31%	67%	95%
Phased returns to work from sickness absence	29%	25%	70%	96%
Workplace adjustments	26%	23%	62%	78%
Additional external support or advice	13%	11%	27%	75%
A job coach or personal assistant	4%	3%	5%	24%
None of these	49%	52%	14%	1%
Additional analysis				
Used one of the above	11%	11%	7%	2%
Used two to three of the above	22%	22%	33%	4%
Used four to five of the above	16%	13%	44%	75%
Used all of the above	1%	1%	3%	18%
Base	*2,564*	*1,457*	*584*	*523*

Base: All employers (unweighted).

** Employers could select more than one response, therefore column percentages do not add to 100%*

Further analysis showed that irrespective of employer size, provision was determined by demand. Namely, employers were more likely to have put measures in place to support employees with health problems where they:

- **Had experienced employee requests for support to accommodate their conditions or disabilities**: 95% of employers who had experienced requests reported taking action for their employees and the figures were broadly similar for small (94%), medium (98%), and large employers (100%). Please see Table 6.2, below.
- **Had experienced instances of LTSA in the last 12 months**: 90% of employers who had experienced instances of LTSA reported taking action for their employees. Again, there were limited differences between small (87%), medium (96%), and large employers (100%[69]).[70]

This shows that whilst small employers had put in place fewer measures to support employees with health problems than medium or large employers, this was because they had not experienced the same level of need and subsequently had fewer cases to provide this support.

Table 6.2: Measures to support employees with health problems to remain in-work or support returning to work amongst employers who had received requests for support from employees (multicode)

	Received requests for support from employees		
	*** All**	**Yes**	**No**
Meetings with employees	40%	86%	29%
Phased return to work from sickness absence	30%	75%	19%
Amending employee workload or job role	35%	80%	24%
Workplace adjustments	26%	59%	19%
Additional external support or advice[71]	13%	39%	7%
A job coach or personal assistant	4%	11%	2%
None of these	49%	5%	59%
Base	*2,564*	*933*	*1,566*

Base: All employers (unweighted).

** Employers could select more than one response, therefore column percentages do not add to 100%*

Ipsos MORI undertook additional latent class analysis[72] to explore patterns of employer behaviour in providing support to employees with health problems to remain in-work or support them to return to work. The LCA revealed five classes of employers providing similar patterns of support to employees with health problems. These classes are shown in Figure 6.1 below.

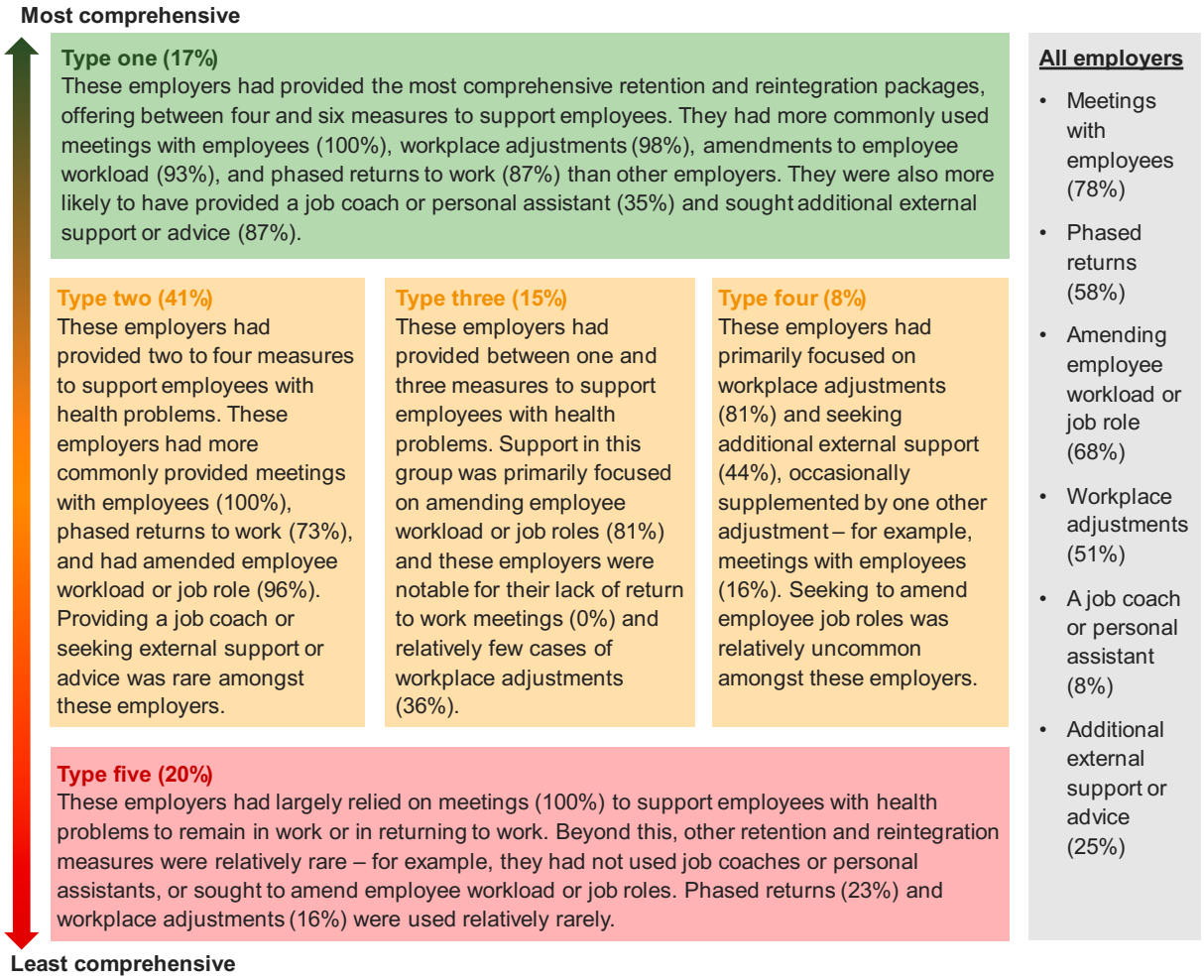
[69] Please note that this is a rounded figure; the actual figure is 99.7%.

[70] A full table of statistics can be found in Table 11.16 in the Appendix.

[71] For example, clinical support such as psychological therapy or another expert or specialist.

[72] Latent class analysis (LCA) is a statistical technique which classifies individual survey responses into unobserved classes. Where respondents choose common combinations of options from multi-coded survey questions, these reveal a 'latent class' which distinguishes them from respondents defined by another class representing a different pattern of chosen options. For more detail on this method, please refer to Section 4.1 of the Technical Report.

Figure 6.1: Typology of retention and reintegration measures



Base (unweighted): All employers who had used measures to support employees with health problems to remain in work or support in returning to work over the last 12 months (1,876).

What informs adjustments and support for employees with health conditions?

This section covers how employers became aware of support or adjustments needed by employees with health conditions, and who or what information they consulted to decide which adjustments to make. Employers took the same steps to inform an adjustment, irrespective of whether it was aimed at supporting an employee with health conditions to stay in work or to facilitate a return to work after sickness absence.

How employers became aware: The qualitative interviews highlighted several ways in which employers identified employees in need of adjustments and support in order to accommodate a health condition or disability. These were:

- **At recruitment:** Some employers proactively asked new employees whether they required any additional support, equipment, or amends to the role to accommodate a health concern or disability. These tended to be large organisations with

dedicated HR resources and a wide suite of health and wellbeing measures, or employers that operated in manual or hazardous environments with heightened health and safety risks.

- **Ongoing monitoring:** Similarly, there were examples of employers in manual or hazardous environments regularly monitoring employee health concerns in annual health questionnaires. These employers used the confidential responses to decide whether any additional measures were needed to ensure the health and safety of their workers. These examples included yearly health checks from an occupational health nurse on-site, and regular health screenings when working on government contracts (for one construction company).
- **Employer starting a conversation about support:** Three in five employers (57%) collected sickness absence data and the qualitative interviews highlighted how some employers monitored this data to provide targeted support for their employees. For example, in one large catering organisation, all sickness absences were centrally recorded and reviewed on a monthly basis. The employer had set certain 'trigger points' to highlight employees who had been absent for a certain number of days over a specified period. If the trigger point was reached, the employee's line manager would tell the employee that another sickness absence would result in an attendance meeting with HR to discuss what additional support the employee might need to do their job (and to ascertain whether the sickness absences were genuine).
- **Employee requests for support:** One in five employers (18%) had received requests for support from employees to accommodate their health condition or disability over the past 12 months. The qualitative research identified examples of employees approaching their line managers, team supervisors, or the owner of the business (in small organisations) for support including: new equipment such as desk chairs (for better support for those with back problems, or pregnant women), and requesting changes to their working hours (shorter days or working from home). Employers reported generally having open conversations with employees about their needs, and they would take the decision away or do further research to understand what modifications were possible in practice. Employers described this as being relatively straightforward in minor cases (for example, agreeing to amended working hours or providing specialist equipment) and more of an ongoing dialogue in more complex cases where additional advice or input was required.
- **OH recommendations:** Employees were referred to an OH provider either because a new health condition was identified whilst they were in-work or following a period of sickness absence. In their reports, OH providers would recommend adjustments to the employee's role or working environment to help accommodate their health condition. As discussed in more depth in other research by Ipsos MORI on this topic,[73] whilst OH providers were seen as a reassuring source of expertise, there were cases where their reports either lacked the level of detail that employers required in order to confidently implement adjustments, or recommended changes to the role that were not feasible for the organisation (feasibility of adjustments is discussed further in the next section).

[73] Ipsos MORI (2019) Employers' motivations and practices: A study of the use of occupational health services, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/789894/employers-motivations-and-practices-a-study-of-the-use-of-occupational-health-services.pdf

- **Through the 'may be fit for work' option on the fit note:**[74] The fit note either indicates that employees are not fit to return to work, or they are subject to certain changes to their role (i.e. reasonable adjustments). If employers are not able to make these adjustments, then the fit note should be treated as if it indicates the employee is unfit for work. Overall, fit notes were seen as a useful starting point for supporting employees to return to work in a gradual manner. However, there were examples, once more, of employers requiring a greater level of detail to feel confident they were adequately supporting their employees to return to work. This is explored further in other research conducted by Ipsos MORI on the fit note, which also found a misunderstanding over the purpose of the fit note (to provide general advice on employees' fitness to work) and what some employers wanted from the fit note (specific guidance on an employee's ability perform their job role).[75]

Who employers consulted: Employers consulted a range of key people when putting in place support employees with health conditions:

- **The employee themselves**, to discuss their needs and to understand how their condition impacted their ability to work and vice versa;
- **HR specialist** (either internally or externally) for additional support and guidance, particularly when a change to job role, working hours or specialist equipment is required;
- **OH professionals**, where the employer had access to this service or when the employee's health condition was deemed too complex to be managed internally; and
- **GPs or doctors**, indirectly, through the fit note, where one had been issued by a GP or hospital doctor to understand, at a high level, their employees' ability to work.[76]

Where the modification or adjustment was relatively straightforward to implement, such as reduced workload or hours, this decision was usually made by the employee's line manager, team leader, or by the owner (in the case of the smallest employers). Where adjustments were more complex, employers tended to discuss the decision with HR and/or OH professionals (in organisations where this support existed).

[74] For a period of sickness absence, employees can self-certify for a period of seven consecutive days (including weekends), before they are required to provide a form of medical evidence, such as the fit note, to their employers. The fit note is signed by a GP or hospital doctor and provides an assessment of the employee's general fitness for work.

[75] Ipsos MORI (2019) Exploring perceptions and attitudes towards the extension of fit note certification, available at: https://www.gov.uk/government/publications/exploring-perceptions-and-attitudes-towards-the-extension-of-fit-note-certification

[76] For a more in-depth discussion of employers' and employees' views on the fit note, please see: Ipsos MORI (2019) 'Exploring perceptions and attitudes towards the extension of fit note certification', available at: https://www.gov.uk/government/publications/exploring-perceptions-and-attitudes-towards-the-extension-of-fit-note-certification

Reasons for providing adjustments and support for employees with health conditions

The qualitative research explored employers' considerations and motivations in providing adjustments and support to retain and reintegrate employees with health conditions or disabilities. Employers' primary focus was their legal duty to provide reasonable adjustments. As discussed in Section 3.3, employers in the follow-up qualitative interviews who employed disabled staff were more aware of their requirements to make reasonable adjustments, by law, than employers who did not. The qualitative research did not come across any employers stating they had not made any reasonable adjustments for disabled employees or had knowingly refused a reasonable adjustment.

What are reasonable adjustments?

There is a legal requirement to provide reasonable adjustments to those who meet the definition of disability under the Equality Act (2010). These are steps taken by employers to ensure that disabled workers are not substantially disadvantaged when doing their jobs. Examples of adjustments might include:

- installing a ramp for a wheelchair user;
- allowing someone with social anxiety to work from home;
- reduced hours; or
- allowing employees to perform different duties or tasks.

'Reasonable' adjustments are changes to an employee's job role or wider working environment that an employer could *reasonably* be expected to make. What counts as a 'reasonable' adjustment will vary depending on whether:

- the adjustment is practical;
- the employer has the resources to pay for it;
- the adjustment will be effective in supporting the employee; and
- the adjustment will have any adverse effects on other members of staff.

Under the Equality Act (2010), the duty to make reasonable adjustments applies to those who meet the Act's definition of disability. Employees with health conditions may be granted changes or modifications to their role or working environment in order to make their condition easier to manage, but this is often at the employer's discretion.

77

[77] For more information, see: https://www.gov.uk/reasonable-adjustments-for-disabled-workers or https://www.acas.org.uk/index.aspx?articleid=6074#When%20must%20an%20employer%20make%20reasonable%20adjustments?

There was evidence that employers used more discretion and flexibility when it came to implementing workplace adjustments for employees with health conditions. As with many decisions relating to employee health and wellbeing, employers explained that workplace adjustments would be made on a case-by-case basis, with the employer considering a variety of factors, including:

- The value of the employee to the organisation (i.e. how crucial their skills were);
- The loyalty of the employee (length of service);
- The difficulty of replacing the employee; or
- The personal relationship between the employer and the employee (more relevant to smaller organisations with a 'tight-knit family feel'). There were examples of employers explaining that they were aware of employees' personal, financial situations, and subsequently making adjustments to support them to stay in work and remain financially stable.[78]

Across the interviews, employers explained that they could usually accommodate adjustments for these reasons:

- **Feasibility:** The nature of the requests they had experienced were relatively easy and low cost to implement. In most cases, the benefit of retaining the employee far outweighed the cost of the adjustment.
- **Professional advice:** The adjustments had been recommended by an external specialist, i.e. a medical professional or OH provider.
- **Duty of care and retention:** Employers were motivated to support employees with their health and wellbeing in work because of a moral duty of care, and the fact that retaining existing employees was preferable to them remaining off work (and having to cover their work), or employees being unable to return to work at all (and employers having to find permanent replacements).

> '*We've not required any paid-for adjustments* [for employees with health conditions] *so far. Adjustments we've had to make are usually amended hours, working from home, or slightly changed what they're doing day-to-day. We never have and never would refuse to grant these adjustments, as we understand how crucial they are in terms of facilitating a sustainable return to work.'*
>
> (Medium, Financial, Professional, and Administrative Services)

Challenges faced by employers when implementing adjustments

Where employers did have to make more of a conscious decision about whether to implement adjustments, these discussions centred on whether the adjustment was practically possible to accommodate and its cost.

Employers explained that they would not be able to implement adjustments that presented a barrier to the employee doing their contracted role. For example, a firm of accountants explained that they would not always be able to accommodate working from home requests where employees needed to work from their clients'

[78] We see similar things in relation to employers paying sick pay above statutory minimums, discussed in more detail in Chapter 6.

premises (to carry out audits). Other examples included those in manual roles (such as construction, hospitality, and cleaning services) requesting more sedentary or office-based roles. Employers could not accommodate these changes if the employee did not have the skillset required for an alternative role. This seemed to be more common where employees had physical health conditions, affecting their ability to carry out their manual role.

Case study: When employers do not grant adjustments

One organisation employed a mix of permanent staff, workers on zero hours contracts, and also used agency workers. The majority of their staff were office-based, but they also employed a number of cleaners across multiple sites. The employer explained that if substantial changes were required that would fundamentally change the job role then the employee was likely not ready to return to work.

> *'There has to be a point to you being at work, basically. So, if we have to adjust something too much, to the extent that you're not actually doing the majority of your role, or a significant amount of your role, then we would maybe consider that, actually, you're not fit for work at the moment.'*

The employer gave an example of a cleaner who worked on one of their housing estates who was signed off as being fit for work following a knee replacement, but was told that she could not walk upstairs, or lift anything above a certain weight. This meant she could not perform her duties, and in the absence of an alternative role, the employer requested that the employee remained off work until she was capable of performing all of her duties.

(Large, Public Administration, Education and Health)

The example below also highlights the importance of employer discretion in these decisions. In this case, the employer had offered alternative work in the past for those unable to return immediately to their normal (manual) roles following a period of sickness absence. The employer's motivation for doing this was out of a moral duty of care, as the business did not need these additional roles.

> *'Some people have phased returns, or we'll let them come in and do some admin if they're not up to their full job. To be fair, it's a waste of my money, but I try to be nice as I know some of them are living hand to mouth and can't afford to be off for six weeks, but they might be able to do a different job. Ultimately, though, I'm bringing them back to do a job I don't need them doing.'*

(Medium, Distribution, Hotels and Restaurants)

The cost of the adjustment was not a major factor for the employers in the qualitative interviews, as their experience of adjustments to-date had focused predominantly on low-cost changes (such as replacing standard equipment), or those involving no direct costs (amending employee hours). There were no examples of employers refusing to implement adjustments on cost grounds, and employers generally found it difficult to think of a scenario where they would refuse adjustments. When prompted, employers explained that any decision relating to the cost of making an adjustment

would involve weighing up the cost of the adjustment, against the cost of the employee remaining on sickness absence, or of the employee being unable to return to work at all, and the employer needing to find a replacement.

Monitoring and phasing out adjustments

Where employers had offered workplace adjustments or modifications to employees' contracted roles, this was usually accompanied by regular reviews to monitor the effectiveness of the adjustments and to make plans for the gradual phasing out the modifications. This took the form of regular catch-ups between the employee and their line manager, who worked together to gradually refine the adjustment – for example, gradually increasing workload or working hours – until the employee felt comfortable to return to their previous role.

6.2 Managing return to work following LTSA

Broadly speaking, employers' roles in managing an employee's return to work after LTSA covered three main areas:

- Understanding an employee's fitness for work;
- Keeping in touch during the absence and agreeing a return to work plan; and
- Facilitating a return to work on a gradual basis.

The survey explored the prevalence of employer behaviours in each of these areas and found that the majority of employers who had faced LTSA in the past 12 months reported putting measures in place to manage their employees' return to work. This was the case regardless of size, with many employers having used:

- **Keeping in touch and planning:** Most employers had used regular meetings (79%) and developed return to work plans (69%) to manage employees' returns work after LTSA.
- **Flexible returns to work:** The vast majority of employers (84%) had made use of opportunities for employees to return to work in a flexible manner (e.g. phased returns, or reduced workload).

The extent to which formal return to work plans and 'keep in touch' calls were developed and scheduled varied greatly from employer to employer, and also depended on the employee's condition and preferences. As with other areas of managing employee health and wellbeing, employers took a case-by-case approach.

Fewer than one in ten employers took no action (7%); these were almost exclusively small employers (9% of small employers took no action).

There were still notable differences between small and large employers in terms of the type of support they put in place. Large employers remained more likely than small employers to draw on paid-for advice and support to employees returning to work following LTSA, such as OH assessments and other, external, specialist support (Table 6.3). For example:

- Large employers were more likely to seek independent assessments of employees' work capacity (80%) than small employers (24%) when managing employees to return to work following LTSA.
- Large employers (70%) were also more likely than small employers (21%) to have sought external, specialist support to manage the employee's return to work.

Table 6.3: Measures to manage employees' returns to work following LTSA (multicode)

	Size of Employer			
	* Total	Small	Medium	Large
Opportunities for employees to return to work in a flexible manner (e.g. phased returns, or reduced workload)	84%	82%	88%	97%
Regular meetings	79%	74%	87%	99%
Develop return to work plans	69%	64%	77%	95%
Independent assessment of employees work capacity (including OH assessment)	34%	24%	48%	80%
External, specialist support to manage the employee's return	28%	21%	36%	70%
Other	*	*	*	*
None of the above	7%	9%	2%	*
Don't know	*	-	*	*
Additional analysis				
Used one option	12%	14%	9%	2%
Used two to three options	45%	50%	42%	15%
Used four to five options	36%	27%	47%	82%
Base	*1,188*	*318*	*388*	*482*

Base: All employers with a long-term sickness absence in the last 12 months (unweighted) [79]

** Employers could select more than one response, therefore column percentages do not add to 100%*

In addition, large employers were more likely to report adopting **a wider variety of measures** to manage their employees' returns to work than small employers. For example, four in five large employers (82%) offered four or more of the above measures to manage employees returning to work following LTSA, compared to a quarter of small employers (27%).

This is because larger employers tended to experience more varied and complex health needs amongst their workforce. For example, large employers reported both a greater number of health concerns among their employees and had more employees with a disabilities or long-term health conditions, compared to medium and small employers.[80]

[79] The following conventions are used in tables throughout the report: less than 0.5 per cent (*), no observations (0), and results based on fewer than 50 observations, which should be interpreted as indicative rather than statistically robust.

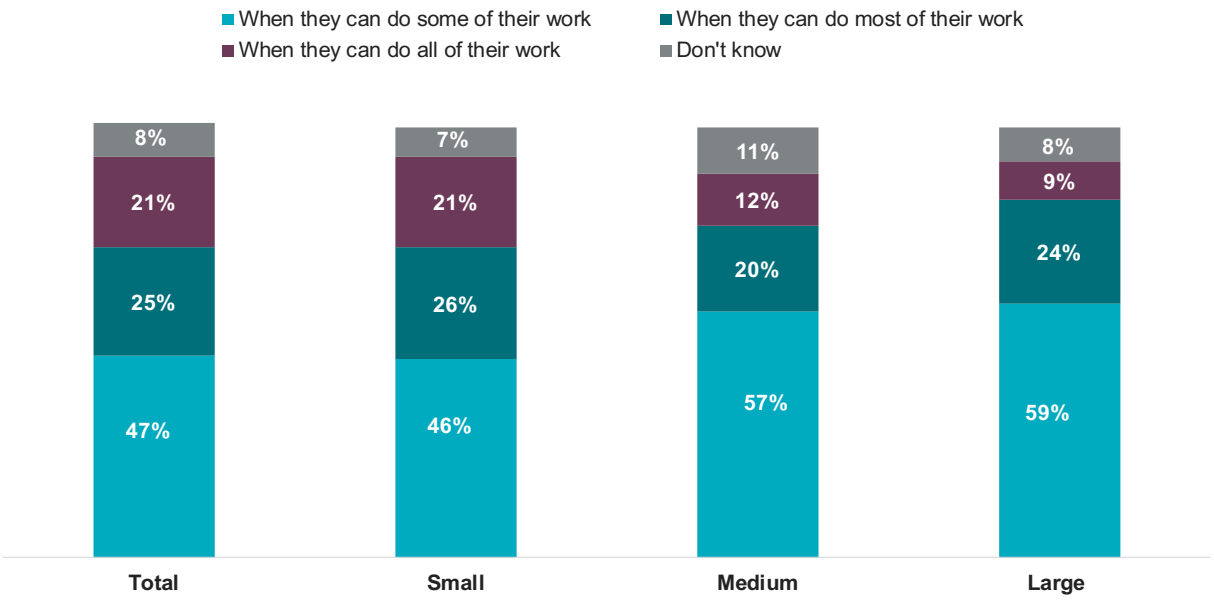
[80] See Chapter 3.

Follow-up qualitative interviews with small and medium-sized employers explored their rationales for seeking and using external, professional support to manage their employees' returns, such as OH advice. It found that these employers took the decision to seek external, paid-for advice *either* at the point at which they had sufficient volume of sickness absence cases to merit investment in contractual support services (such as OH services), *or* when they encountered cases that were beyond their level of expertise and wanted the reassurance of a professional. More generally, small employers did not proactively put policies or procedures relating to health and wellbeing in place, until they had experienced it themselves and it therefore became relevant to their organisation.

When employers felt employees should return to work

Employers widely used opportunities for employees to return to work in a flexible manner (84%), such as phased returns, and widely endorsed this approach for helping a successful reintegration following sickness absence. As discussed in Section 6.1, the fit note also encouraged employees to return to work when some of their work is possible through the 'may be fit for work' option. However in practice, employers were divided on when was a good time for employees to return to work following sickness absence (of any length). Nearly half believed employees should return when they could do all or most of their work (21% and 25% respectively), compared with 47% who said they should return when they could do some of their work.

Figure 6.1: Employers' views on when employees should return to work following sickness absence of any length



Base (unweighted): All employers (2,564), small employers (1,457), medium employers (584), large employers (523)

Employers who believed employees should return to work when they could do some of their work were more likely to have developed return to work plans (72%) and offered a phased return to work from sickness absence (88%), to facilitate a return to work in the past 12 months[81] than those who believed employees should return to work when they could do all of their work (52% and 66% respectively).

Small employers were more likely than larger ones to want employees to return only once they were ready to do all of their work (Figure 6.2). This may reflect the lack of formal support mechanisms in place to support employees to return to work in small organisations, or the duty of care that small employers tend to feel toward their staff.

Employers working in manual or hazardous environments[82] were also more likely to want employees to return to work when they could do **all** of their work (25%) than employers operating in mainly office based environments (15%).[83] In particular, employers in the Construction sector (who tended to be small) were the most likely to only want employees to return once they could do all of their work (31% versus 21% overall), due to the physical risks involved in taking up work before they are fully ready to do so.[84]

Other research has shown that employers operating in hazardous working environments preferred only to have an employee return to work when they had been certified as fit for *all of their role* by a medical professional. These employers operated in environments where the nature of the work posed heightened health and safety risks. Some employers explained that they were unwilling to bear what they perceived as the additional risk of having an employee return to work before they were 'fully fit' to fulfil their role in its entirety. Employers explained that waiting until employees were fully fit to perform all of their role reduced the risk that their health may be further compromised at work.[85]

[81] Amongst those who had experienced a LTSA in the past 12 months.

[82] These categories were derived for analytical purposes post-survey, and do not reflect how individual employers defined the nature of their working environment:

- **Mostly manual or hazardous work environment** – Agriculture, Forestry and Fishing; Mining and Quarrying; Utilities, Waste Management and Remediation Activities.; Manufacturing; Construction; Accommodation and Food Service Activities; Human Health and Social Work Activities.
- **Mostly office-based work environment** – Information and Communications; Financial and Insurance Activities; Real Estate Activities; Professional, Scientific and Technical Activities; Administrative and Support Services; Public Administration, Defence and Compulsory Social Security.
- **Mixed work environments** – Wholesale and Retail Trade; Repair of Motor Vehicles and Motorcycles; Transportation and Storage; Education; Arts, Entertainment and Recreation; and Other Service Activities.

[83] A full table of statistics can be found in Table 11.17 in the Appendix.

[84] A full table of statistics can be found in Table 11.18 in the Appendix.

[85] Ipsos MORI (2019) 'Exploring perceptions and attitudes towards the extension of fit note certification', available at: https://www.gov.uk/government/publications/exploring-perceptions-and-attitudes-towards-the-extension-of-fit-note-certification

Barriers to providing support around return to work following LTSA

Three in five employers (60%) who had experienced LTSA in the last 12 months reported facing barriers when supporting employees to return to work (Table 6.4). Two in five employers (39%) did not face any barriers; these were mostly small and medium-sized employers. This is because instances of LTSA were less common amongst smaller employers meaning they are less likely to have experienced more complex health cases.

The most common barrier faced in providing support around return to work following LTSA, cited by employers of all sizes, was a lack of time or resources (41%). Employers in the qualitative interviews explained that lack of time or staff resources were a challenging, but inevitable, part of supporting an employee to return to work. They broadly acknowledged that whilst intensive in the short-term, the additional time and resources were a necessary and worthwhile investment to ensure a successful return to work, particularly in the case of key personnel. A small minority (13%) stated the benefits of investing in retaining an employee did not warrant the cost.

Regardless of size, employers most commonly cited two to three barriers which made it difficult for them to support their employees to return to work following LTSA (Table 6.4). Where employers faced two to three barriers, lack of time and resources (73%) and lack of capital to invest in support (42%) were commonly mentioned together.

Table 6.4: Barriers faced by employers when supporting employees to return to work following LTSA (multicode)

		Size of Employer		
	* Total	Small	Medium	Large
Lack of time or staff resources	41%	42%	33%	46%
Employee engagement in the process	23%	20%	27%	44%
Lack of flexibility in the way work is organised	28%	26%	22%	55%
Lack of expertise or specialist support	23%	25%	16%	22%
Lack of capital to invest in support	27%	32%	19%	6%
The benefits of investing in retaining an employee do not warrant the investment	13%	14%	8%	9%
Lack of support from senior leaders	7%	7%	11%	5%
We do not face any barriers	39%	40%	42%	24%
Other	1%	1%	*	*
Don't know	*	0	0	*
Additional analysis				
One barrier faced	16%	14%	21%	24%
Two or three barriers faced	27%	27%	29%	30%
Four or more barriers faced	17%	18%	8%	22%
Base	*1,188*	*318*	*388*	*482*

Base: All employers who reported long-term sickness absences in the last 12 months (unweighted)[86]

** Employers could select more than one response, therefore column percentages do not add to 100%*

Whereas small employers were more likely to cite a lack capital to invest in support (32%), large employers reported struggling with a lack of flexibility in the way work was organised (55%) and a lack of employee engagement (44%).

Employers in the follow-up qualitative research gave the following examples of how they perceived employees' attitudes and preferences sometimes acting as a barrier to a return to work:

- **Employees trying to return to work prematurely**, either for financial reasons (for example, being unable to manage on Statutory Sick Pay alone), or because they missed the structure, socialisation and stimulation that work provided.[87] Employers explained that this carried risks of further sickness absences, and they took steps such as seeking OH or other medical advice to guard against this occurring.

[86] The following conventions are used in tables throughout the report: less than 0.5 per cent (*), no observations (0), and results based on fewer than 50 observations, which should be interpreted as indicative rather than statistically robust.

[87] These findings chime with other research done in this area, please see: Ipsos MORI (2019) Exploring perceptions and attitudes towards the extension of fit note certification, available at: https://www.gov.uk/government/publications/exploring-perceptions-and-attitudes-towards-the-extension-of-fit-note-certification

'Any requests from employees for phased returns or amended duties are decided by their line manager and HR, if OH aren't already involved. If they're asking for too much it may suggest to us that, actually, are they even ready to come back to work? That may prompt us to maybe allow them to come back to work but do an OH referral as well.'

(Large, Public Administration, Education and Health)

- **Employees refusing additional support to return to work**, for example because they did not want to be perceived as a special case, felt embarrassed or simply wanted to get back to their normal working routine.

  'Sometimes they just don't care and don't want to come back. Sometimes, they come back but can't do any heavy lifting for a bit. Sometimes, they want to come back all guns blazing, and we've got to try and slow them down a bit – usually when they don't want to be seen getting special treatment and just want to get back on with it, really.'

  (Medium, Distribution, Hotels and Restaurants)

- **Employees unwilling to disclose details of their health condition for personal reasons**. Employers explained that they handled sensitive or personal information confidentially, restricting access to this information only to those with a business need to know and after discussing it with the employee.
- **Employees not returning to work at all following sickness absence**. Employers who mentioned this in the interviews explained that, in some circumstances, employees never returned to work following a period of sickness absence. The length of the absence varied in these cases and culminated in employees handing in their notice, rather than discussing return to work plans with their employers. The employers were unable to elaborate on the reasons behind this, as the employees had often chosen not to disclose the reasons. Related research[88] with employees and healthcare professionals highlights the detrimental impact of long-term sickness absences on individuals' likelihood of returning to work. In short, the longer the sickness absence, the less likely an individual is to return to work at all.[89]

  'From our experience, as soon as people are out of work, if it goes on for longer than a few months, it's extremely difficult to get people back in, and work is crucial to wellbeing. Loss of work is a disaster really. It can exacerbate, or cause, mental health issues. It causes major income problems, it causes a downward drift whereby they can lose one thing and then another – relationships, their accommodation – it's a key component of any kind of spiral into decline for many individuals that we see on long-term sick.'

  (General practitioner)

[88] Ipsos MORI (2019) Exploring perceptions and attitudes towards the extension of fit note certification, available at: https://www.gov.uk/government/publications/exploring-perceptions-and-attitudes-towards-the-extension-of-fit-note-certification

[89] DWP and DHSC, 'Health in the workplace – patterns of sickness absence, employer support and employment retention', 2019, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/817124/health-in-the-workplace-statistics.pdf

Despite most employers facing barriers around LTSA, these challenges **did not appear to affect the measures they put in place to support their employees to returns to work**. There was little difference in the provision of employers who reported barriers in facilitating a return to work compared to employers who reported no barriers.

Experiences of handling return to work

Most employers who had experienced LTSA in the past 12 months regularly met their employees (79%) and developed return to work plans (69%). The qualitative interviews identified the importance of clear communication and clarity on both sides to ensure a successful return to work. Lack of communication was more prominent where employers:

- did not have dedicated personnel in place within the organisation to manage the return to work (such as trained line managers and/or HR personnel);
- did not have clear policies in place to guide the return to work;
- could not draw on external, specialist support (such as OH provision) for more difficult cases; or
- did not have prior experience of supporting employees returning to work.

Employers who had not previously experienced LTSA did not have established procedures and measures in place to manage returns to work, and lacked confidence as a result. This was especially the case for more complex cases of LTSA. For example, employers described not knowing which party was responsible for instigating return to work conversations, how often these should happen, or which issues should be discussed. Some employers were not sure whether or not they should contact employees at all.

Knowing how to strike the balance between concern and not unduly pressuring employees was a key issue for inexperienced employers. Employers described wanting to show their employees they were concerned about them and to find out when they might be able to return to work (to support with planning work and cover), but also being concerned about over-contacting them during their sickness absence.

These findings chimed with other research,[90] which included employees' perspectives on what a successful return to work looked like. Employees emphasised the importance of good communications, and how poor communication during their sickness absence prevented a shared understanding of the impact on their health condition at work, which affected the level of support they received when they returned.

[90] Ipsos MORI (2019) 'Exploring perceptions and attitudes towards the extension of fit note certification', available at: https://www.gov.uk/government/publications/exploring-perceptions-and-attitudes-towards-the-extension-of-fit-note-certification

'There wasn't much contact during the first six weeks, and I would've expected them to check up on me, how my leg was healing. I was getting x-rays every two weeks, so could've updated them if they had asked about my recovery. The lack of contact made me feel annoyed.'

(Patient, physical health condition, mostly manual work)[91]

[91] Verbatim taken from the same report noted above.

7. Sick pay provision

This chapter examines the different types of sick pay offered by employers, including how this varies by contract type, the amount offered and duration of payments.

Key findings

The majority of employers paid some form of sick pay to their employees (82%). A greater number of large employers paid *above* Statutory Sick Pay (SSP) than smaller ones. Where employers have a sick pay (occupational) scheme, this offers employees more than SSP.

- Half of employers paid SSP only (54%), 28% paid above SSP, 13% did not provide any form of sick pay and 5% did not know. Micro employers were more likely than other employers to not offer sick pay (17%). Employers also explained in the qualitative interviews that they did not pay sick pay to employees on certain types of contracts, including those on zero hours or temporary contracts.
- Paying only SSP was more common amongst small (55%) than large employers (16%), those in Distribution, Hotels and Restaurants (62%), as well as among employers who did not provide OH services (58%). Employers cited cost as the main reason for paying only SSP in the qualitative interviews.
- Employers paid *above* SSP to attract and retain the best employees and enhance employee engagement and productivity. The majority (78%) offered it to all their employees and one in five offered it to some of their employees (20%).
- The most common criteria for paying above SSP was length of service (59%). Large employers had different employment contracts for employees eligible for above SSP. In contrast, small employers tended to use their discretion.
- The average duration occupational sick pay (OSP) was available for was 53 days. However, one in six employers reported that they paid OSP indefinitely (17%).
- Among employers that offered OSP, three in ten (29%) reduced the rate paid over time. Four in ten employers (37%) reduced it to between 81% and 100% of employees' usual wage.

7.1 Type of sick pay offered

What is Statutory Sick Pay (SSP)?

Employees are entitled to Statutory Sick Pay (SSP) if they are too ill to work. It is paid by the employer. In order to qualify for SSP, the individual must:

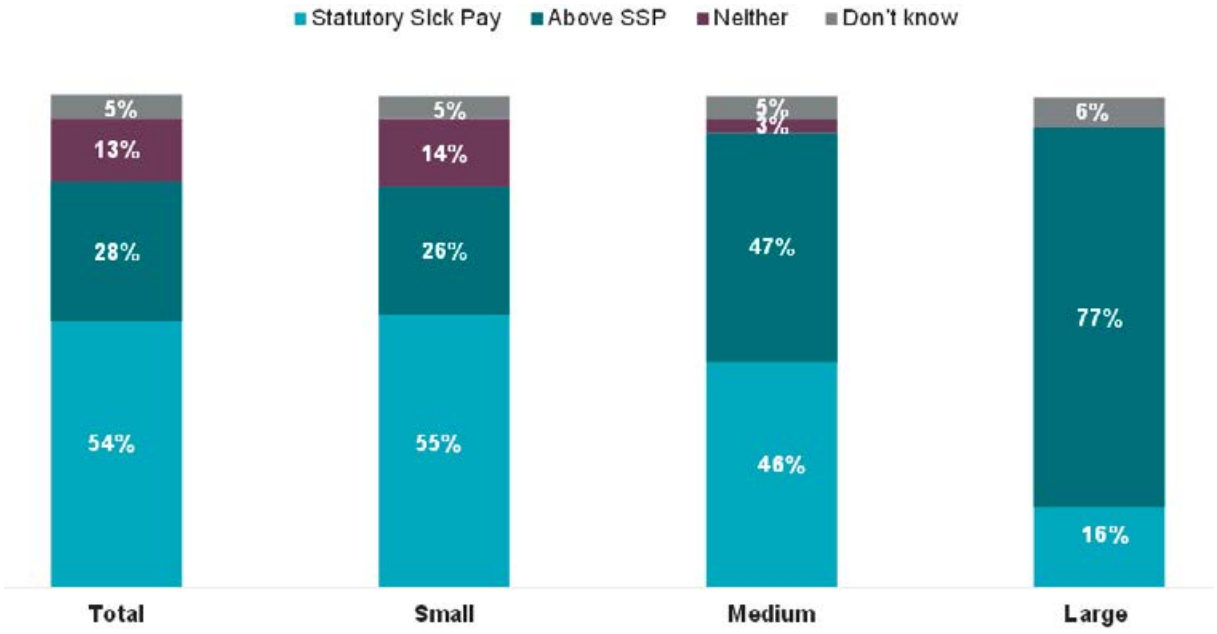
- be classed as an employee or a worker (meaning they have an employment contract) and have done some work for their employer;
- have been ill for at least four days in a row including non-working days;
- earn an average of at least £120 per week; and
- tell their employer they are sick within seven days, or before their employer's own deadline.

Agency and zero hours contract workers are also entitled to SSP as long as they meet the above requirements.

Employees can get £95.85 a week (from April 2020) for up to 28 weeks. It's paid in the same way as their normal wages; tax and National Insurance are deducted. Employers with an Occupational Sick Pay (OSP) scheme will pay their employees more than this amount.

Four in five employers (82%) reported paying *at least* the Statutory Sick Pay (SSP) to their employees, while 13% did not provide any (see Section 7.2) and five percent did not know. The most common form of sick pay was SSP (54%). Three in ten employers offered more generous sick pay, including 10% who only paid OSP and 19% who paid both SSP and OSP. Payment of more generous sick pay (above SSP) increased with employer size.

Figure 7.1: Type of sick pay offered



Base (unweighted): All employers (2,564), small employers (1,457), medium employers (584), large employers (523). N.B. Large employers offering neither form of sick pay (0.2%)

Table 7.1 shows both the proportion of employers offering different forms of sick pay and the proportion of employees who work for employers offering these arrangements. For employees these are grossed estimates, which assumes everyone within an organisation receives the same form of sick pay. However, employers may pay different employees differently within the organisation.

Table 7.1: Grossed estimates for different forms of sick pay

	Employers who offer sick pay	Employees who receive sick pay[92]
Statutory Sick Pay (SSP)	54%	42%
Above SSP	28%	52%
Neither	13%	4%
Don't know	5%	3%
Base	*1,093,353*	*20,594,580*

Base: All employers and employees in Great Britain.

Source: Inter-Departmental Business Register (IDBR), 25 April 2018.

7.2 Which employers do not offer sick pay, and why?

There is a statutory minimum level of sick pay that employers must pay when their employees are unable to work (Section 7.1). One in eight employers did not report paying any form of sick pay (13%)*, predominantly small employers (see Figure 7.1). This equates to 4% of employees in Great Britain working in organisations that do not pay any form of sick pay.

Micro employers were more than four times as likely not to pay sick pay (17%) than other employers. It was comparatively rare for small employers with 10-49 employees (4%), medium-sized (3%) and large employers (less than 1%) to not offer any form of sick pay.

As discussed in earlier chapters, this was linked to need: where employers had experienced LTSA or employees requesting support, they were more likely to pay sick pay.[93] For example, 15% of employers who had not experienced LTSA paid no sick pay compared to 4% of employers who *had* experienced LTSA. Likewise, 15% of employers who had not received employee request for help paid no sick pay, compared to 6% of employers who had received requests.

In the qualitative interviews, there were examples of small employers explaining that when their staff were absent from work it was only for minor ailments (such as colds), and they usually only missed one or two days work. These employers explained that these sick days were covered by employees' salaries, and no additional sick pay arrangements were required.

[92] Percentages calculated by weighting the data by the number of employees that work for employers that mentioned these sick pay arrangements.

* Employers may not pay sick pay for a range of reasons for example, employees being paid below the LEL, sickness absence lasting less than 4 days, sick pay being covered by employees' salaries or due to employer non-compliance with sick pay policy, although this was not raised in the course of the research.

[93] Sick pay is paid from the 4th day of absence by the employer and does not need to be requested by an employee.

The follow up qualitative research also included employers whose employees were not eligible to receive SSP. These employers used agency, casual and zero-hour contracts to respond to fluctuations in workload. Some of them restricted the hours of these workers to ensure they earnt less than £120 per week (the lower earnings limit[94] for SSP, tax and NIC), which meant that these workers were not eligible for SSP. These employers tended to have high turnover of casual workers, job roles that were low or unskilled and manual, such as companies providing services for cleaning, hospitality or unskilled labourers.

> *'I don't want staff to feel loyal as I want the freedom to replace staff as needed. We have a high turnover, it's the nature of the job. I try and keep staff to 20 hours or below a week and as a result I don't pay SSP. But for most staff this is their second job so if they were off sick which employer would be responsible for SSP and how would you determine this?'*[95]
>
> (Small, Construction)

There were also employers who were confused about what SSP entailed. These employers initially stated that they did not provide any form of sick pay, but through discussion in the interviews it became apparent that they *did* pay SSP for employees on sick leave.

The qualitative findings suggested that some employers did not see SSP as a form of sick pay, but rather as a government benefit. These employers could not explain how long SSP lasted for, how much it was, or how the process of paying it worked, and there were several examples of misconceptions surrounding SSP across the interviews, including:

- that they could claim SSP back from the government;[96]
- that employees themselves were responsible for claiming SSP; and
- how long an employee received SSP for depended on their length of service.

The employers who could not explain the details of SSP or who held these misconceptions were exclusively micro employers, and used external payroll companies, or passed on responsibility for processing SSP to their accountants.

> *'SSP is managed by* [name of external payroll company]. *I don't get involved and tell* [staff who are off]*, 'I have no idea what you will get paid within statutory sick pay'. I just pass on the dates of the absence to the payroll company. I don't know how long SSP carries on for … We're a small business and we pay people for the hours they work, they're not salaried. So, in the same way, I wouldn't expect to pay them for not working the hours they're meant to work.'*
>
> (Micro, Distribution, Hotels and Restaurants)

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[94] https://www.gov.uk/government/publications/rates-and-allowances-national-insurance-contributions/rates-and-allowances-national-insurance-contributions

[95] The lower earnings limit is determined in terms of earnings rather than hours worked. There are other factors that can exclude employees from being paid SSP, such as contract type.

[96] When the research was conducted, employers could no longer reclaim SSP for sick leave. At the time of writing, this is still the case, unless they are a small or medium-sized employer (fewer than 250 employees) with employees with absence related to COVID-19, please see: https://www.gov.uk/employers-sick-pay/help-with-sick-pay

Taken together, the interviews with employers who stated they did not pay sick pay indicate that, in reality, the proportion of employers not providing statutory sick pay may be slightly lower than the 13% reported, and the proportion paying SSP only, slightly higher.

7.3 Which employers offer SSP only, or above SSP, and why?

Which employers pay SSP only?

Over half of employers (54%) offered SSP only compared to 28% who paid above SSP. Paying only the statutory minimum was more common amongst small employers (55%) than medium-sized (46%) and large employers (16%). It was also particularly prevalent among employers in Distribution, Hotels and Restaurants (62%) compared to employers overall.[97] This was a sector with a high proportion of semi- and unskilled workers, small employers and, in addition, relatively few health concerns (53% of employers in this sector reported facing no health concerns, compared to 45% overall).

Paying SSP only was more common among employers who did not provide OH services (58%) than those who did (40%). Conversely, paying SSP only was higher amongst those who focused purely on health and safety training and guidance (63%) than employers overall (54%).

Employers who expected employees to return to work only when they were fully capable of completing all their work, mainly small employers, were more likely to only pay SSP than employers overall (63% compared to 54%).

Multivariate analysis: Which employers pay above SSP?

Given the associations between the employer characteristics, such as size and sector, a logistic regression analysis was undertaken to explore which factors were independently associated with employers paying above SSP.[98] These factors were included in a step-wise model:

- **Employer characteristics:** size, sector, presence of disabled employees in the workforce, and age profile of the workforce;
- **Employer practices and perceptions:** whether employers offered OH services, provision of health and wellbeing services, and employer expectations of when employees should return to work following a period of sickness absence.

Variables that showed no statistically significant association (at a 90 per cent significance level) were dropped from the model.

[97] A full table of statistics can be found in Table 11.19 in the Appendix.

[98] Defined as providing occupational sick pay or both versus providing only statutory sick pay. Employers providing neither or who did not know were excluded from the analysis.

The following employer characteristics and practices were found to be independently associated with paying above SSP (P<0.05, see Table 3.8 in the Technical Report for the full detail):

- **Size:** When controlling for other factors, employer size was found to be a key influential factor in whether or not employers paid above SSP, with large employers found to be almost four times more likely to pay above SSP than small employers.
- **Sector:** A similar, although less strong, relationship was identified with sector. Employers in "office-based" sectors, such as Public Administration, Education and Health, were nearly twice as likely as employers in other sectors such as Agriculture and Energy, to pay above SSP.

Some significant relationships were also found with other employer characteristics and health and wellbeing provisions:

- Employers who expected employees to return to work only when they were fully capable of completing all of their work, were less likely to pay above SSP;
- Employers that reported having any disabled employees were more likely to pay above SSP; and
- Employers who offered health and wellbeing initiatives and occupational health services were more likely to pay above SSP.

A similar model, restricted to only small employers, found that the patterns were similar for small employers.

Both models delivered limited explanatory power,[99] suggesting that there were other influential factors explaining why employers pay above SSP, beyond those captured in the survey.

Why did employers decide to pay above SSP, or not?

The qualitative research provides some additional insight into employers' underlying rationale for only paying SSP or for offering OSP.

One of the factors cited by employers who paid OSP was to aid recruitment; employers recounted that they wanted to match or exceed what their competitors were offering in order to attract and retain the best talents. Others explained that they offered OSP to aid productivity, by demonstrating to employees that they were valued. Some employers believed that paying above SSP was a moral duty of care and 'the right thing to do'.

There was also an example of a small employer considering an OSP scheme, by using an insurance plan, as their organisation grew in size and sickness absence became a more common issue.

[99] The final model accounted for an estimated 12% of the (pseudo) variance.

Case study: Looking to introduce OSP in a rapidly growing organisation

One organisation paid SSP from day four to day 27 of the sickness absence and had an insurance plan in place to cover sick pay up to six months. Subject to a successful claim, the insurance paid up to half pay or the living wage, whichever was greater. If employees' claim was unsuccessful, then they would remain on SSP for 28 weeks. Whilst a form of OSP, the employer was looking to enhance their offer to include:

- A living wage payment for the first three days of the sickness absence, that were currently unpaid, for all permanent staff who had passed their probation; and
- Replacing SSP with the living wage as part of a company OSP scheme.

The employer was considering this change due to a combination of taking on more staff, seeing sickness absences increase, and demands from employees.

> *'It's only when you start employing more and more staff that you actually kind of start to realise, 'wait a second, I think things are changing, so perhaps I need to review my policies' … We had staff feedback suggesting that unpaid sick leave, especially where people take one day off at a time, might impact on morale in the longer term, and encourage staff to look for work elsewhere.'*
>
> (Medium, Distribution, Hotels and Restaurants)

Employers in the qualitative interviews who paid SSP only did this because it was the statutory default option. These employers cited cost as the main reason for not paying more generous sick pay:

> *'There's only eight of us, we just can't afford to. I worked in a large business before buying this one - a big, PLC company. We all had company sick pay. But there's just no way we could afford to provide those benefits, you know, six months full pay and then six months half pay.'*
>
> (Small, Distribution, Hotels and Restaurants)

Employers who paid SSP only also considered the effect that offering different types of sick pay could have on employees' return to work. On the one hand, employers either suspected or had experience of employees returning to work too quickly because they could not manage financially on SSP alone. In a similar vein, some employers explained that they would be *reluctant* to offer OSP as they thought it might encourage employees to stay off work for longer, or even lead to an increase in sickness absence in the first place. They explained that the incentive came from being paid full, or close to full, pay whilst being off work.

> *'We do have quite a high level of sickness, being a call centre, and I don't know if people would take more time off. I think if you don't pay people [during their sickness absence] and they know they're not being paid for that day, they'll be like 'oh I need to work, I need the money'. I think if we did pay [OSP], I could be*

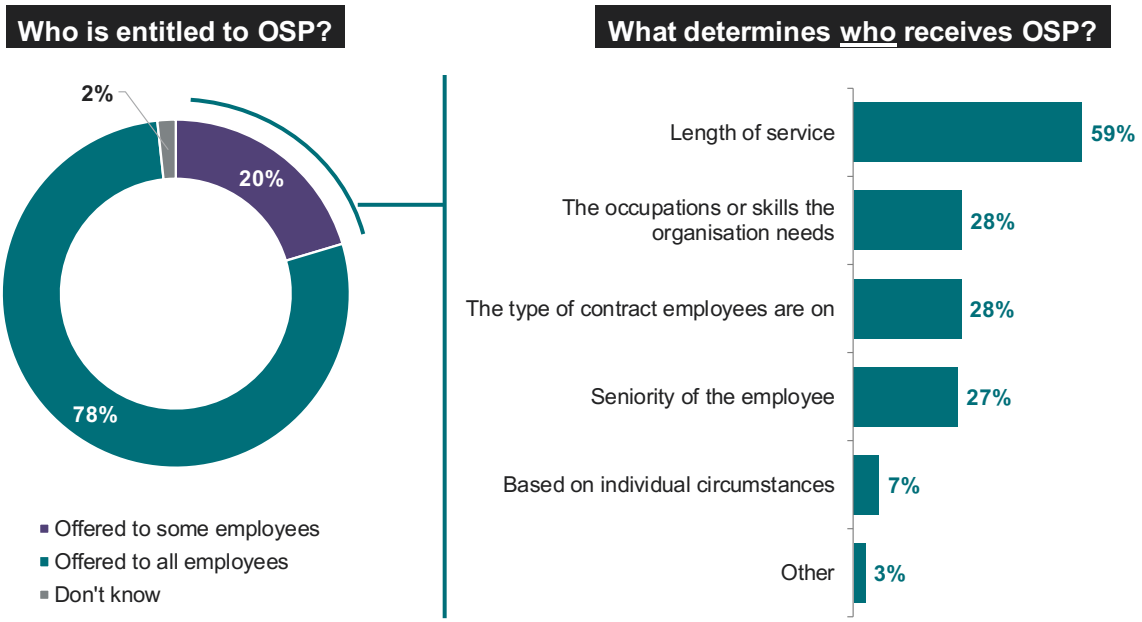
wrong, but I think our sickness levels would be higher. They may feel guilty and think 'oh I'm getting paid I better go back to work today' or they may say 'I'm getting paid I don't care'.'

(Medium, Financial, Professional and Administrative Services)

7.4 Occupational sick pay provision for different employees

Where employers offered OSP, the majority offered this to all of their employees (78%), with one in five offering it to *some* of their employees (20%), the remainder not knowing (2%). Figure 6.2 below shows whether employers offered OSP to all of their employees or not, and also the criteria by which they determined who received OSP.

Figure 7.2: Eligibility criteria for OSP



Base (unweighted): Left hand side of chart – All employers who offer OSP (1,069); Right hand side of chart – All employers who offer OSP to some of their employees (334)

Paying above SSP was more common amongst large employers than small, but where it was provided, the smallest employers were more likely to offer OSP to *all* of their employees than larger employers. Four in five micro employers (86%) offered OSP to all of their staff, compared to 68% of small (with 10 to 49 employees), 67% of medium-sized and 64% of large employers.

If employers offered OSP only to some employees, different criteria were used to determine this (shown above in Figure 7.2). These findings were substantiated by the qualitative interviews. Employers who offered a combination of SSP and OSP gave examples of the types of staff who were entitled to OSP:

- Staff who had been with the organisation for a certain length of time (and qualified for OSP); newer staff members were entitled to SSP only; and
- Had reached a certain seniority within the organisation (and became entitled to OSP as a benefit).

Decisions to pay above SSP were made on a case-by-case basis

As discussed in earlier chapters, some employers made decisions around health and wellbeing in the workplace on a case-by-case basis, and this extended to their sick pay policies. For example, some employers reported that they selected individual staff to receive OSP (rather than their standard SSP offer) to reward their loyalty or good performance.

There were also examples of employers who usually only paid SSP 'topping up' employees' SSP payments on a discretionary basis, supporting employees to pay their bills, or buying food or supplies, where they knew their employees would struggle to manage financially on SSP alone. In these cases, the individual circumstances of the employee and the relationship they had with their employer played a key role in the level of sick pay provided. Even larger employers, with formal sick pay policies, stressed the importance of having a flexible approach to sick pay. While policies provided assurance that employees were being treated equally and fairly, it was also seen as essential to have the flexibility to support an employee based on their individual needs.

> *'We only offer SSP but that doesn't mean we don't help out, we do and have provided financial support in the past - we just have to do it on a case-by-case basis, but we make sure we are fair to all of our staff. It's important we have this flexibility … We show our employees we care and we value them, just not in a formal way.'*
>
> (Small, Manufacturing)

These discretionary decisions were often made based on employee's length of service, the length of time the employee needed to be off work, and the level of skill and the role of the employee in the workplace. These decisions were made by company owners or the board of directors and were informed by other members of the management team. Where smaller employers did offer above SSP, this was sometimes a result of senior decision makers experiencing periods of long-term sick personally, which provided them with the drive to support their employees more formally.

> *'When there's somebody who's been with us a long time that goes off sick, that policy goes out the window. This is the type of place where if you put effort in, you get rewarded. They only get SSP according to their contracts, but if I choose so, I can pay them more.'*
>
> (Medium, Distribution, Hotels and Restaurants)

Different ways of delivering OSP schemes

Where employers paid OSP, they had different models for providing it, including:

- **A 'single pay scheme'** – providing sick pay above SSP, covering all employees providing they had completed their probationary period.

- **Separate schemes for different employees** – this could either be set out in the organisation's sick pay policy, or subject to discretionary decisions. In either case, the amount of sick pay received was dependent on various factors, including:
  - the number of years' service;
  - the type of employment contract;
  - the level of employee skill; and
  - the job role or level of seniority.

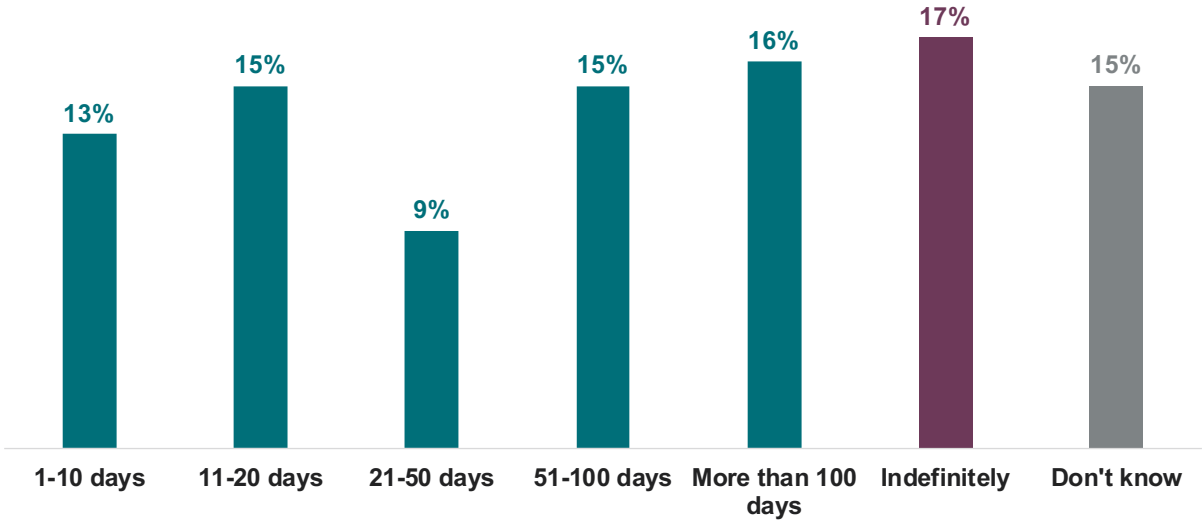
  In practice, this meant that permanent employers, with more business-critical roles that were harder to replace, tended to receive a better sick pay scheme. Even employers with a more structured 'tiered' scheme highlighted the importance of discretionary decisions where employees may not be eligible for a scheme. For example, one employer's OSP scheme started after 12 months' service with the company, but if something happened (ill-health or injury) to a newer employee, they would review the case and provide support where appropriate. Again, employers thought it was essential to have this flexibility.
- **Sickness absence protection insurance** – other employers had access to an insurance scheme that paid out a rate of sick pay above SSP after a given period.

7.5 Details of OSP payments

Employers who offered OSP were asked how long they would pay OSP to eligible employees in any one period of absence. One in six (17%) said that they would pay OSP indefinitely, while among those giving a finite amount of time, the average was 53 days. The average number of days was higher among large employers (71 days), non-private sector organisations (96 days) and employers that offered all four employer benefit options[100] (73 days). It was also higher among those employing mainly managerial and professional occupations (22% paid more than 100 days and 29% indefinitely).

[100] Regular flexible working, employer contribution to employee pensions above the statutory requirement, more than 20 days paid annual leave, and enhanced maternity/paternity pay above statutory levels.

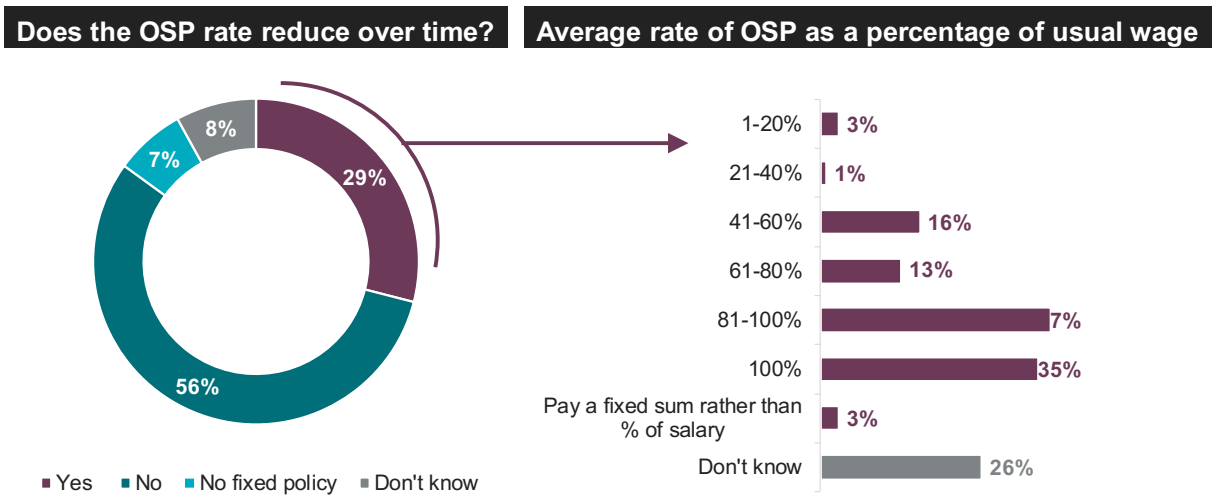
Figure 7.3: Length of time employers would pay OSP



Base (unweighted): All employers who offer OSP (1,069)

Among employers that offered OSP, three in ten (29%) said that the rate reduced over time during periods of sickness absence. This practice was more common among medium and large employers compared to small (42% and 43% respectively, compared to 27% of small employers) since larger employers tended to pay OSP for longer. The practice of reducing OSP rate over time was also more common among employers in Public Administration, Education and Health (52%),[101] among employers who had temporary staff (38%) and those who said they had disabled employees in the workforce (37%).[102] This is likely to be a feature of size, since these characteristics are more commonly associated with medium and large employers.

Figure 7.4: OSP rate reduction over time



Base (unweighted): Left hand side of chart – All employers who offer OSP (1,069); Right hand side of chart – All employers whose rate of OSP reduced over time (386)

Employers who paid OSP for more than 100 days were more likely to reduce their rate over time compared to those paying for a shorter duration (45% compared to 30%). However, the majority of employers (72%) who paid OSP indefinitely reported

[101] A full table of statistics can be found in Table 11.20 in the Appendix.

[102] A full table of statistics can be found in Table 11.21 in the Appendix.

that they did not reduce their rate over time. The qualitative interviews aligned with the findings of the survey, with the length of time for which an employee received OSP varying markedly. In addition, a few employers gradually reduced the amount of OSP over time, which they did to avoid too much of a financial shock to employees.

Similar to the above, employers stressed the importance of considering the length of time they paid OSP on a case-by-case basis, explaining that if they felt the situation merited it, they would offer OSP for longer than their policy stated.

Case study: Considering length of OSP on a case-by-case basis

One charity's sick pay policy was two weeks full pay, followed by SSP. They explained that they would offer SSP plus an additional top-up, in practice. This was not written in their sick pay policy, and the board of directors would discuss how much extra to pay.

In one case, an employee took a three-month absence for elective surgery. The board met and decided that they should remain on full pay throughout their absence and gradual return to work. The employer made this decision because the employee was a valued member of the team, and they knew she would struggle financially on SSP for three months.

> *'Everybody here goes the extra mile while they're working, so we felt it was only right that we should support our staff when they need it most.'*
>
> (Small, Charity)

Based on this case, the board of directors decided that they would review all sickness absence cases individually going forwards, to determine the level of sick pay offered.

8. Employers' provision of occupational health services

This chapter explores employers' provision of occupational health (OH) services, the reasons why they do and do not puchase OH, and how they use these services in practice.

Key findings

One in five employers offered OH services to their employees (21%; see Figure 8.1) and this was more common amongst large (92%) than medium (49%) or small employers (18%). Perceptions of need were a key factor as to whether employers offered OH services or not. The most common reason why employers did not offer OH services was a lack of employee demand or employees not disclosing they were in need of support (42%).

- Overall, a third of employers cited cost as the main barrier (too expensive, 16%; or too few cases to justify the expense, 22%; see Table 8.4) but knowledge of actual costs amongst small employers was limited. Smaller employers only sought OH advice when they felt out of their depth or had experienced multiple cases of ill-health to warrant longer-term investment in external, formalised support.
- The most common reason why employers used OH services was to help minimise sickness absence and improve employee health and wellbeing (57%; see Table 8.2). Employers also cited the influence of legal obligations on their decision to use OH services. This may explain why riskier, or more physical, workplaces had higher levels of OH provision on average.
- OH provision tended to be part of a wider package of health-related support aimed at keeping employees healthy and in work, such as health and safety training, Employee Assistant Programmes (EAPs), or other measures to support staff with health conditions to remain in work or return to work following a sickness absence.
- Regardless of size, employers offering OH services indicated they would pay for follow-up treatments recommended by OH professionals but would make decisions on a case-by-case basis considering the importance of the individual for the organisation.
- Of those employers that provided access to OH, large employers were more likely to purchase long-term contracts (48%) compared to small and medium employers (24% and 26% respectively). Instead small and medium employers were more likely to provide OH on an ad-hoc basis (43% and 63% respectively), reflecting perceptions of both employee need and cost effectiveness (see Figure 8.3).

8.1 Provision of OH services

What are occupational health (OH) services?

Occupational health (OH) comprises advisory and support services to help employers 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, for example to improve work environments and cultures. OH focuses on the physical and mental wellbeing of employees at work including:

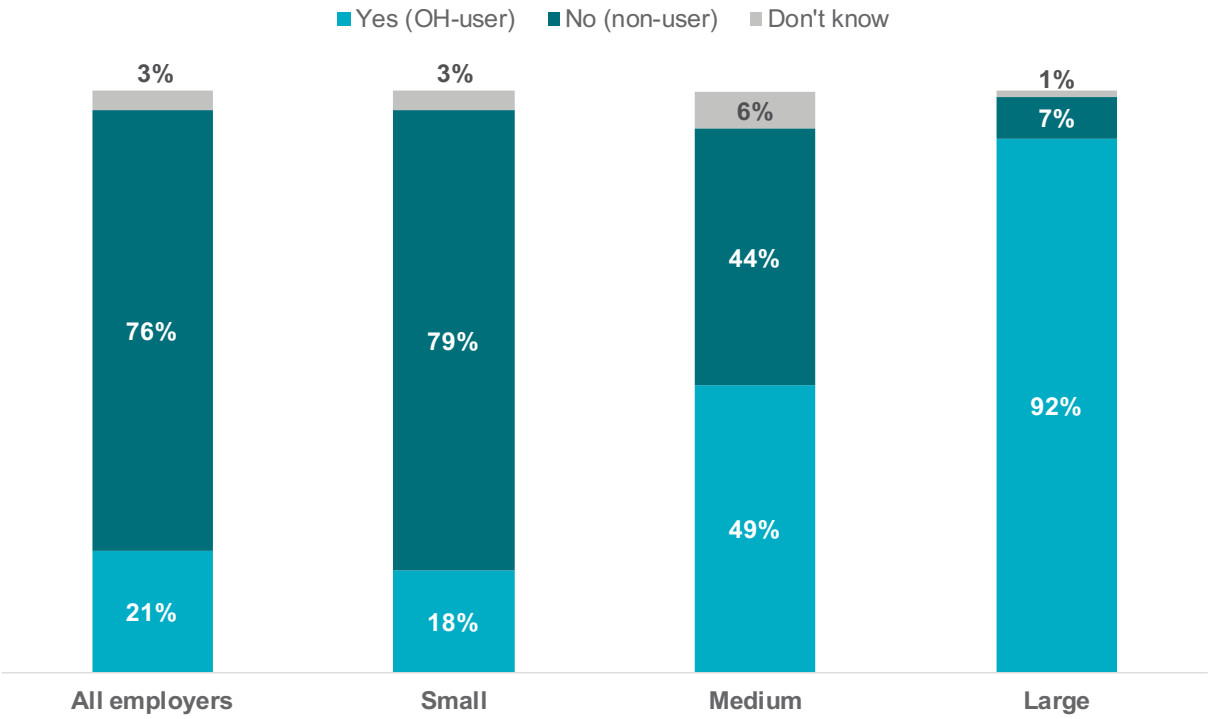
- Preventing work-related illness or injury through encouraging safe working practices, and helping employers to implement policies and health and safety compliance;
- Supporting employees to manage conditions and remain in-work through reasonable adjustments (e.g. ensuring the workplace is accessible, making changes to employees' desks or chairs for more comfortable working, amending job roles, or sign-posting appropriate interventions);
- Supporting the management of sickness absence, both long and short-term, and employees' return to work (including amending job roles, or adopting flexible/phased returns);
- Preventing common health concerns from becoming a problem through monitoring the health of the workforce (trying to proactively prevent sickness absence), including conducting pre-employment health assessments, or supporting health promotion and education programmes; and
- Providing advice and counselling to employees around non-health or non-work related problems.
- OH services are delivered by professionals employed by private providers. In recent years, the OH market has adopted a multidisciplinary workforce which includes, but is not limited to, healthcare professionals (doctors or nurses), physiotherapists, hygienists, psychologists, occupational therapists and ergonomic experts.

103

Provision of OH services was common amongst large employers but was far less widely reported amongst small and medium-sized employers; large employers (92%) were five times more likely than small employers (18%) to provide OH services (Figure 8.1).

[103] Ipsos MORI (2019) Employers' motivations and practices: A study of the use of occupational health services, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/789894/employers-motivations-and-practices-a-study-of-the-use-of-occupational-health-services.pdf

Figure 8.1: Provision of OH services by employer size



Base (unweighted): All employers (2,564), small employers (1,457), medium employers (584), large employers (523).

Employers in Public Administration, Education and Health were most likely to provide OH to their employees (44%), whilst employers in Distribution, Hotels and Restaurants were least likely (14%).[104]

Table 8.1 shows the figures for OH provision, grossed to the population of employers and employees. Overall, 21% of employers provide OH services, while 55% of employees work in organisations that offer OH services.

Table 8.1 Grossed estimates for OH provision

	Employers who offer OH	Employees who receive OH[105]
Provide/have access to OH services	21%	55%
Do not provide/do not have access to OH services	76%	41%
Don't know	3%	4%
Base	*1,093,353*	*20,594,580*

Base: All employers and employees in Great Britain.

Source: Inter-Departmental Business Register (IDBR), 25 April 2018.

[104] A full table of statistics can be found in Table 11.22 in the Appendix.

[105] Percentages calculated by weighting the data by the number of employees that work for employers that mentioned provision of OH. This assumes that all employees in those employers receive OH (which may not be the case).

Multivariate analysis

Given the associations between the employer characteristics, such as size and sector, a logistic regression analysis was undertaken to isolate the factors most strongly associated with employer provision of OH services.[106]

The following factors were included in the stage-wise[107] model:

- **Employer characteristics:** size, sector, age profile of the workforce, proportion of employees with long-term health conditions or disabilities in the workforce, occupational skill level, staff turnover and whether employers had experienced LTSA in the last 12 months.
- **Employer practices and perceptions:** whether employers offered OSP, health and wellbeing provisions, had measures to prevent ill-health and what they perceived as barriers to supporting return-to-work.

Factors that showed no statistically significant association (at a 90 per cent significance level) were dropped from the model.

The following employer characteristics and practices were found to be independently associated with providing OH services (see Table 3.6 in the Technical Report for the full detail):

- **Size:** The impact of employer size was found to be larger than presented by the descriptive statistics, with the model showing large employers around 19 times more likely than other employers to provide OH services.[108]
- **Sector:** The sector the employer operated in also showed statistically significant association to whether or not an employer offered OH. Employers in Public Administration, Education and Health were around twice (1.7 times) as likely to provide OH services than employers in other sectors after controlling for all other factors.
- **Staff turnover:** In addition, employers with an annual staff turnover rate of over 20% (mainly small employers) reduced the likelihood of OH provision by over one half compared to 1-4% staff turnover.
- **Employee age:** Age was also found to be statistically significant. Employers with an older workforce (defined as more than half the workforce aged above 50, mainly small employers) were less likely to provide their employees with access to OH services.
- **Provision of other health and wellbeing services:** Significant relationships were also found with health and wellbeing provisions, with employers who offered any health and wellbeing related services being more likely to provide OH services than those who offered nothing. Specifically, those who provided an Employee

[106] The analysis focused on employers who reported they provided OH services.

[107] In a stage-wise regression, at each step where a variable is added to the model, all variables currently in the model are checked to see if they are still significant. If any variables are no longer significant, they are removed from the model.

[108] This is based on odds ratios; a statistic that quantifies the strength of association between two variables.

Assistance Programme (EAP)[109] were over three times more likely to provide OH services than employers without and those who offered three or more measures to support employees with health conditions were almost twice as likely to provide OH services than employers who offered nothing.

- **Sick pay:** Employers who paid OSP were more than three times as likely to provide OH services as employers paying no sick pay.
- **Barriers to supporting an employee's return to work after LTSA:** Employers who reported 'employee engagement in the process' as a barrier were more (1.7 times) likely to provide OH services than employers who did not report it as a barrier. In addition to this, employers who reported 'a lack of expertise or specialist support' as a barrier were less likely to have OH.

Size dominated the results of the initial model, so a second model was repeated with small employers only. The second model found similar patterns to the initial model, in relation to sector, OSP and health and wellbeing provisions.

The explanatory power[110] of both models was higher than that of the sick pay models. The explanatory power of the model for small employers was almost half of that of the model for all employers. This means there are other factors (particularly for small employers), beyond those captured in the survey, that also explain OH provision. This was further explored in the qualitative follow-up research with employers.

Perceptions of need

The qualitative research was designed to explore additional factors influencing employer behaviour, beyond those included in the survey (and therefore used in the regression analysis).

The qualitative research highlighted that perceived need was a key factor in employers' motivations to provide OH services and other health and wellbeing measures. Employers' assessment of this need were related to a range of interlinked characteristics such as:

- Size of their workforce which influenced likely demand for OH services;
- The prevalence of sickness absences which also influenced likely demand for OH services;
- The seriousness of sickness absences which influenced the types of OH services required including the need for expert advice; and
- The availability of other sources of support for employees with health conditions.

[109] The qualitative research provided examples of OH-users having a form of EAP as part of their OH package. These employers explained that their OH services included a free, confidential, 24-hour telephone helpline providing advice and support to employees, and the option to signpost or refer to additional support services, including counselling. This suggests that the relationship between having an EAP and the likelihood of providing OH services could be explained by the fact that employers' OH packages might include an EAP, or similar service.

[110] Analysis of all employers provided a reasonable model in that around 21 per cent of the pseudo-variance was explained. The model results for small and micro employers were not as good; the final model accounted for 11% of the pseudo variance.

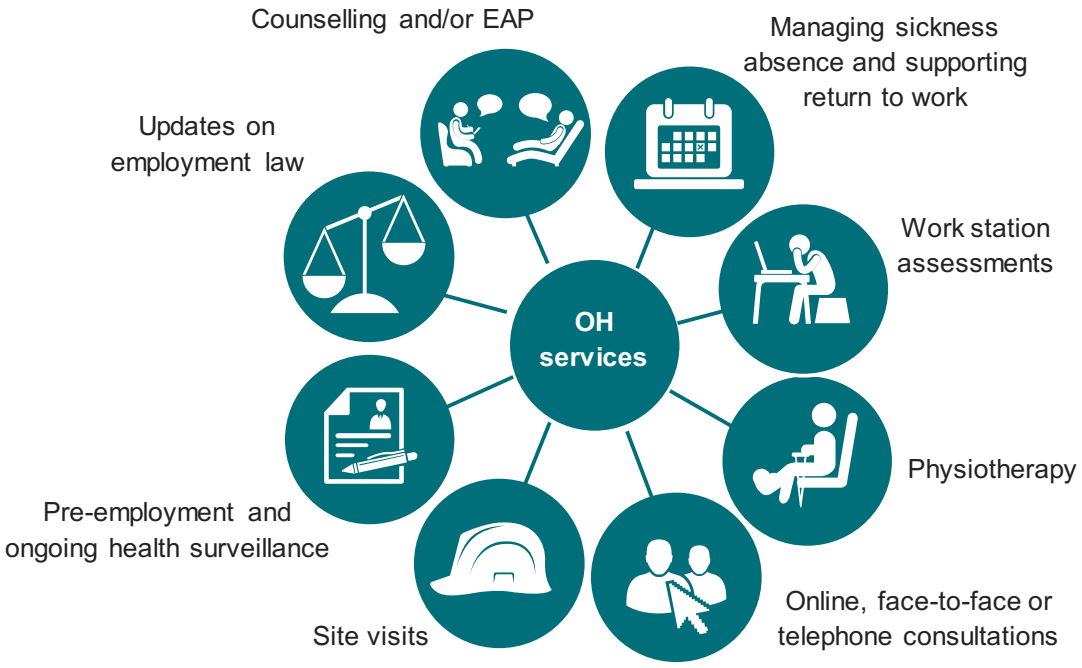
Small employers explained that they did not have enough employees to justify using OH services (either on a permanent contract or an ad hoc basis). This, in turn, was because they did not face a high enough number of sickness absences to feel that sickness absence was becoming an issue for the business, *or* they had not faced employees with sufficiently serious conditions to merit bringing in external support and expertise. This is expanded on in more detail in Section 8.4.

> *'I've just got no need for* [OH]*. If I needed it, I suspect I could get somebody in - I don't think I need an ongoing contract to be able to access these services. I'm sure I could just book a one hour consultation and get everything I need from that. We're so small that I can be a bit more reactive with it, rather than having to be proactive, like a massive organisation. They have to be more proactive, as they've got so many people to handle - so many potential issues could come up if there's no consistency. They need a fair and consistent service. And, when you've got so many employees, you need to keep them healthy and in work for financial reasons as much as anything else. The cost to the business would be so much greater. You couldn't have people off sick all the time and not do anything about it.'*
>
> (Small, Distribution, Hotels and Restaurants)

8.2 Why and how do employers use their OH services?

The follow-up qualitative research explored employers' use of OH services. The different services employers used are summarised in Figure 8.2 below.

Figure 8.2: Different OH treatments and services



In the survey and follow-up qualitative research, employers were asked both *why* they used OH services and *how* they used them. In practice, employers' reasons for using OH services and their actual use of OH were very similar, as shown in Tables

8.2 and 8.3, below. The most common *reason* why employers used OH services was to help minimise sickness absence and improve employee health and wellbeing (57%) and the most common *use* of OH services was to help maintain a healthy workforce (42%).

Table 8.2: Employers' reasons for providing OH services for staff (multicode)

		Size of Employer		
	*** Total**	**Small**	**Medium**	**Large**
Helping to minimise sickness absence and improve employee health and wellbeing	57%	52%	63%	86%
Meeting expectations from employees or their representatives	19%	18%	22%	27%
Fulfilling a legal obligation	11%	11%	11%	11%
Helping recruitment or retention	10%	9%	9%	17%
Managing or increasing productivity	9%	9%	12%	6%
Helping to minimise cost resulting from sickness absence	9%	8%	11%	12%
Maintaining a moral obligation/duty of care	4%	4%	6%	*
Maintaining the organisation's reputation	3%	3%	5%	7%
Managing return to work	1%	*	5%	1%
Helping staff to get seen earlier or be treated quicker	1%	1%	*	*
Varies on a case-by-case basis	1%	1%	1%	*
Other	2%	2%	2%	*
Don't know	10%	12%	3%	2%
Base	*1,059*	*313*	*311*	*435*

Base: All employers who provide occupational health services (unweighted)[111]

** Employers could select more than one response, therefore column percentages do not add to 100%*

[111] The following conventions are used in tables throughout the report: less than 0.5 per cent (*) and no observations (0).

Table 8.3: How employers use their OH services (multicode)

	Size of Employer			
	*** Total**	**Small**	**Medium**	**Large**
To help maintain a healthy workforce	42%	41%	42%	54%
To manage an employee's sickness absence	32%	28%	33%	67%
To prevent and remove health risks arising in the workplace	32%	31%	35%	37%
To give independent and professional diagnosis, prognosis, and advice about staff unable to work due to health problems	30%	25%	41%	54%
To ensure your organisation meet its statutory responsibilities	26%	24%	31%	27%
To provide screening and health surveillance services	21%	18%	30%	38%
It is used as and when required	8%	9%	4%	1%
Other	3%	2%	5%	1%
Don't know	14%	15%	12%	2%
Base	*1,059*	*313*	*311*	*435*

Base: All employers who provide occupational health services (unweighted)

** Employers could select more than one response, therefore column percentages do not add to 100%*

As the multivariate analysis in Section 8.2 indicated, OH provision tended to be embedded within a wider suite of health-related support aimed at keeping employees healthy and in work, such as health and safety training or guidance, EAPs, or a range of measures to support staff with health conditions to remain in work or return to work following a sickness absence.[112] Employers who used OH services saw these as one part of a wider package of support to keep their employees healthy and in-work.

As covered in Section 5.2, employers explained how disruptive sickness absence could be for productivity and those with higher instances of sickness absence understood well the benefits of investing in retaining staff. The qualitative research, and other research conducted by Ipsos MORI on this topic, found three key factors underpinning employers' use of OH services to address sickness absences, improve employee health and wellbeing, and ultimately to retain staff:

- **Legal:** Using OH professionals to support compliance with health and safety guidelines and to ensure employers handled sickness absences in a legally compliant manner;
- **Business:** Using OH services to avoid costly sickness absences and costs associated with replacing staff/skills; and
- **Moral:** Providing OH services out of a moral duty of care to employees.

[112] This included: meetings with employees; phased returns to work from sickness absence (returning to full duties and hours at work gradually, over a defined time period); amending employee workload or job role (e.g. reduced hours/days, extra breaks, or different duties); workplace adjustments (such as different chairs or desks, building modifications, or other specialised equipment); a job coach or personal assistant (e.g. a sign-language interpreter for meetings); and additional external support or advice (e.g. clinical support such as psychological therapy or physiotherapy, or another expert or specialist).

These factors are discussed in more depth in 'Employers' motivations and practices: A study of the use of occupational health services'.[113]

How do employer characteristics shape use of OH services?

Employer size shaped their use of OH services. Large employers were more likely to experience LTSA including severe health conditions and to have employees requesting help than small employers. Linked to this, large employers were more likely to use their OH services across almost all of the reported uses of OH services (Table 8.3).

For example, large employers were more likely to use their OH services to give an independent and professional diagnosis (54%) than small employers (25%). In the qualitative interviews, employers managing employees with more severe conditions explained that seeking an independent and professional diagnosis in these cases was important for two reasons: First, to better understand how to accommodate the employee's condition in-work and second, to get a better indication of when employees might be able to return to work.

Large employers (80%) were also more likely to seek an independent assessment of an employee's work capacity (including via an OH assessment), in order to manage a return to work after a LTSA[114] than small employers (24%). This finding, supported by the qualitative interviews, suggests that large employers drew on OH services more routinely than small employers who tended to only use OH services when they encountered cases that were beyond their expertise.[115]

By contrast, the responses of large and small employers were more similar regarding uses of OH services that focused on health and safety aspects,[116] and legal requirements.[117] This suggests that the volume and severity of employee sickness absences and request for support played less of a role in this area, with compliance with legal requirements being an important reason to use OH services across all sizes.

Focusing on Manufacturing, as a result of their riskier working environment, these employers were more likely to use their OH services proactively, provide screening and health surveillance services (49% compared to 21% of employers overall).

[113] Ipsos MORI (2019) Employers' motivations and practices: A study of the use of occupational health services, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/789894/employers-motivations-and-practices-a-study-of-the-use-of-occupational-health-services.pdf

[114] See Table 6.3 in Chapter 6.

[115] See Section 6.2 for more detail.

[116] Employers using their OH services 'to prevent and remove health risks arising in the workplace'.

[117] Employers using their OH services to 'ensure the organisation meets its statutory responsibilities'.

When do employers pay for OH treatments or recommended modifications?

The qualitative research found that employers with OH contracts offered assessments to employees in need regardless of their seniority or length of service, though there were examples of employers restricting access to contracted employees (i.e. excluding those on zero hours contracts, or agency staff).[118]

The research also found that, in some cases, whilst employees had access to assessments, employers needed to make decisions on whether or not to pay for further treatment (such as physiotherapy). Their decision-making depended on:

- **the value of the employee to the organisation** – namely, whether the employer felt it was worthwhile investing in private treatment in order to retain the employee, or whether signposting them to NHS support would suffice. There were examples of employers in the interviews choosing to pay for private treatment, in order to reward loyalty to the organisation, or to ensure a quicker return to work.
- **how affordable the treatments were** – this was a particularly important consideration for small and medium employers with tighter margins, who had to weigh up the potential length of an extended sickness absence, or wait for NHS services, against the cost of private OH treatment. Large employers were more unequivocal in their explanation that if paying for treatment would help them retain valued employees, then they would do so.

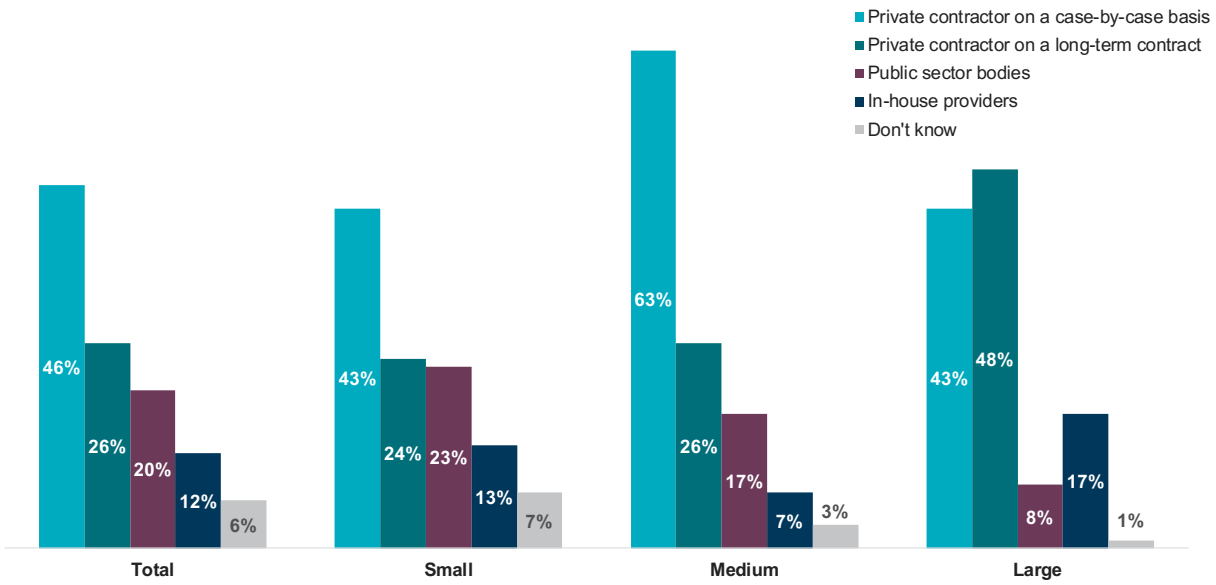
Employers' rationale in these cases were similar to those already discussed in Chapter 6 on making reasonable adjustments.

8.3 What do employers' OH contracts look like in practice?

Seven in ten employers (72%) used external private contractors for their OH services, either on an ad hoc basis (46%) or long-term contract (26%). The proportion of employers using in-house providers was less common (12%). One in five employers (20%) across a range of sectors had access to public sector OH provision or the NHS Health at Work Service. NHS bodies, most importantly NHS Health at Work, primarily provide their services to NHS staff, but also has a commercial arm. Figure 8.3 below shows the type of OH provider by employer size.

[118] See Section 8.4 for more detail.

Figure 8.3: Type of OH provider by employer size



Base (unweighted): All employers who provide OH services (1,059), small employers (313), medium employers (311), large employers (435).

Employers' motivations for using OH services and the nature of their OH contracts were linked. Employers who used private contractors, either on a case-by-case basis (63%) or with a long-term contract in place (67%), were more likely to use their OH services to minimise sickness absence and improve employee health and wellbeing than OH-users overall (57%). In contrast, employers who had in-house OH provision tended to have broader objectives for providing OH, such as meeting expectations from employees or their representatives (32%) and helping with staff recruitment and retention (17%) than OH-users overall (19% and 10% respectively).

The idea that employers used different contracts depending on purpose is supported by additional qualitative research carried out by Ipsos MORI on this topic.[119] This research found that, in general, employers with long-term OH contracts or in-house provision used their OH services to address broader objectives than sickness absence and work capability assessment. Rather, these employers used their OH providers to take a strategic look at health and wellbeing support across the organisation including the provision of proactive support.

The qualitative research also explored why some employers chose to purchase OH services on an ad hoc basis, rather than engaging a permanent provider on a long-term contract. Small employers in particular explained that they were too small and/or had an insufficient volume of cases for which a permanent OH contract was required, and it was therefore not cost-effective to have a long-term contract in place.

[119] Ipsos MORI (2019) Employers' motivations and practices: A study of the use of occupational health services, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/789894/employers-motivations-and-practices-a-study-of-the-use-of-occupational-health-services.pdf

> *'We're a small business, so it's just prohibitively expensive to have someone there all the time. If we had more regular sickness absences then we might … refer staff to OH, but we're just not big enough to merit any kind of ongoing contract.'*
>
> (Employer without OH services, Small, Agriculture and Energy)[120]

Finally, sector and working environment also influenced employers' choice of OH provider. This was also evident in previous research on employers' use of OH services conducted by Ipsos MORI in 2019 which found the following:

- Employers whose **OH services were delivered in-house by specialist OH teams** adopted this model because they operated in highly-specialised environments and did not feel that an external OH professional would be able to provide the level of support they required.[121]
- **Employers working in or on behalf of the public sector were more likely to use** publicly-funded providers. This practice was more common in Public Administration, Education and Health (43%) and Construction (26%) than amongst employers overall (20%).[122] Examples included employers who:
  - had access to an NHS offer (in these cases, the NHS was providing OH services to its employees *as an employer*, not as an OH provider. Examples included a GP practice and an NHS subsidiary company); and
  - worked in Construction and were required to provide certification for their employees when they won certain contracts, namely for government clients. In these cases, they had to provide proof of an OH assessment (which they could also source privately), approving their fitness to work, before they could begin on any government contract.

Payment structures of OH contracts

The follow-up qualitative research explored the different types of payment structures used by employers and OH providers. Small to medium employers commonly used ad hoc contracts with a 'pay-as-you-use' pricing structure. This was seen as more cost-efficient for employers whose need for OH services was intermittent, as it avoided any ongoing fixed monthly fees.

Larger employers, who were more likely to experience instances of LTSA and employee requests for support with their health concerns, were more likely to have permanent contracts in place. Large employers (48%) were twice as likely to use permanent contracts as small employers (24%).

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[120] Quote taken from Ipsos MORI (2019) Employers' motivations and practices: A study of the use of occupational health services, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/789894/employers-motivations-and-practices-a-study-of-the-use-of-occupational-health-services.pdf

[121] Ipsos MORI (2019) Employers' motivations and practices: A study of the use of occupational health services, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/789894/employers-motivations-and-practices-a-study-of-the-use-of-occupational-health-services.pdf

[122] A full table of statistics can be found in Table 11.23 in the Appendix.

Payment structures on permanent contracts varied. In some cases, monthly payments were made based on employers' use of OH services, while others had fixed fees which were paid either as a one-off annual payment or by 12 equal monthly instalments. Employers with annual fixed fees tended to have unlimited access to OH services outlined within their agreement. One employer mentioned that while their contract was based on a fixed annual fee it was 'experience rated', i.e. the fee could increase the following year if they exceeded the agreed limit for that year.

> *'It's the same as if you make a claim on your car insurance, if you have a smash you know next year it's going up.'*
>
> (Large, Distribution, Hotels and Restaurants)

There were no examples across the follow-up qualitative interviews of employers who were aware of any subsidies or incentives available to reduce the cost of using OH services.

8.4 Reasons for not providing OH

Three in four employers (76%) did **not** provide access to OH services, mostly small and medium-sized employers: 79% small; 44% medium and 7% large. Employers cited a range of reasons for why they did not provide access to OH services, with over half (64%) citing a lack of employee demand, or too few cases to justify the expense. As discussed, these individual reasons were all factors that shaped employers' overall perceptions of whether they *needed* to provide OH services or not (Table 8.4).

Four in five employers gave a single reason for not providing OH services for their staff (79%). The most common, single reason given was lack of employee demand (42%).

Lacking employee demand or having too few cases to justify the expense of OH services was related to instances of LTSA. Employers who had not experienced LTSA in the last 12 months were more likely to cite having too few cases (23%) or lack of demand (38%) than employers who had experienced LTSA (18% and 27% respectively). This finding was consistent with the experiences of small and medium employers in the qualitative interviews, who did not use OH services. These employers explained that lack of demand and cost were linked, in terms of whether or not they could justify the expense associated with purchasing OH.

Table 8.4: Reasons for not providing OH services (multicode)

		Size of Employer		
	*** Total**	**Small**	**Medium**	**Large**
No employee demand/employees not disclosing they are in need of OH/not required	42%	42%	33%	10%
Too few cases to justify the expense	22%	22%	15%	8%
Cost/too expensive or unable to get funding	16%	16%	25%	32%
Not a priority for this organisation	15%	15%	15%	3%
Lack of knowledge (what services to buy, who to buy from)	3%	3%	4%	23%
General make-up of the workforce doesn't make it worthwhile	3%	3%	7%	7%
Lack of time to investigate	3%	3%	13%	5%
Too complicated	1%	1%	1%	2%
Lack of awareness or support amongst senior management	1%	1%	1%	0
Don't know	7%	7%	13%	18%
Base	*1,410*	*1,083*	*252*	*75*[123]

Base: All employers who do not provide occupational health services (unweighted)

** Employers could select more than one response, therefore column percentages do not add to 100%*

Non-users who were familiar with what OH services entailed recognised the value of OH for employers with high incidences of sickness absences affecting productivity. However, they did not see themselves in this category and could not justify purchasing OH services in the absence of demand. For small and medium employers, demand meant having both high incidence of sickness absence that posed a barrier to productivity, and/or employees with health conditions that require external specialist support (including request for support from employees). In short, employers needed a business case for investments in OH services.

However, non-users of OH in the qualitative research generally lacked knowledge on the actual costs of OH services. They perceived OH services as unaffordable, and this had prevented them from looking into purchasing OH services in more detail.

The advanced statistical analysis showed that having a low-skilled workforce did not influence OH provision or non-provision. The qualitative research included interviews with employers who had a high proportion of unskilled workers on zero-hour, casual or agency contracts, to understand whether this had any bearing on employers' decisions to offer OH services. There were examples of employers **not** offering OH services to workers on these contracts, but these were exclusively small employers. In these cases, employers explained that they had balanced the cost of providing OH services for staff on temporary contracts against the cost of replacing casual workers if they were unable to work due to illness. Whilst this does not mean that this is a factor for *all* employers with casual workers, it does suggest it is a reason for some.

[123] Caution: extremely low weighted base size (4); findings should be interpreted with caution.

> *'It's not something we would offer for zero-hours contractors. It would be too costly. If they don't work, there will be another person available to do that role.'*
>
> (Small, Construction)

Other reasons offered by employers in the qualitative research for why they did not provide OH included:

- Having a 'tight-knit family' culture meaning most issues can be dealt with informally and internally;
- Lacking the knowledge or holding misconceptions about OH services;
- Having negative perceptions of OH services; and
- Feeling that alternatives (namely the NHS, see following page) to OH were sufficient.

Employers who preferred to support their employees informally were usually small and staff were friends outside of work, meaning that employers and employees could check in with each other in terms of their health and wellbeing, outside of the 'formal' employer-employee relationship. These employers regarded these informal approaches as sufficient and did not feel the need for formal OH services.

Secondly, some non-users explained that they lacked the knowledge to make an informed choice on whether to offer OH services to their employees. The survey found that three percent of employers did not provide OH services due to a lack of knowledge around what services to buy or who to buy them from. Separate qualitative research carried out by Ipsos MORI on employers' reasons for using and not using OH services also found examples of misconceptions around how OH services were used, namely that:[124]

- OH services were only used by, or relevant for, large companies;
- OH services were only for disabled people or people with long-term health conditions; or
- OH services could be used to 'force employees out of a business'.

There was evidence that some still have negative perceptions of OH services from both pieces of qualitative research on OH services (the 2019 report and current research). Those who held these views explained that, for them, OH services had connotations with dismissals and managing workers out of an organisation. The below case study is from the follow-up qualitative work and highlights this association.

[124] Ipsos MORI (2019) Employers' motivations and practices: A study of the use of occupational health services, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/789894/employers-motivations-and-practices-a-study-of-the-use-of-occupational-health-services.pdf

Case study: Negative perceptions of OH services

One micro employer did not offer OH services, as they did not feel it was necessary in such a small organisation. If the employer required specialist medical advice, they would suggest their employee approached their GP in the first instance.

The participant explained that in a previous role, she was tasked with overseeing a large number of redundancies, and it was suggested that she should use OH referrals as a way to facilitate this.

> *'It used to be that once the OH-bomb was dropped, or they were brought in, that was it - they wanted to get rid of you. The mere mention of OH was enough to get employees out - let them know we were onto them, and this was the start of it, getting rid of them without any need for more formal processes. It was always phrased in a nice way, but the undertone was that we want to find out if you're a problem, and whether you're going to be sticking around for much longer. OH was a way to get people to jump before they were pushed.'*
>
> (Small, Distribution, Hotels and Restaurants)

Despite this association, the participant was very positive about her own, later experience of being referred to an OH provider.

Finally, there was also a perception that alternatives to OH provision (namely the NHS) were sufficient to support employees with health conditions. Among employers who could not justify the cost of providing OH services, the availability of free medical expertise from employees' GPs rendered an investment in OH services unnecessary. However, recent qualitative work conducted by Ipsos MORI on the fit note found a lack of understanding of the role of the NHS and OH services.[125] For example, some employers wanted and/or expected GPs and hospital doctors to provide job-specific advice on the 'maybe fit for work' option on the fit note, to support an employee's return to work. However, the fit note is only designed to indicate an employee's fitness to work *in general*, and is not job specific.

[125] Ipsos MORI (2019) Exploring perceptions and attitudes towards the extension of fit note certification, available at: https://www.gov.uk/government/publications/exploring-perceptions-and-attitudes-towards-the-extension-of-fit-note-certification

9. Segmenting the employer population

This chapter presents the findings of segmentation analysis that was undertaken to differentiate the employer population according to their behaviour in relation to employee health and wellbeing. Previous chapters have indicated that certain behaviours might go hand in hand, but this chapter explores how these behaviours fit together as a whole.

Key findings

Segmentation analysis was undertaken on the survey data to categorise employers into distinct groups based on their health and wellbeing provision. The analysis identified seven different groups. These ranged from employers whose support was largely confined to health and safety requirements (the 'Minimal Support' and 'Reluctant Support' groups), to employers who offered more comprehensive, yet informal, non-financial provisions such as meetings and amends to job role (the 'Informal', 'Pragmatic' and 'Reactive Support' groups), to employers who invested in a comprehensive and proactive package of health and wellbeing support, including workplace health promotion, OH services, and OSP (the 'Intensive' and 'Structured Support' groups).

- The analysis found that greater levels of health-related support tended to be provided alongside more generous wider employee benefits, such as enhanced maternity pay or pensions contributions.
- Three in ten employers were in the **'Minimal Support'** group (29%). Micro employers were overrepresented, making up 82% of the segment compared to 67% of the overall employer population. Preventative measures were focused predominantly on providing health and safety training, access to OH services was rare, and employers were more likely to not pay sick pay compared to other segments.
- One in twenty employers (6%) were in the **'Intensive Support'** group, with large employers overrepresented (9% of the group versus 2% of employers overall). This segment had the most extensive and established provisions. They provided multiple measures to prevent non-work related ill-health, including Employee Assistance Programmes (EAPs), and were the most likely of any segment to offer OH services (99%), and to pay above SSP.
- Though larger organisations tend to provide more generous and more varied health and wellbeing support to their employees, organisation size did not always predetermine generous health and wellbeing provisions. One in seven (15%) small employers were in the two most comprehensive segments ('Structured' or 'Intensive Support'), whilst half of medium-sized (52%) and 14% of large employers were not in these segments.

9.1 Introducing the segments

A key objective of the research was to differentiate the employer population according to their behaviour regarding employee health and wellbeing, based on the assumption that a greater level of provision in this area tends to cluster. A statistical technique (known as segmentation analysis) was applied to analyse and group employer behaviour in terms of how similar their responses were to set questions. The analysis identified seven groups of employers who shared similar workplace practices and behaviours with other employers within their segment, but were distinctly different to employers outside their segment.

The questions included in the analysis (detailed in Table 9.1) covered a range of both preventative and support measures, as well as provision requiring differing levels of financial input from an employer. In turn, the analysis demonstrated how the variables interacted; enhanced levels of support and provision tended to be provided together.

At this stage, it is important to re-iterate that the segments were modelled to differ on workplace behaviour. The segments are intended only to show broad characteristics, and as a result no employer will ever conform perfectly to the segmentation typology, but they will still be closer in their characteristics to one of these groups rather than the others. A second caveat is that the qualitative research found widespread use of informal approaches to improve employee health and wellbeing amongst smaller employers. These informal behaviours were not captured by the survey, and therefore do not feature in the segmentation. Fuller technical details of the segmentation approach used can be found in Technical Report Appendix A and full details of the questions used for the analysis and the results for each segment, can be found in Appendix B.

Table 9.1: Variables included in the segmentation

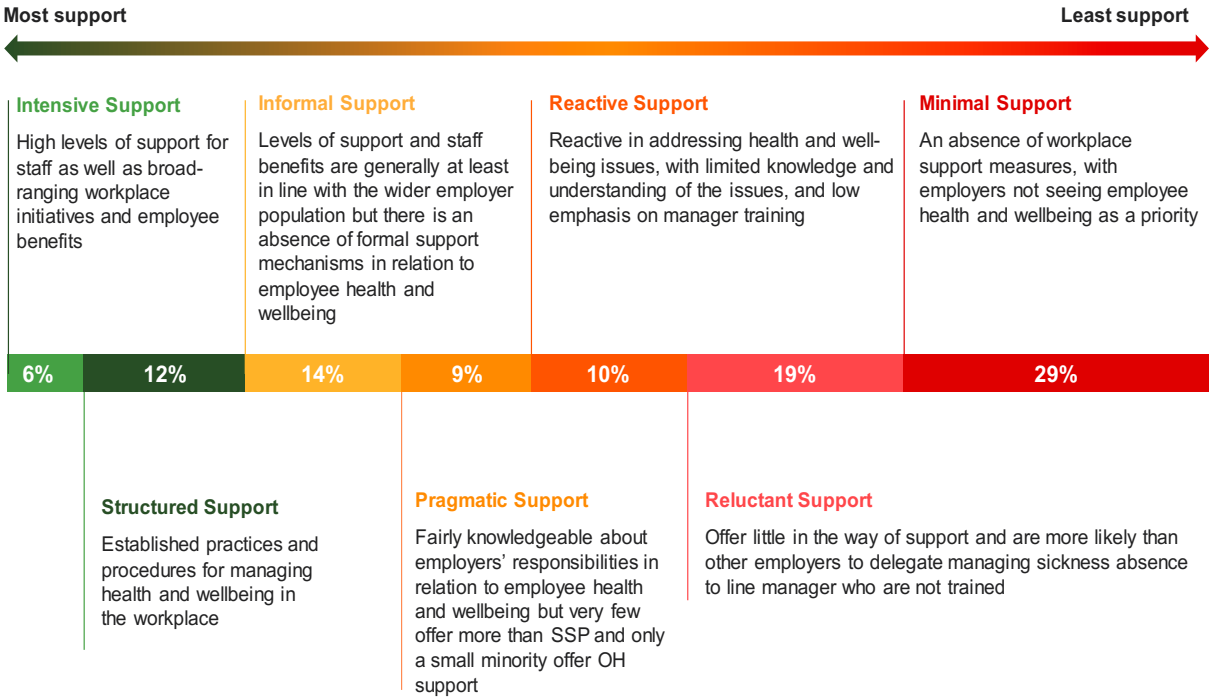
	Description	Rationale for inclusion
Measures in place to prevent ill-health (Chapter 4)	Whether the employer provides one or more of the following: • Health and safety training or guidance; • Health and wellbeing promotion programmes; • Interventions to prevent common health conditions becoming a problem; • Training for line managers on ways to improve employee health and wellbeing; • An EAP or staff welfare/counselling programme; or • Not providing/knowing if the organisation provided any of these measures.	Chapter 4 showed that employers tend to either offer just health and safety guidance, or they go above and beyond. Employers who offered a range of preventative measures, beyond health and safety training or guidance, were more likely to have higher quality, formal offer of support that included OH and above SSP.

	Description	Rationale for inclusion
Provision of OH services (Chapter 8)	Whether employers provide one of the following: • OH purchased privately on a case-by-case basis or not knowing how OH services were delivered; • OH delivered in-house, through a public sector body, or privately on a long-term contract; or • No OH services/not knowing if the organisation provided OH services.	Employers who offered comprehensive OH delivered on a long-term, permanent contract, or providing OH services in-house, were more likely to adopt proactive behaviours in relation to employee health and wellbeing, compared to those who purchased OH services as and when needed.
Support for employees with health problems (Chapter 6)	Whether in the last 12 months the employer provided none, one or two, three or four, or five or more of the following provisions: • Meetings with employees; • Phased returns to work from sickness absence; • Amending employee workload or job role; • Workplace adjustments; • A job coach or personal assistant; • Additional external support or advice.	Employers who provided more comprehensive support, beyond meetings with employees, were more likely to adopt other preventative measures to prevent employee ill health. The tipping point for the level of support provided seems to be where there is a financial cost related to the provision and bring in external support.
Line managers' role in managing sickness absence (Chapter 5)	Whether: • Line managers do not take responsibility for managing sickness absence; • Line managers are responsible for managing sickness absence and not trained; • Line managers are responsible for managing sickness absence and received training.	Employers manage sickness absence in different ways. But where line managers do have responsibility for managing a sickness absence, they are more effective in doing so where employers have provided training.
Provision of sick pay (Chapter 7)	Whether employers pay: • No form of sick pay; • SSP; • Above SSP.	Employers that pay above SSP, are more likely to offer other formal offers of support, including OH
Information sources to guide decisions regarding employee health (Chapter 3)	Whether employers use one or multiple of the following sources for additional information: • No advice sought/do not know where to see advice; • Internet searches; • Professional or personal networks; • HR team; • Legal sources; • OH professionals or provider.	Employers providing more formal support (e.g. access to OH) tended to use OH/health professionals to guide their decisions. Those providing less formal forms of support tended to rely on informal sources (e.g. internet searches and professional or personal networks).

	Description	Rationale for inclusion
Benefits offered to employees (Chapter 4)	Whether employers offer one or multiple of the following benefits: • No additional benefits/not knowing if any of these benefits were provided; • Regular flexible working; • Pensions contributions above statutory requirements; • More than 20 days paid annual leave; • Enhanced maternity/paternity pay.	Employers offering structured and comprehensive health and wellbeing support to employees were more likely to offer other benefits and perks too suggesting that investment in employee health and wellbeing is embedded in wider employee support. This is also linked to the level of skill the employees have, and how difficult it is to recruit and/or retain them.

By putting these variables into the model, the segmentation analysis identified seven groups of employers who show similar combinations of behaviours to each other, and different to employers in the other segments. These are summarised below and the remainder of this chapter provides a more detailed exploration of each.

Figure 9.1: Segmentation of employers (% of employers)



Base (unweighted): All employers (2,564).

The **Intensive** and **Structured Support** segments had the highest proportions of large employers (25% and 61% respectively) and provided comprehensive and high-quality support. Both segments provided multiple measures to prevent ill-health, including support requiring financial investment such as an EAP, staff welfare, or counselling programme. The Structured Support segment were the highest segment to use legal sources for support (19%). In contrast, the Intensive Support segment were more likely to search for support among professional or personal networks (30%), or with OH (26%) and HR (16%) professionals, seemingly reflective of their proactivity.

Almost all (bar 1%) of the Intensive Support segment provided OH services, although mainly on a case-by-case basis. The Structured Support segment were the most likely (62%) of any segment to use OH delivered in-house,[126] through a public sector body, or privately on a long-term contract, reflective of the high proportion of large employers in the segment. Both segments paid more generous sick pay than other employers, and the Intensive Support segment were the least likely not to pay any form of sick pay (4%). In terms of sickness absence, line mangers did not always take responsibility for managing it, but where they did, more line managers received training compared to other segments (62% of the Intensive and 44% of the Structured support groups).

For both segments, health and wellbeing was embedded within a generous and supportive employee offer which included a range of additional benefits for staff, such as enhanced pensions contributions (83% of the Intensive Support segment and 78% of the Structured Support segment) and maternity/paternity pay (50% and 41% respectively). There was more emphasis on support requiring financial investment by the employer compared to other segments. The Structured Support segment showed the highest level of provision of support for employees with health conditions across all segments (24% of employers in this segment offered five or more provisions, which is likely to be related to the number of large employers in the group).

Employers in the **Informal, Pragmatic** and **Reactive Support** segments provided less comprehensive health and wellbeing support than employers in the Intensive and Structured Support segments, but more comprehensive than employers in the Reluctant and Minimal Support segments. These employers had low levels of OH-provision, somewhat reflecting the current lack of statutory requirement to provide OH, and their additional benefits tended to focus on lower-cost options not requiring financial investment (access to flexible working, rather than enhanced pensions contributions, for example). The support provided was more informal across these segments, for example high level of internet searches and use of professional or personal networks to gain additional information to support employees with health conditions. However, the Informal and Pragmatic Support segments were more likely to put in place measures to prevent ill-health but again limited to the lower-cost options. The three segments behaved quite differently in terms of sick pay, due to the characteristics of the employers in these segments (explored in more detail in Section 9.3): paying above SSP was the most likely for Informal Support employers of any of the segments (80% did so), whereas Pragmatic and Reactive Support employers tended to provide SSP only.

Employers in the **Reluctant** and **Minimal Support** segments provided the least in terms of health and wellbeing support for their employees; they were focused on meeting the minimum legal requirements. Where they used preventative measures to improve health and wellbeing, these were focused predominantly on health and safety training (44% of the Reluctant and 39% of the Minimal Support segments), and access to OH was very rare, with less than 10% of either segment providing access to any form of OH services. These segments also had some of the highest instances of paying SSP only (Reluctant Support) or no sick pay at all (Minimal Support), and were the most likely segments to report no measures in place to support employees with health problems. They were also less likely than other segments to search for information on how to support employees. These behaviours were driven by the

[126] 21% of the Structured Support segment provided OH in-house.

related factors of size and employee demand; half of small employers (51%) were in these two segments and there were relatively few instances of long-term sickness absences (LTSA) or employees specifically requesting support to accommodate their health concerns and/or disabilities compared to other segments.

9.2 Explaining variation in behaviour

The key factor explaining the variations in behaviours displayed by the segments was **employee demand for support** which, in turn, was related to organisation size. This was not the only factor influencing employer behaviour, but the analysis in the previous chapters and the follow-up qualitative research with employers indicated that it was an overriding factor explaining the differences in **formal** health and wellbeing practices.

Tables 9.2 shows that employers offering the most extensive provisions (those in the **Intensive** and **Structured Support** segments) experienced higher than average instances of LTSA or employee requests for support. This also reflects the higher proportion of large and medium employers in these groups, whom are more likely to experience these things. Employers offering 'moderate' provisions (in the Informal, Pragmatic and Reactive Support segments) experienced fewer instances of both LTSA and demand for support from employees, whilst employers in the Reluctant and Minimal Support segments experienced relatively low demand for both and subsequently provided the least (formal) support to their employees.

Table 9.2: Employer segment by instances of LTSA and requests for support

	Column Percentages						
	Intensive	**Structured**	**Informal**	**Pragmatic**	**Reactive**	**Reluctant**	**Minimal**
LTSA	41%	34%	18%	28%	21%	11%	10%
No LTSA	59%	66%	82%	72%	79%	89%	90%
Base	*378*	*617*	*330*	*290*	*188*	*348*	*413*
Requests	37%	34%	24%	23%	19%	12%	7%
No requests	62%	66%	73%	76%	80%	87%	91%
Base	*378*	*617*	*330*	*290*	*188*	*348*	*413*

Base: All employers (unweighted)

It is important to note that 15% of small employers are also found in the Intensive and Structured segments (see Table 9.3), whilst 14% of large and half of medium size employers (52%) are not despite their greater instances ill health in the workplace.

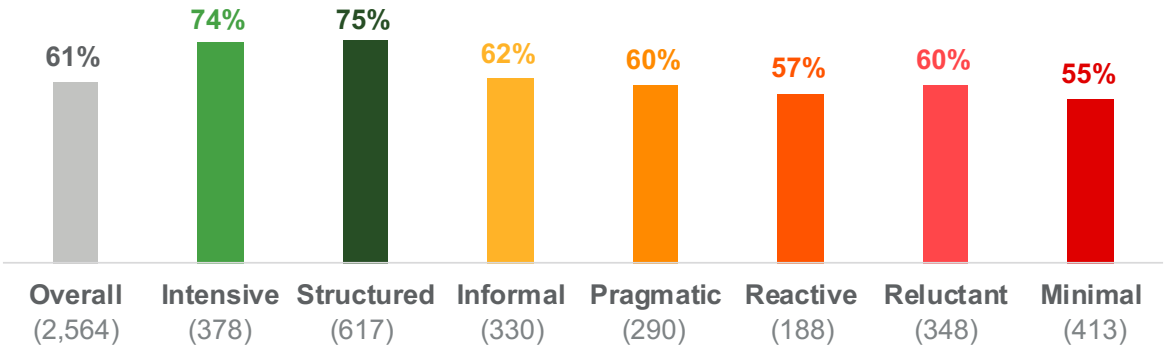
Table 9.3: Employer segment by size

	Column Percentages		
	Small	**Medium**	**Large**
Intensive Support	4%	26%	25%
Structured Support	11%	22%	61%
Informal Support	15%	13%	7%
Pragmatic Support	9%	15%	3%
Reactive Support	11%	3%	2%
Reluctant Support	20%	13%	1%
Minimal Support	31%	8%	1%
Base	*1,457*	*584*	*523*

Base: All employers (unweighted)

There were minor differences in employer attitudes to health and wellbeing across the segments, with most tending to acknowledge the links between health and work. The most notable differences between the segments were seen in relation to views on whether the financial benefits of spending money on employee health and wellbeing outweighed the cost, with employers in the Intensive and Structured segments most likely to believe in the benefits as shown in Figure 9.2 below.

Figure 9.2: The financial benefits of spending money on employee health and wellbeing outweigh the cost (% agree)



Base (unweighted): All employers (2,564), individual bases shown.

9.3 Profiling the segments

The **Intensive Support** group is the smallest of the segments (**6% of the population**). Employers in this group have the **most comprehensive practices** in relation to employee health and wellbeing, along with the Structured Support group. This is based on high levels of support for staff as well as broad-ranging initiatives and employee benefits.

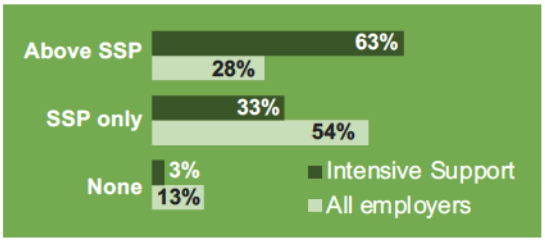
INTENSIVE SUPPORT

Health and wellbeing approach and provision

Takes steps to identify and address employee health and wellbeing issues at the earliest possible opportunity

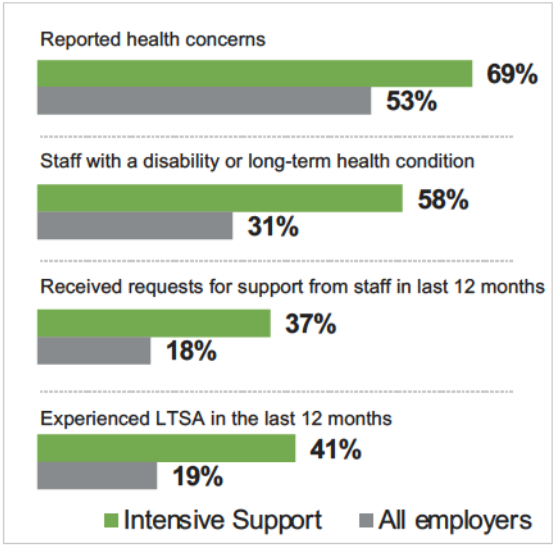
Offers **three or more** provisions to prevent ill-health or improve the health and wellbeing of the workforce

Sick pay provision

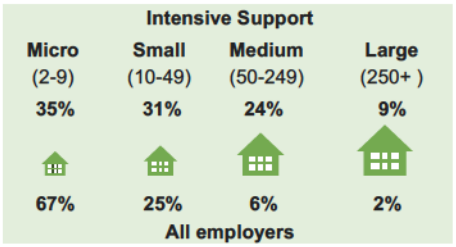


Provide access to OH services

Health of the workforce



Size of employer



Sector

The **Structured Support** segment make up an estimated **12% of the employer population** and are characterised as having the **most comprehensive practices** and behaviour in relation to employee health and wellbeing. This is based on the presence of established practices and procedures for managing health and well-being in the workplace.

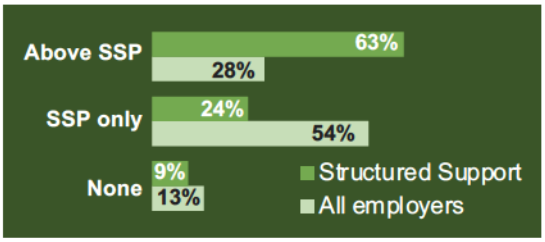
STRUCTURED SUPPORT

Health and wellbeing approach and provision

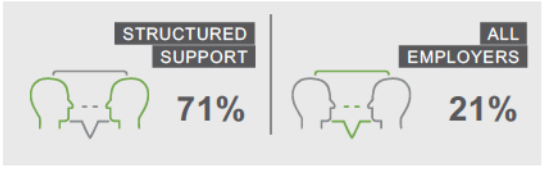
Takes steps to identify and address employee health and wellbeing issues at the earliest possible opportunity

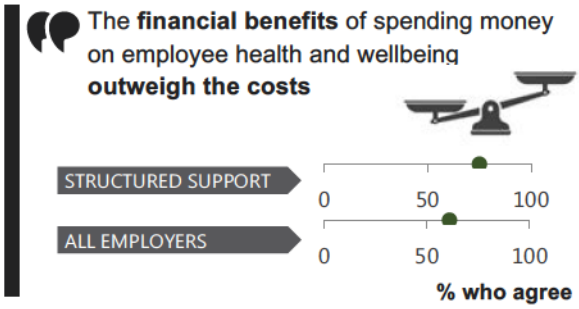
Offers **three or more** provisions to prevent ill-health or improve the health and wellbeing of the workforce

Sick pay provision

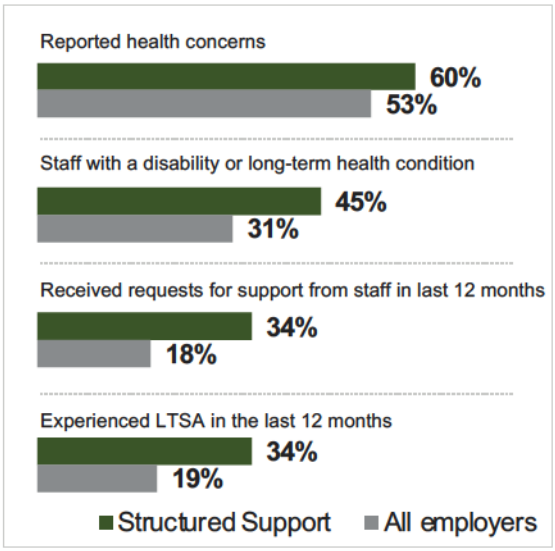


Provide access to OH services

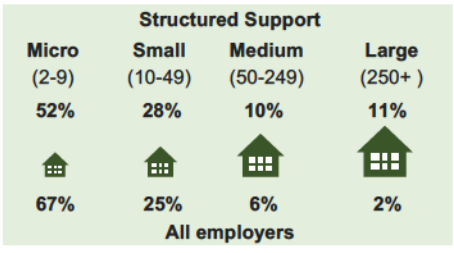




Health of the workforce



Size of employer



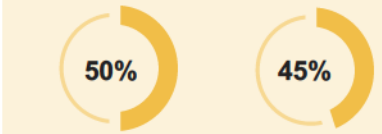
Sector

The **Informal Support** group makes up an estimated **14% of the employer population**. Many employers in this group pay **above SSP**, and levels of support and staff benefits are generally at least in line with the wider employer population. However, there is an **absence of formal support mechanisms** in relation to employee health and wellbeing.

INFORMAL SUPPORT

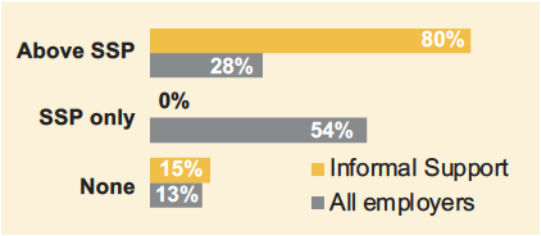
Health and wellbeing approach and provision

Takes steps to identify and address employee health and wellbeing issues at the earliest possible opportunity

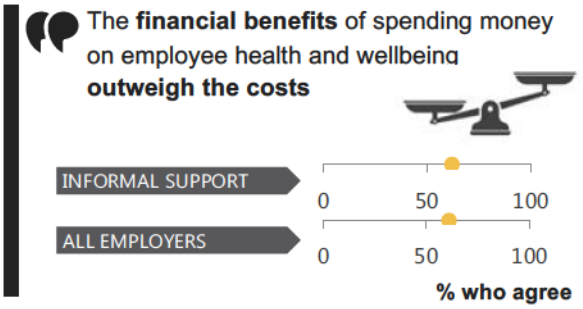


Offers **three or more** provisions to prevent ill-health or improve the health and wellbeing of the workforce

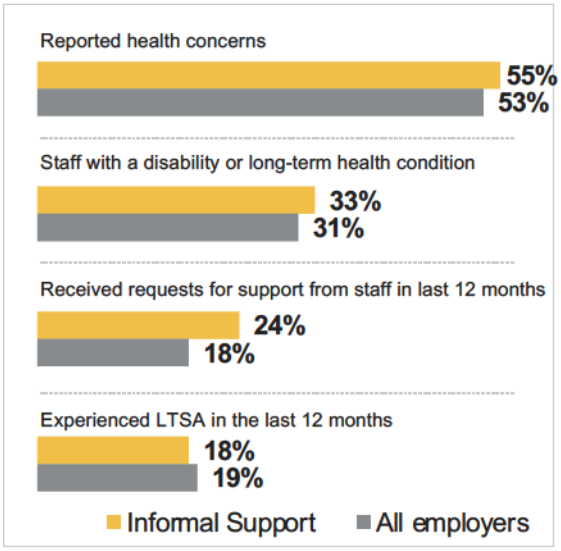
Sick pay provision



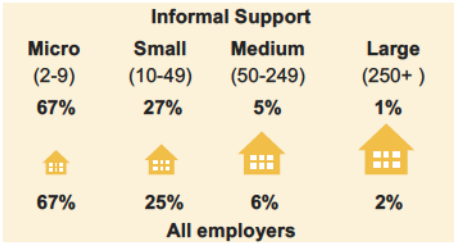
Provide access to OH services



Health of the workforce



Size of employer



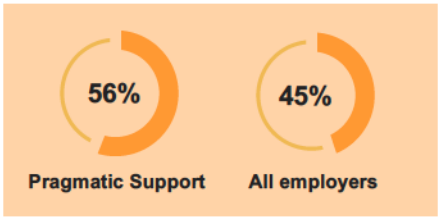
Sector

The **Pragmatic Support** group makes up an estimated **9% of the employer population**. Employers in this group are **conscientious in their behaviour** and fairly knowledgeable about their responsibilities in relation to employee health and wellbeing. However, **very few employers offer more than SSP** and only a small minority offer OH support.

PRAGMATIC SUPPORT

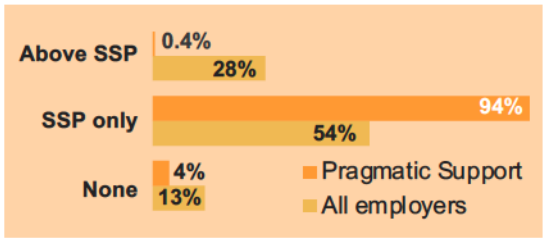
Health and wellbeing approach and provision

Takes steps to identify and address employee health and wellbeing issues at the earliest possible opportunity



Offers **three or more** provisions to prevent ill-health or improve the health and wellbeing of the workforce

Sick pay provision



Provide access to OH services

Of this segment

55%

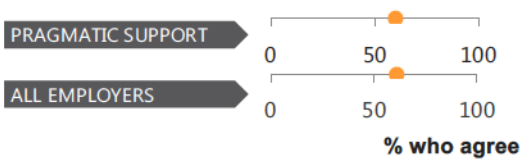
Understand their legal responsibilities relating to health and safety ***very*** **well**

Of all employers

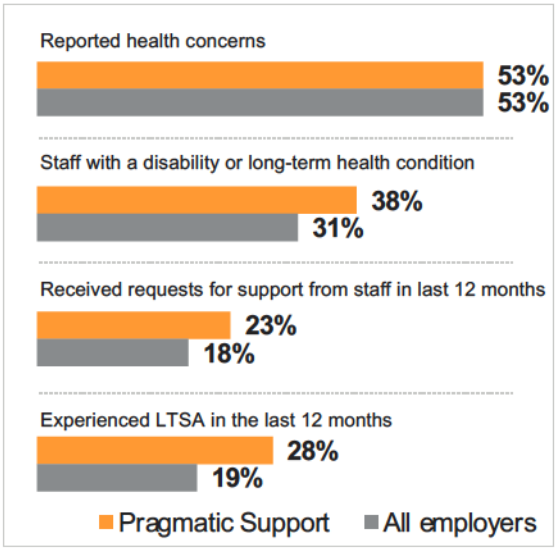
46%

Understand their legal responsibilities relating to health and safety ***very*** **well**

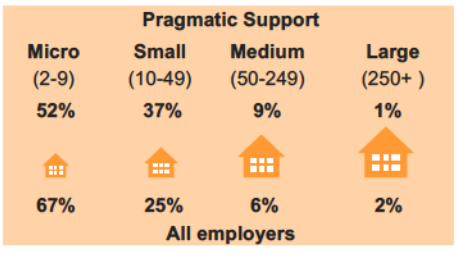
The **financial benefits** of spending money on employee health and wellbeing **outweigh the costs**



Health of the workforce



Size of employer



Sector

The **Reactive Support** group makes up an estimated **10% of the employer population**. Most employers in this group admit to being **reactive in addressing health and wellbeing issues**, with limited knowledge and understanding of the issues, and a low emphasis on manager training.

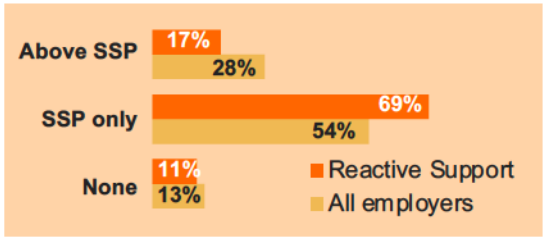
REACTIVE SUPPORT

Health and wellbeing approach and provision

Takes steps to identify and address employee health and wellbeing issues at the earliest possible opportunity

Offers **three or more** provisions to prevent ill-health or improve the health and wellbeing of the workforce

Sick pay provision



Provide access to OH services

Of this segment

36%

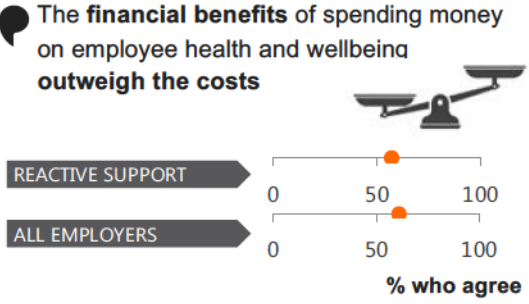
Understand their legal responsibilities relating to health and safety ***very*** **well**

Of all employers

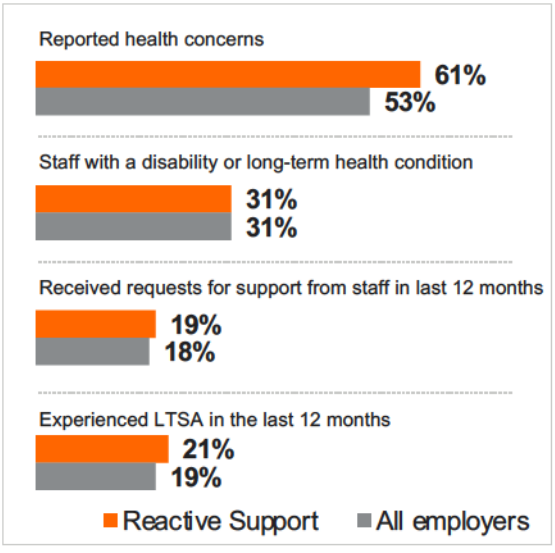
46%

Understand their legal responsibilities relating to health and safety ***very*** **well**

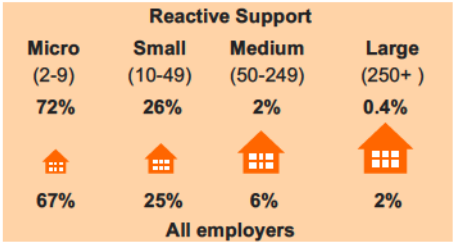
The **financial benefits** of spending money on employee health and wellbeing **outweigh the costs**



Health of the workforce



Size of employer



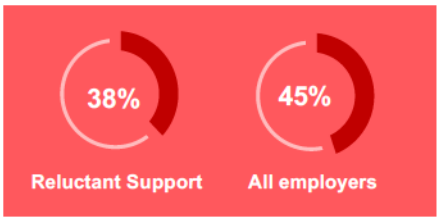
Sector

The **Reluctant Support** group is one of the larger groups, making up an estimated **19% of the employer population**. Employers in this group offer **little in the way of support**, are generally reactive in their approach, and are more likely than other employers to see risks and difficulties in managing sickness absence.

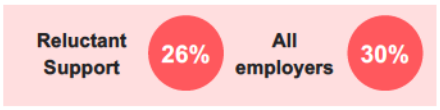
RELUCTANT SUPPORT

Health and wellbeing approach and provision

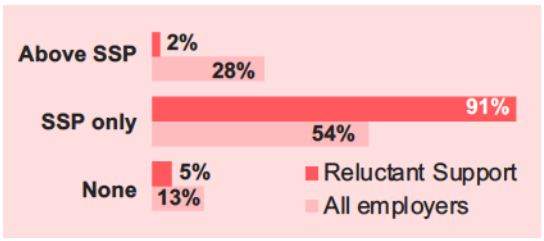
Takes steps to identify and address employee health and wellbeing issues at the earliest possible opportunity



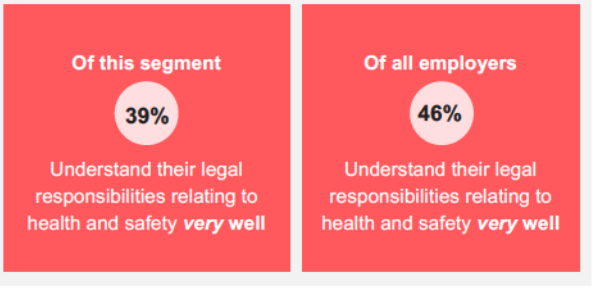
Offers **three or more** provisions to prevent ill-health or improve the health and wellbeing of the workforce



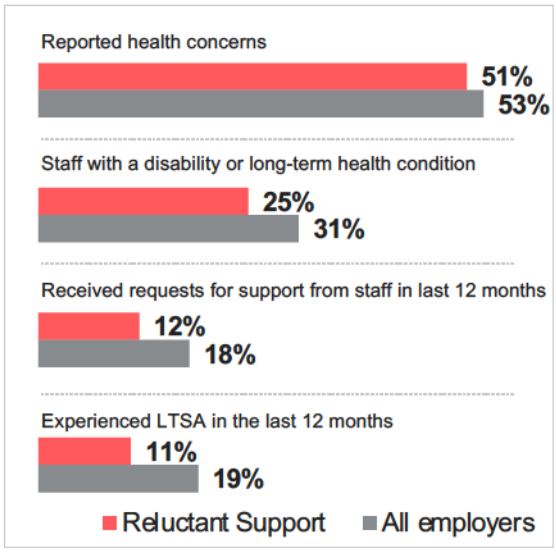
Sick pay provision



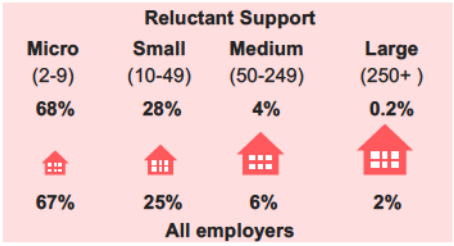
Provide access to OH services



Health of the workforce



Size of employer



Sector

The **Minimal Support** group is the largest of the groups, making up **29% of the employer population**, and is characterised as having the **least comprehensive practices**. This is based on an absence of workplace support measures, with employers adopting a reactive approach and not seeing employee health and wellbeing as a priority.

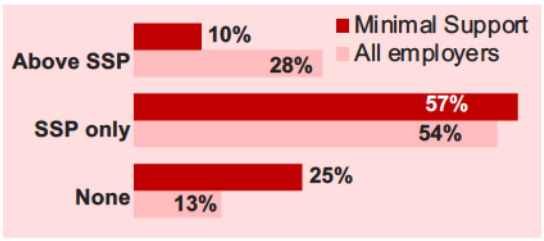
MINIMAL SUPPORT

Health and wellbeing approach and provision

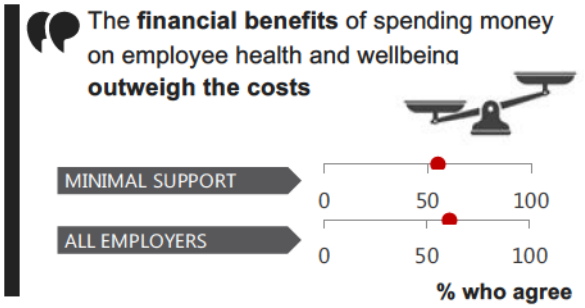
Takes steps to identify and address employee health and wellbeing issues at the earliest possible opportunity

Offers **three or more** provisions to prevent ill-health or improve the health and wellbeing of the workforce

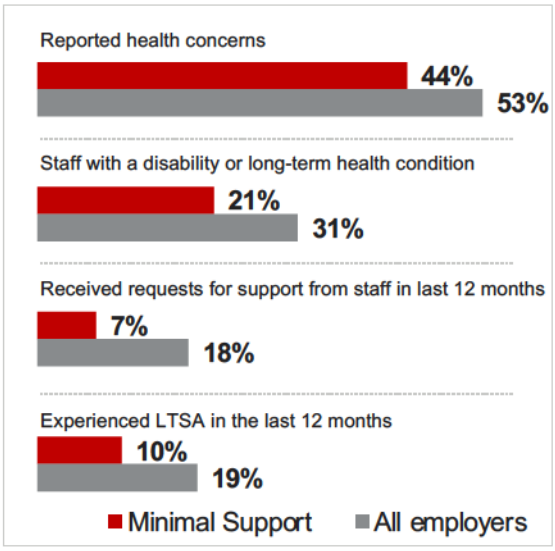
Sick pay provision



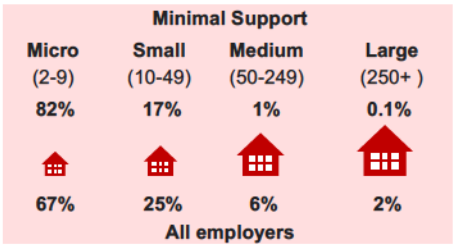
Provide access to OH services



Health of the workforce



Size of employer



Sector

10. Conclusions

This research explored employer attitudes, behaviours, support and provisions around employee health, sickness and disability in the workplace. The research was carried out in 2018 and 2019, prior to the COVID-19 pandemic.

The research showed that employers' attitudes are generally positive regarding their role in employees' health and wellbeing at work, with the majority feeling a sense of responsibility and acknowledging that there is a link between work, and health and wellbeing. However, the research also showed that regardless of size, displaying positive attitudes alone is not a strong predictor of positive action in this space.

Legal minimum and compliance

The key legal responsibilities, in the area of health and disability, include an employers' responsibility regarding employee health and safety, paying at least SSP to those that are eligible, and the need to provide reasonable adjustments under the Equality Act (2010). Although there are some sectors with additional, specific risk-based regulations they must adhere to, beyond the Health and Safety at Work Act. These include workplaces who handle asbestos, lead, construction and chemicals.

Across this research, legal responsibilities have been seen as a key motivator for employers. Whilst health and safety obligations were often at the forefront of employers' considerations, their levels of understanding about other legal responsibilities such as SSP were not as high. In particular, the payment of SSP was misunderstood among micro employers, either as a result of not having to pay sick pay or because it was outsourced.

The Equality Act, specifically in relation to the duty to make reasonable adjustments, is particularly important for disabled employees (as explored in Chapter 3). However, this research found that 59% of employers who had received requests for support from their employee in the last 12 months provided workplace adjustments (see Chapter 6), with some employers exercising discretion because they believed the adjustments were unreasonable or too costly. There was also evidence that employers who had no disabled employees or employees with health conditions did not fully understand their duty to provide reasonable adjustments as set out in the Equality Act.

Evidence from the segmentation (see Chapter 9) suggests that there is a balance between the costs of going beyond the minimum legal requirement and the overall health of their employees that needs to be seen in order to encourage small employers to do more.

These findings indicate a need to do more to raise employer understanding of their duty in relation to SSP and workplace adjustments, using channels that resonate with small and micro employers in particular.

Formal versus informal approaches

The survey focused primarily on formalised interventions, such as phased returns or workplace adjustments (see Chapter 6). The qualitative research demonstrated that tailored and personalised measures to support people with health conditions and disabilities to remain in work may, in fact, take a range of forms – in both small and large organisations. Small employers, in particular, see an informal approach to employee health and wellbeing as positive and proportionate given their size and resources. These informal approaches tend not to require paid-for expert-led advice. Conversely, the majority of large employers offer a comprehensive package of tailored support that includes EAPs, OSP and access to OH.

Whilst large employers are more likely than small employers to have formalised interventions and policies in place, both use their discretion to support employees with health conditions or disabilities to remain in work (see Chapter 5). This discretion gives employers the flexibility to tailor support to individual employees, and their given circumstances, but also to support their wider business objectives – namely, to retain employees that are key to their organisation.

It is not the case that all large employers have a formal, comprehensive support offer, and all small employers take an informal approach (see Chapter 9). Segmentation analysis identified a sizeable proportion of small employers falling into the two most comprehensive provision segments (15%) and a sizeable proportion of medium (52%) and large employers (14%) falling outside of these two segments.

Flexibility in policies

Employers sought to balance the flexibility of their policies' application, with ensuring employees are treated fairly and equally (see Chapter 5). However, discretionary decisions were made, with employers taking into account the importance of the employee for the organisation to go beyond the minimum legal requirements.

Evidence suggested that employers also used more discretion and flexibility when it came to implementing workplace adjustments for employees with health conditions (see Chapter 6). While focused foremost on their legal duties under the 2010 Equalities Act as well as a sense of duty of care to support their employees, some employers exercised discretion if they believed the adjustments were unreasonable or too costly. Employer discretion is also seen in relation to occupational health (OH), whereby all employees are covered by the policies in place, but the decision to pay for additional treatment or implement a recommendation is made on a case-by-case basis (see Chapter 8). However, it is important that the employer has the ability to be flexible in the application of their policies in such decisions, to ensure the best outcome for their employee.

Investing in health related support

Employers invest in the health and wellbeing of their employees for many reasons, beyond meeting their legal requirements. This includes having high levels of sickness absence and high employee demand for support with health conditions or disabilities, including for conditions requiring external specialist support. These demands are

more prevalent in large than medium and small organisations and, consequently, the majority of large employers offer comprehensive packages of support for their employees.

Sickness absence management

Whilst the research asked employers to consider long term sickness absence as a period of 4 weeks of more, employers indicated in the qualitative research that they defined it more in terms of when the absence triggered formal processes or start to have a serious impact on their day-to-day activity. Line managers were often responsible for short term sickness absences, with HR or OH professionals being brought in when employers' policies indicated (see Chapter 5).

Large organisations tended to delegate the handling of health and sickness related matters to line managers, supported by central policies on sickness absence management, and access to OH advice and assessment. However, there were varying degrees to which the line managers were trained and supported for this responsibility. Two thirds (62%) of small employers did not have any formal policies in place.

Regardless of size, a range of policies were used for managing sickness absence. These included both supportive sickness absence and wellbeing policies, and disciplinary and capability policies, with employers applying them almost equally.

Where employers get advice

This research reflected on different aspects of advice that employers use to support their employees, including use of different types of advice to retain employees with health conditions or disabilities, use of OH services and use of the information provided by the fit note.

Small and medium employers tended to look for expert-led paid-for advice, such as through OH services, only at the point when they are facing a situation they do not feel confident in handling for the first time (see Chapter 3). Until then they mainly sought out free advice through the internet or their own network. For supporting employees return to work, there were examples of employers requiring a greater level of detail in order to do so. The research identified that whilst many, mostly, small employers indicated that the fit note provided insufficient detail on an individuals' ability to work, they also reported 'a lack of expertise or specialist support' as a barrier to support employees return to work (23% of all employers). However, these employers were also less likely to have OH services, often indicating there was no need for them (see Chapter 8).

Employers that did use OH identified using different types of contracts depending on what they want to use these services for, with longer term contracts being linked to broader objectives and more holistic services and ad hoc ones being used when employers felt unable to handle situations themselves. There was evidence of employers with long term contracts also using ad hoc services to supplement the range of options available to them.

Small employers, in particular, generally lack the internal structures (such as a dedicated HR function) to research, design and implement their own more formalised processes of support (see Chapter 3). Instead, they were most likely to use the

internet and network contacts to meet their ad hoc information needs. This suggests that there may be a market for cost-effective advice on managing employee health and wellbeing at work, that is easy to understand, trustworthy and accessible.

Considerations for further research

The survey and follow-up interviews were conducted with employers, more specifically with central decision-makers. This captured the existence of policies and services to a greater degree than the way in which they are implemented or disseminated within the organisation. It would be beneficial to be able to further research policies, organisational decision making and support services from a different view point, such as from research with employees, or line managers.

Support can take many forms, from formalised services to more informal substitutes. The survey covered formalised interventions, but tailored and personalised support for employees can take a range of forms, and actual practices may differ to policy intent because staff members take different approaches to implementation. Future research could include a case study approach to explore employer practices from multiple perspectives – HR managers, line managers and employees. This type of research may also provide greater exploration of employers' understanding of and compliance with their legal responsibilities.

The research asked about specific interventions employers used in past 12 months to support employees with health condition stay or return to work. This highlighted a difference between large and small employers, which was in part a result of the lower frequency of ill-health in workplace rather than an unwillingness to provide support should it be needed. It would be beneficial to get a better understanding of the information and advice needs of small employers, to enable them to support employees if needed.

11. Appendix

The appendix includes statistical tables for findings that were included in the report, but only descriptively.

Table 11.1: Proportion of employees with a disability by sector

	Column Percentages				
	Sector				
	Total	**Agriculture and Energy**	**Public Admin, Education and Health**	**Construction**	**Distribution, Hotels and Restaurants**
None	68%	69%	49%	72%	72%
Less than 10%	16%	12%	32%	10%	14%
11 to 50%	13%	16%	13%	15%	12%
51% or higher	1%	0	*	2%	1%
Some do, but don't know proportion	1%	2%	5%	*	1%
Not to my knowledge	1%	*	1%	1%	1%
Refused	*	*	0	0	*
Base	*2,564*	*107*	*283*	*225*	*572*
	Total	**Transport and Comms**	**Financial, Professional and Admin Services**	**Manufacturing**	**Other Services**
None	68%	65%	71%	62%	67%
Less than 10%	16%	19%	13%	28%	11%
11 to 50%	13%	12%	14%	9%	19%
51% or higher	1%	2%	2%	0	0
Some do, but don't know proportion	1%	2%	*	*	3%
Not to my knowledge	1%	*	1%	1%	*
Refused	*	0	*	0	0
Base	*2,564*	*220*	*657*	*351*	*149*
Base: All employers (unweighted)[127]					

[127] The following conventions are used in tables throughout the report: less than 0.5 per cent (*) and no observations (0).

Table 11.2: Employee skill level by sector

	Column Percentages				
	Sector				
	Total	**Agriculture and Energy**	**Public Admin, Education and Health**	**Construction**	**Distribution, Hotels and Restaurants**
Mixed	37%	40%	27%	45%	32%
Technicians and skilled trades	27%	15%	40%	39%	22%
Semi and unskilled	20%	27%	17%	5%	37%
Professional and managerial	16%	18%	16%	11%	10%
Base	*2,445*	*102*	*267*	*210*	*552*
	Total	**Transport and Comms**	**Financial, Professional and Admin Services**	**Manufacturing**	**Other Services**
Mixed	37%	33%	44%	31%	33%
Technicians and skilled trades	27%	36%	17%	41%	30%
Semi and unskilled	20%	11%	12%	18%	24%
Professional and managerial	16%	20%	27%	10%	14%
Base	*2,445*	*213*	*625*	*333*	*143*

Base: All employers included in the analysis. The analysis excluded employers who could not give complete information on the skill level of their workforce (unweighted).

Table 11.3: Types of health concerns affecting the most number of staff, by sector (multicode)

		Sector			
	*** Total**	**Agriculture and Energy**	**Public Admin, Education and Health**	**Construction**	**Distribution, Hotels and Restaurants**
Musculoskeletal conditions[128]	19%	32%	24%	23%	16%
Stress	18%	16%	26%	17%	12%
Anxiety[129]	11%	8%	24%	4%	9%
Physical injuries caused by workplace incidents	7%	13%	1%	16%	8%
Other[130]	15%	4%	11%	16%	10%
None of these	45%	42%	31%	40%	53%
Don't know	2%	3%	1%	1%	3%
Additional analysis					
1 heath concern	41%	39%	55%	47%	36%
2 health concerns	8%	15%	11%	8%	6%
3+ health concerns	4%	1%	3%	4%	3%
Base	*2,564*	*107*	*283*	*225*	*572*

** Employers could select more than one response, therefore column percentages do not add to 100%*

	*** Total**	**Transport and Comms**	**Financial, Professional and Admin Services**	**Manufacturing**	**Other Services**
Musculoskeletal conditions	19%	18%	13%	22%	27%
Stress	18%	23%	22%	12%	24%
Anxiety	11%	10%	12%	15%	15%
Physical injuries caused by workplace incidents	7%	6%	4%	8%	3%
Other	15%	20%	18%	17%	14%
None of these	45%	39%	46%	46%	45%
Don't know	2%	2%	1%	2%	2%
Additional analysis					
1 heath concern	41%	48%	41%	36%	37%
2 health concerns	8%	7%	8%	10%	5%
3+ health concerns	4%	5%	4%	6%	11%
Base	*2,564*	*220*	*657*	*351*	*149*

Base: All employers (unweighted).

** Employers could select more than one response, therefore column percentages do not add to 100%*

[128] Including repetitive strains or injuries.

[129] Including depression or other common mental ill-health conditions

[130] 'Other' includes health concerns whose total mentions amounted to less than 6%, and have been combined into one category for presentational purposes.

Table 11.4: Employer attitudes relating to employee health and wellbeing, by size

	Column Percentages			
	Size of Employer			
	Total	Small	Medium	Large
Employers have a responsibility to encourage employees to be physically and mentally healthy				
Agree	90%	90%	91%	89%
Neither agree nor disagree	5%	5%	4%	9%
Disagree	4%	4%	5%	1%
Don't know	1%	1%	*	1%
Currently, sickness absence is a barrier to productivity in this organisation				
Agree	26%	26%	22%	33%
Neither agree nor disagree	8%	7%	11%	15%
Disagree	65%	65%	66%	46%
Don't know	2%	1%	1%	6%
The financial benefits of spending money on employee health and wellbeing outweigh the costs				
Agree	61%	61%	64%	77%
Neither agree nor disagree	18%	18%	17%	17%
Disagree	14%	14%	15%	4%
Don't know	7%	7%	4%	1%
There is a link between work and employees' health and wellbeing				
Agree	91%	91%	88%	90%
Neither agree nor disagree	5%	5%	9%	7%
Disagree	3%	3%	3%	*
Don't know	2%	2%	*	3%
The things that affect employees' health and wellbeing are out of our control				
Agree	32%	33%	22%	16%
Neither agree nor disagree	18%	18%	22%	21%
Disagree	48%	47%	55%	62%
Don't know	2%	2%	1%	1%
We know what to do to improve our employees' health and wellbeing at work				
Agree	83%	83%	86%	90%
Neither agree nor disagree	9%	10%	7%	6%
Disagree	5%	4%	6%	3%
Don't know	3%	3%	1%	1%

	Column Percentages			
	Size of Employer			
	Total	Small	Medium	Large
It is difficult for us to find time to do things to improve the health and wellbeing of our employees				
Agree	33%	32%	32%	56%
Neither agree nor disagree	13%	13%	15%	12%
Disagree	52%	53%	50%	31%
Don't know	2%	2%	2%	1%
Base	*2,564*	*1,457*	*584*	*523*

Base: All employers (unweighted)[131]

Table 11.5: Employer attitudes relating to employee health and wellbeing, by sector

	Column Percentages		
	Sector		
	Agriculture and Energy	Manufacturing	Construction
Employers have a responsibility to encourage employees to be physically and mentally healthy			
Agree	92%	90%	92%
Neither agree nor disagree	6%	4%	1%
Disagree	-	5%	5%
Don't know	2%	*	2%
Currently, sickness absence is a barrier to productivity in this organisation			
Agree	27%	39%	30%
Neither agree nor disagree	1%	6%	5%
Disagree	67%	54%	64%
Don't know	5%	1%	1%
The financial benefits of spending money on employee health and wellbeing outweigh the costs			
Agree	66%	61%	61%
Neither agree nor disagree	15%	23%	16%
Disagree	6%	12%	15%
Don't know	13%	4%	8%
There is a link between work and employees' health and wellbeing			
Agree	93%	91%	91%
Neither agree nor disagree	3%	7%	4%
Disagree	3%	1%	2%
Don't know	1%	*	2%

[131] The following conventions are used in tables throughout the report: less than 0.5 per cent (*) and no observations (0).

	Column Percentages		
	Sector		
	Agriculture and Energy	Manufacturing	Construction
The things that affect employees' health and wellbeing are out of our control			
Agree	34%	35%	34%
Neither agree nor disagree	14%	18%	16%
Disagree	50%	44%	48%
Don't know	2%	2%	2%
We know what to do to improve our employees' health and wellbeing at work			
Agree	92%	83%	89%
Neither agree nor disagree	3%	12%	6%
Disagree	4%	3%	2%
Don't know	1%	2%	3%
It is difficult for us to find time to do things to improve the health and wellbeing of our employees			
Agree	34%	28%	36%
Neither agree nor disagree	14%	13%	8%
Disagree	46%	57%	55%
Don't know	6%	3%	1%
Base	*107*	*351*	*225*
Base: All employers (unweighted)[132]			

Table 11.5 (cont.): Employer attitudes relating to employee health and wellbeing, by sector

	Column Percentages		
	Sector		
	Distribution, Hotels and Restaurants	Transport and Communications	Financial, Professional and Admin Services
Employers have a responsibility to encourage employees to be physically and mentally healthy			
Agree	88%	87%	91%
Neither agree nor disagree	6%	9%	7%
Disagree	5%	4%	2%
Don't know	1%	*	1%
Currently, sickness absence is a barrier to productivity in this organisation			
Agree	29%	24%	19%
Neither agree nor disagree	7%	9%	10%
Disagree	61%	64%	71%
Don't know	2%	3%	*

[132] The following conventions are used in tables throughout the report: less than 0.5 per cent (*) and no observations (0).

	Column Percentages		
	Sector		
	Distribution, Hotels and Restaurants	Transport and Communications	Financial, Professional and Admin Services
The financial benefits of spending money on employee health and wellbeing outweigh the costs			
Agree	52%	64%	66%
Neither agree nor disagree	22%	23%	14%
Disagree	15%	9%	15%
Don't know	10%	4%	6%
There is a link between work and employees' health and wellbeing			
Agree	88%	89%	92%
Neither agree nor disagree	6%	7%	4%
Disagree	4%	4%	3%
Don't know	3%	*	1%
The things that affect employees' health and wellbeing are out of our control			
Agree	38%	27%	28%
Neither agree nor disagree	22%	15%	16%
Disagree	36%	57%	55%
Don't know	3%	*	1%
We know what to do to improve our employees' health and wellbeing at work			
Agree	82%	84%	80%
Neither agree nor disagree	10%	11%	11%
Disagree	4%	5%	6%
Don't know	4%	*	2%
It is difficult for us to find time to do things to improve the health and wellbeing of our employees			
Agree	36%	35%	28%
Neither agree nor disagree	12%	12%	15%
Disagree	50%	52%	55%
Don't know	1%	1%	2%
Base	*572*	*220*	*657*

Base: All employers (unweighted)[133]

[133] The following conventions are used in tables throughout the report: less than 0.5 per cent (*) and no observations (0).

Table 11.5 (cont.): Employer attitudes relating to employee health and wellbeing, by sector

	Column Percentages	
	Sector	
	Public Administration, Education and Health	Other Services
Employers have a responsibility to encourage employees to be physically and mentally healthy		
Agree	93%	87%
Neither agree nor disagree	5%	4%
Disagree	1%	7%
Don't know	2%	2%
Currently, sickness absence is a barrier to productivity in this organisation		
Agree	27%	21%
Neither agree nor disagree	7%	8%
Disagree	64%	71%
Don't know	2%	*
The financial benefits of spending money on employee health and wellbeing outweigh the costs		
Agree	65%	65%
Neither agree nor disagree	21%	10%
Disagree	10%	17%
Don't know	4%	8%
There is a link between work and employees' health and wellbeing		
Agree	92%	92%
Neither agree nor disagree	7%	4%
Disagree	*	2%
Don't know	1%	3%
The things that affect employees' health and wellbeing are out of our control		
Agree	24%	32%
Neither agree nor disagree	17%	25%
Disagree	58%	39%
Don't know	2%	5%
We know what to do to improve our employees' health and wellbeing at work		
Agree	86%	80%
Neither agree nor disagree	11%	7%
Disagree	2%	6%
Don't know	*	7%

	Column Percentages	
	Sector	
	Public Administration, Education and Health	Other Services
It is difficult for us to find time to do things to improve the health and wellbeing of our employees		
Agree	30%	38%
Neither agree nor disagree	18%	15%
Disagree	52%	43%
Don't know	*	4%
Base	*283*	*149*
Base: All employers (unweighted) [134]		

[134] The following conventions are used in tables throughout the report: less than 0.5 per cent (*) and no observations (0).

Table 11.6: Employers' spending or investment priorities, by size

	Column Percentages			
	Size of Employer			
	Total	**Small**	**Medium**	**Large**
Training and skills development of employees				
Rated 0-3 out of 10	12%	13%	1%	*
Rated 4-7 out of 10	37%	37%	42%	20%
Rated 8-10 out of 10	49%	48%	56%	75%
Don't know	1%	1%	1%	4%
Mean	6.83	6.76	7.63	8.06
New business, service or product development				
Rated 0-3 out of 10	20%	21%	12%	13%
Rated 4-7 out of 10	34%	35%	27%	33%
Rated 8-10 out of 10	43%	42%	57%	47%
Don't know	3%	3%	4%	7%
Mean	6.18	6.10	7.18	7.01
Recruitment of new employees				
Rated 0-3 out of 10	38%	41%	3%	4%
Rated 4-7 out of 10	37%	36%	54%	32%
Rated 8-10 out of 10	24%	22%	40%	60%
Don't know	1%	1%	2%	5%
Mean	4.58	4.36	6.97	7.96
Improving employee health and wellbeing (e.g. via pay, benefits and flexible working options)				
Rated 0-3 out of 10	11%	11%	5%	1%
Rated 4-7 out of 10	40%	40%	44%	30%
Rated 8-10 out of 10	48%	48%	50%	65%
Don't know	2%	2%	1%	5%
Mean	6.89	6.84	7.16	8.07
Investment in infrastructure (e.g. machinery, property, equipment)				
Rated 0-3 out of 10	26%	28%	13%	7%
Rated 4-7 out of 10	40%	40%	38%	32%
Rated 8-10 out of 10	32%	31%	44%	54%
Don't know	2%	1%	4%	6%
Mean	5.47	5.36	6.59	7.28
Base[a]	*2,564*	*1,457*	*584*	*523*

	Column Percentages			
		Size of Employer		
	Total	**Small**	**Medium**	**Large**
Focusing on existing core activities and brand strength				
Rated 0-3 out of 10	4%	5%	1%	*
Rated 4-7 out of 10	24%	25%	22%	19%
Rated 8-10 out of 10	65%	65%	63%	68%
Don't know	3%	3%	4%	2%
Mean	7.89	7.86	8.11	8.69
Base[b]	*2,445*	*1,411*	*551*	*483*

Base[a]: All employers (unweighted) – base applies to all figures unless otherwise specified

Base[b]: All private sector employers (unweighted)[135]

[135] The following conventions are used in tables throughout the report: less than 0.5 per cent (*) and no observations (0).

Table 11.7: Employers' spending or investment priorities, by sector

	Column Percentages			
	Sector			
	Agriculture and Energy	**Manufacturing**	**Construction**	**Distribution, Hotels and Restaurants**
Training and skills development of employees				
Rated 0-3 out of 10	22%	13%	11%	12%
Rated 4-7 out of 10	29%	45%	33%	35%
Rated 8-10 out of 10	44%	40%	54%	52%
Don't know	5%	1%	1%	1%
Mean	6.11	6.46	6.98	6.92
New business, service or product development				
Rated 0-3 out of 10	32%	11%	24%	18%
Rated 4-7 out of 10	31%	35%	36%	35%
Rated 8-10 out of 10	30%	52%	39%	44%
Don't know	7%	2%	1%	3%
Mean	5.13	7.10	5.85	6.29
Recruitment of new employees				
Rated 0-3 out of 10	54%	41%	35%	33%
Rated 4-7 out of 10	28%	33%	43%	37%
Rated 8-10 out of 10	18%	24%	21%	28%
Don't know	*	2%	2%	2%
Mean	3.72	4.46	4.59	4.98
Improving employee health and wellbeing (e.g. via pay, benefits and flexible working options)				
Rated 0-3 out of 10	18%	8%	9%	10%
Rated 4-7 out of 10	30%	51%	36%	36%
Rated 8-10 out of 10	47%	39%	54%	53%
Don't know	5%	2%	1%	1%
Mean	6.44	6.69	7.10	7.09
Investment in infrastructure (e.g. machinery, property, equipment)				
Rated 0-3 out of 10	18%	16%	23%	22%
Rated 4-7 out of 10	32%	43%	39%	42%
Rated 8-10 out of 10	46%	39%	36%	36%
Don't know	4%	2%	1%	1%
Mean	6.50	6.20	5.67	5.78
Base[a]	*107*	*351*	*225*	*572*

	Column Percentages			
	Sector			
	Agriculture and Energy	Manufacturing	Construction	Distribution, Hotels and Restaurants
Focusing on existing core activities and brand strength				
Rated 0-3 out of 10	1%	3%	8%	5%
Rated 4-7 out of 10	24%	28%	26%	24%
Rated 8-10 out of 10	68%	66%	64%	65%
Don't know	5%	2%	2%	6%
Mean	8.19	8.00	7.57	7.90
Base[b]	*105*	*350*	*225*	*565*

Base[a]: All employers (unweighted); Base[b]: All private sector employers (unweighted)[136]

Table 11.7 (cont.): Employers' spending or investment priorities, by sector

	Column Percentages			
	Sector			
	Transport and Communications	Financial, Professional and Admin Services	Public Administration, Education and Health	Other Services
Training and skills development of employees				
Rated 0-3 out of 10	16%	11%	2%	18%
Rated 4-7 out of 10	42%	40%	34%	35%
Rated 8-10 out of 10	41%	49%	63%	47%
Don't know	*	1%	1%	*
Mean	6.52	6.88	7.84	6.52
New business, service or product development				
Rated 0-3 out of 10	19%	20%	22%	27%
Rated 4-7 out of 10	23%	34%	44%	40%
Rated 8-10 out of 10	56%	42%	30%	32%
Don't know	2%	3%	3%	*
Mean	6.56	6.23	5.81	5.46
Recruitment of new employees				
Rated 0-3 out of 10	41%	43%	26%	35%
Rated 4-7 out of 10	43%	32%	39%	41%
Rated 8-10 out of 10	16%	24%	31%	23%
Don't know	1%	1%	4%	1%
Mean	4.12	4.32	5.50	4.67

[136] The following conventions are used in tables throughout the report: less than 0.5 per cent (*) and no observations (0).

	Column Percentages			
	Sector			
	Transport and Communications	**Financial, Professional and Admin Services**	**Public Administration, Education and Health**	**Other Services**
Improving employee health and wellbeing (e.g. via pay, benefits and flexible working options)				
Rated 0-3 out of 10	12%	13%	6%	10%
Rated 4-7 out of 10	44%	42%	37%	38%
Rated 8-10 out of 10	43%	43%	55%	50%
Don't know	1%	2%	2%	2%
Mean	6.55	6.68	7.50	6.98
Investment in infrastructure (e.g. machinery, property, equipment)				
Rated 0-3 out of 10	31%	35%	22%	32%
Rated 4-7 out of 10	41%	40%	35%	37%
Rated 8-10 out of 10	27%	24%	39%	30%
Don't know	1%	1%	5%	*
Mean	5.10	4.87	5.82	5.06
Base[a]	*220*	*657*	*283*	*149*
Focusing on existing core activities and brand strength				
Rated 0-3 out of 10	6%	3%	2%	5%
Rated 4-7 out of 10	32%	23%	17%	16%
Rated 8-10 out of 10	60%	69%	53%	71%
Don't know	1%	3%	4%	1%
Mean	7.63	8.00	8.17	8.04
Base[b]	*217*	*630*	*220*	*133*

Base[a]: All employers (unweighted) – base applies to all statements unless otherwise specified.

Base[b]: All private sector employers (unweighted)

Table 11.8: Employers' understanding and ability to meet their legal responsibilities, by size

	Column Percentages			
	Size of Employer			
	Total	**Small**	**Medium**	**Large**
How well employers report understanding their legal responsibilities				
Very well	45%	43%	66%	77%
Fairly well	48%	49%	28%	22%
Not very well	5%	5%	3%	*
Not well at all	1%	1%	*	0
Don't know	1%	1%	2%	1%
How easy or difficult employers report finding it to meet their legal responsibilities				
Very easy	22%	22%	22%	29%
Fairly easy	46%	45%	49%	50%
Neither easy nor difficult	18%	19%	17%	12%
Fairly difficult	9%	9%	9%	8%
Very difficult	2%	2%	*	*
Don't know	3%	3%	3%	1%
Base	*2,564*	*1,457*	*584*	*523*

Base: All employers (unweighted)[137]

[137] The following conventions are used in tables throughout the report: less than 0.5 per cent (*) and no observations (0).

Table 11.9: Employers' understanding and ability to meet their legal responsibilities, by sector

	Column Percentages				
	Sector				
	Total	**Agriculture and Energy**	**Public Admin, Education and Health**	**Construction**	**Distribution, Hotels and Restaurants**
How well employers report understanding their legal responsibilities					
Very well	45%	29%	60%	48%	46%
Fairly well	48%	56%	32%	48%	48%
Not very well	5%	11%	6%	2%	6%
Not well at all	1%	1%	0	1%	*
Don't know	1%	3%	2%	1%	0
Base	*2,564*	*107*	*283*	*225*	*572*
	Total	**Transport and Comms**	**Financial, Professional and Admin Services**	**Manufacturing**	**Other Services**
How well employers report understanding their legal responsibilities					
Very well	45%	41%	48%	44%	32%
Fairly well	48%	52%	45%	48%	57%
Not very well	5%	2%	5%	4%	7%
Not well at all	1%	2%	*	1%	4%
Don't know	1%	2%	2%	2%	0
Base	*2,564*	*220*	*657*	*351*	*149*

Base: All employers (unweighted)

Table 11.9 (cont.): Employers' understanding and ability to meet their legal responsibilities, by sector

	Column Percentages				
	Sector				
	Total	**Agriculture and Energy**	**Public Admin, Education and Health**	**Construction**	**Distribution, Hotels and Restaurants**
How easy or difficult employers report finding it to meet their legal responsibilities					
Very easy	22%	17%	23%	17%	21%
Fairly easy	46%	47%	45%	46%	45%
Neither easy nor difficult	18%	19%	17%	15%	19%
Fairly difficult	9%	13%	10%	17%	10%
Very difficult	2%	0	2%	2%	2%
Don't know	3%	3%	3%	3%	3%
Base	*2,564*	*107*	*283*	*225*	*572*
	Total	**Transport and Comms**	**Financial, Professional and Admin Services**	**Manufacturing**	**Other Services**
How easy or difficult employers report finding it to meet their legal responsibilities					
Very easy	22%	19%	28%	18%	22%
Fairly easy	46%	45%	45%	51%	43%
Neither easy nor difficult	18%	24%	19%	14%	19%
Fairly difficult	9%	7%	5%	8%	7%
Very difficult	2%	0	1%	6%	4%
Don't know	3%	5%	2%	3%	4%
Base	*2,564*	*220*	*657*	*351*	*149*

Base: All employers (unweighted)

Table 11.10: Sources of information on how to retain an employee with a long-term health condition, by sector (multicode)

		Sector			
	*** Total**	**Agriculture and Energy**	**Public Admin, Education and Health**	**Construction**	**Distribution, Hotels and Restaurants**
Internet search[138]	47%	31%	31%	41%	47%
Networks[139]	26%	25%	32%	31%	28%
Legal sources	10%	9%	13%	10%	7%
OH provider	9%	18%	20%	10%	7%
HR team	6%	4%	9%	3%	6%
Don't know	12%	19%	11%	15%	12%
Base	*2,564*	*107*	*283*	*225*	*572*

Base: All employers (unweighted). Only responses by at least 5% are shown.

** Employers could select more than one response, therefore column percentages do not add to 100%*

Table 11.10 (cont.): Sources of information on how to retain and employee with a long-term health condition, by sector (multicode)

		Sector			
	*** Total**	**Transport and Comms**	**Financial, Professional and Admin Services**	**Manufacturing**	**Other Services**
Internet search	47%	54%	56%	36%	42%
Networks	26%	21%	21%	32%	30%
Legal sources	10%	8%	11%	14%	10%
OH provider	9%	7%	7%	10%	8%
HR team	6%	6%	5%	14%	3%
Don't know	12%	13%	10%	9%	18%
Base	*2,564*	*220*	*657*	*351*	*149*

Base: All employers (unweighted). Only responses by at least 5% are shown.

** Employers could select more than one response, therefore column percentages do not add to 100%*

[138] For example, government or ACAS website, occupational health specialists.

[139] For example, professional or personal networks or contacts (including trade bodies).

Table 11.11: Health and wellbeing provisions by sector (multicode)

		Sector	
	* Total	Agriculture and Energy	Manufacturing
Health and safety training or guidance	77%	85%	83%
Interventions to prevent common health conditions becoming a problem[140]	29%	20%	26%
Training for line managers on ways to improve employee health and wellbeing	26%	20%	21%
Health and wellbeing promotion programmes to improve employees' physical activity or lifestyle[141]	23%	16%	19%
An Employee Assistance Programme (EAP), or welfare programme provided by an external organisation	16%	20%	14%
Activities to encourage supportive culture[142]	2%	2%	2%
Other	2%	3%	3%
We don't currently provide anything	16%	11%	15%
Don't know	*		
Additional analysis			
Only provide health and safety training or guidance	32%	47%	42%
Provide more comprehensive offer[143]	51%	42%	43%
Base	*2,564*	*107*	*351*

Base: All employers (unweighted)[144]

** Employers could select more than one response, therefore column percentages do not add to 100%*

[140] For example: free health checks, free vaccinations, smoking or weight loss support.

[141] For example: health food choices, health advice or events, dedicated health and wellbeing section on the intranet, loans or discounts on bicycles, free or subsidised gym membership.

[142] For example: staff meetings, team bonding and social events.

[143] Includes employers who offered some or all of the following measures: Health and safety training or guidance, health and wellbeing promotion programmes, interventions to prevent common health conditions from becoming a problem, and/or EAPs.

[144] The following conventions are used in tables throughout the report: less than 0.5 per cent (*) and no observations (0).

Table 11.11 (cont.): Health and wellbeing provisions by sector (multicode)

	Sector		
	* Construction	Distribution, Hotels and Restaurants	Transport and Communications
Health and safety training or guidance	88%	80%	65%
Interventions to prevent common health conditions becoming a problem[145]	32%	22%	32%
Training for line managers on ways to improve employee health and wellbeing	29%	25%	29%
Health and wellbeing promotion programmes to improve employees' physical activity or lifestyle[146]	23%	18%	29%
An Employee Assistance Programme (EAP), or welfare programme provided by an external organisation	13%	17%	15%
Activities to encourage supportive culture[147]	1%	1%	3%
Other	2%	*	1%
We don't currently provide anything	11%	16%	18%
Don't know	*	1%	1%
Additional analysis			
Only provide health and safety training or guidance	37%	37%	24%
Provide more comprehensive offer[148]	52%	46%	57%
Base	*225*	*572*	*220*

Base: All employers (unweighted)[149]

** Employers could select more than one response, therefore column percentages do not add to 100%*

[145] For example: free health checks, free vaccinations, smoking or weight loss support.

[146] For example: health food choices, health advice or events, dedicated health and wellbeing section on the intranet, loans or discounts on bicycles, free or subsidised gym membership.

[147] For example: staff meetings, team bonding and social events.

[148] Includes employers who offered some or all of the following measures: Health and safety training or guidance, health and wellbeing promotion programmes, interventions to prevent common health conditions from becoming a problem, and/or EAPs.

[149] The following conventions are used in tables throughout the report: less than 0.5 per cent (*) and no observations (0).

Table 11.11 (cont.): Health and wellbeing provisions by sector (multicode)

	Sector		
	*** Financial, Professional and Admin Services**	**Public Administration, Education and Health**	**Other Services**
Health and safety training or guidance	67%	94%	79%
Interventions to prevent common health conditions becoming a problem[150]	31%	48%	26%
Training for line managers on ways to improve employee health and wellbeing	24%	48%	22%
Health and wellbeing promotion programmes to improve employees' physical activity or lifestyle[151]	23%	37%	20%
An Employee Assistance Programme (EAP), or welfare programme provided by an external organisation	17%	25%	15%
Activities to encourage supportive culture[152]	2%	2%	1%
Other	1%	3%	5%
We don't currently provide anything	23%	4%	10%
Don't know	0	0	1%
Additional analysis			
Only provide health and safety training or guidance	26%	20%	33%
Provide more comprehensive offer[153]	50%	76%	56%
Base	*657*	*283*	*149*

Base: All employers (unweighted)

** Employers could select more than one response, therefore column percentages do not add to 100%*

[150] For example: free health checks, free vaccinations, smoking or weight loss support.

[151] For example: health food choices, health advice or events, dedicated health and wellbeing section on the intranet, loans or discounts on bicycles, free or subsidised gym membership.

[152] For example: staff meetings, team bonding and social events.

[153] Includes employers who offered some or all of the following measures: Health and safety training or guidance, health and wellbeing promotion programmes, interventions to prevent common health conditions from becoming a problem, and/or EAPs.

Table 11.12: Approaches to managing employee health and wellbeing, by sector

	Column Percentages				
	Sector				
	Total	**Agriculture and Energy**	**Public Admin, Education and Health**	**Construction**	**Distribution, Hotels and Restaurants**
We take steps to identify and address employee health and wellbeing issues at the earliest possible opportunity	45%	50%	56%	45%	42%
We take action as and when employee health and wellbeing becomes a problem	55%	50%	44%	55%	58%
Base	*2,564*	*107*	*283*	*225*	*572*
	Total	**Transport and Comms**	**Financial, Professional and Admin Services**	**Manufacturing**	**Other Services**
We take steps to identify and address employee health and wellbeing issues at the earliest possible opportunity	45%	52%	45%	44%	41%
We take action as and when employee health and wellbeing becomes a problem	55%	48%	55%	56%	59%
Base	*2,564*	*220*	*657*	*351*	*149*

Base: All employers (unweighted)

Table 11.13: Instances of LTSA in the last 12 months, by sector

	Column Percentages				
	Sector				
	Total	**Agriculture and Energy**	**Public Admin, Education and Health**	**Construction**	**Distribution, Hotels and Restaurants**
Had LTSA	19%	15%	38%	12%	19%
No LTSA	81%	85%	62%	88%	81%
Base	*2,564*	*107*	*283*	*225*	*572*
	Total	**Transport and Comms**	**Financial, Professional and Admin Services**	**Manufacturing**	**Other Services**
Had LTSA	19%	20%	14%	35%	13%
No LTSA	81%	80%	86%	65%	87%
Base	*2,564*	*220*	*657*	*351*	*149*

Base: All employers (unweighted)

Table 11.14: The main business risks or costs associated with LTSA, by sector (multicode)

	Sector		
	*** Total**	**Agriculture and Energy**	**Manufacturing**
Covering work within the organisation (additional pressure, readjusting work processes)	57%	46%	57%
Additional cost/time arranging temporary cover/ recruiting and training new staff	41%	44%	41%
Having to pay sick pay	28%	14%	25%
Uncertainty of return to work and planning around it (including reintegrating employees back into the business, time involved)	25%	28%	21%
Impact on productivity or quality of work	21%	24%	26%
Keeping job open	17%	9%	15%
Low morale among rest of staff	15%	11%	18%
Missing client deadlines/dissatisfied clients	12%	1%	11%
Legal risk resulting from employees who do not feel they have had appropriate support	6%	5%	6%
Reputational risk resulting from employees who do not feel they have had appropriate support	6%	2%	5%
General impact on costs	1%	8%	0
Costs associated with OH	1%	0	*
Other	*	0	*
No risks reported	2%	0	1%
Don't know	12%	13%	12%
Additional analysis			
One risk reported	38%	52%	38%
Two risks reported	18%	7%	19%
Three or more risks reported	30%	29%	29%
Base	*1,188*	*43*[154]	*229*

Base: All employers with a long-term sickness absence in the last 12 months (unweighted)[155].

**Employers could select more than one response, therefore column percentages do not add to 100%*

[154] Caution: low base size (under 50). Results should be interpreted as indicative rather than statistically robust.

[155] The following conventions are used in tables throughout the report: less than 0.5 per cent (*) and no observations (0)).

Table 11.14 (cont.): The main business risks or costs associated with LTSA, by sector (multicode)

	Sector		
	* Construction	Distribution, Hotels and Restaurants	Transport and Communications
Covering work within the organisation (additional pressure, readjusting work processes)	56%	58%	49%
Additional cost/time arranging temporary cover/recruiting and training new staff	47%	34%	26%
Having to pay sick pay	46%	28%	21%
Uncertainty of return to work and planning around it (including reintegrating employees back into the business, time involved)	44%	26%	23%
Impact on productivity or quality of work	31%	11%	23%
Keeping job open	34%	20%	13%
Low morale among rest of staff	8%	17%	2%
Missing client deadlines/dissatisfied clients	9%	13%	5%
Legal risk resulting from employees who do not feel they have had appropriate support	9%	7%	1%
Reputational risk resulting from employees who do not feel they have had appropriate support	8%	7%	1%
General impact on costs	0	1%	0
Costs associated with OH	0	0	0
Other	3%	0	0
No risks reported	11%	2%	2%
Don't know	9%	17%	17%
Additional analysis			
One risk reported	10%	39%	52%
Two risks reported	31%	11%	9%
Three or more risks reported	37%	31%	20%
Base	*1,188*	*260*	*87*[156]

Base: All employers with a long-term sickness absence in the last 12 months (unweighted)[157]

**Employers could select more than one response, therefore column percentages do not add to 100%*

[156] Caution: low base size (under 100). Results should be interpreted with caution.

[157] The following conventions are used in tables throughout the report: less than 0.5 per cent (*) and no observations (0).

Table 11.14 (cont): The main business risks or costs associated with LTSA, by sector (multicode)

	Sector		
	*** Financial, Professional and Admin Services**	**Public Administration, Education and Health**	**Other Services**
Covering work within the organisation (additional pressure, readjusting work processes)	60%	59%	58%
Additional cost/time arranging temporary cover/recruiting and training new staff	38%	70%	44%
Having to pay sick pay	22%	35%	34%
Uncertainty of return to work and planning around it (including reintegrating employees back into the business, time involved)	23%	23%	21%
Impact on productivity or quality of work	25%	15%	32%
Keeping job open	10%	18%	19%
Low morale among rest of staff	14%	24%	27%
Missing client deadlines/dissatisfied clients	19%	11%	11%
Legal risk resulting from employees who do not feel they have had appropriate support	3%	13%	*
Reputational risk resulting from employees who do not feel they have had appropriate support	7%	7%	*
General impact on costs	3%	0	1%
Costs associated with OH	3%	0	0
Other	*	1%	0
No risks reported	*	*	0
Don't know	5%	6%	9%
Additional analysis			
One risk reported	41%	31%	45%
Two risks reported	24%	27%	5%
Three or more risks reported	30%	35%	42%
Base	*1,188*	*170*	*56*[158]

Base: All employers with a long-term sickness absence in the last 12 months (unweighted)[159]

**Employers could select more than one response, therefore column percentages do not add to 100%*

[158] Caution: low base size (under 100). Results should be interpreted with caution.

[159] The following conventions are used in tables throughout the report: less than 0.5 per cent (*) and no observations (0).

Table 11.15: Policies used to manage employees' sickness absences from work, by sector (multicode)

		Sector			
	*** Total**	**Agriculture and Energy**	**Public Admin, Education and Health**	**Construction**	**Distribution, Hotels and Restaurants**
We do not have a specific policy	58%	73%	21%	61%	62%
Sickness absence management policy	29%	21%	63%	21%	26%
Disciplinary policy	20%	12%	33%	14%	20%
Wellbeing at work policy	15%	6%	25%	20%	14%
Capability policy	10%	10%	30%	8%	9%
Other	2%	0	1%	0	*
Don't know	1%	*	2%	1%	*
Base	*2,564*	*107*	*283*	*225*	*572*
	Total	**Transport and Comms**	**Financial, Professional and Admin Services**	**Manufacturing**	**Other Services**
We do not have a specific policy	58%	57%	59%	58%	59%
Sickness absence management policy	29%	35%	29%	28%	26%
Disciplinary policy	20%	20%	20%	21%	16%
Wellbeing at work policy	15%	18%	14%	9%	7%
Capability policy	10%	10%	8%	11%	11%
Other	2%	4%	1%	1%	2%
Don't know	1%	1%	1%	*	3%
Base	*2,564*	*220*	*657*	*351*	*149*

Base: All employers (unweighted)[160]

**Employers could select more than one response, therefore column percentages do not add to 100%*

[160] The following conventions are used in tables throughout the report: less than 0.5 per cent (*) and no observations (0).

Table 11.16: Measures to support employees with health problems to remain in-work or support returning to work amongst employers who had experienced instances of LTSA in the past 12 months (multicode)

	Experienced LTSA in the last 12 months		
	*** All**	**Yes**	**No**
Meetings with employees	40%	75%	32%
Phased return to work from sickness absence	30%	74%	19%
Amending employee workload or job role	35%	73%	26%
Workplace adjustments	26%	51%	20%
Additional external support or advice	13%	30%	9%
A job coach or personal assistant	4%	8%	3%
None of these	49%	10%	58%
Base	*2,564*	*1,188*	*1,376*

Base: All employers (unweighted).

**Employers could select more than one response, therefore column percentages do not add to 100%*

Table 11.17: Employers' views on when employees should return to work following sickness absence of any length, by nature of working environment

	Column Percentages			
	Nature of the working environment			
	Total	**Manual or hazardous**	**Office based**	**Mixed**
Employees should return to work when they can do…				
…some of their work	47%	43%	52%	45%
…most of their work	25%	25%	26%	24%
…all of their work	21%	25%	15%	22%
Don't know	8%	7%	7%	9%
Base	*2,564*	*1,111*	*793*	*660*
Base: All employers (unweighted)[161]				

[161] These categories were derived for analytical purposes post-survey, and do not reflect how individual employers defined the nature of their working environment:

- **Mostly manual or hazardous work environment** – Agriculture, Forestry and Fishing; Mining and Quarrying; Utilities, Waste Management and Remediation Activities.; Manufacturing; Construction; Accommodation and Food Service Activities; Human Health and Social Work Activities.
- **Mostly office-based work environment** – Information and Communications; Financial and Insurance Activities; Real Estate Activities; Professional, Scientific and Technical Activities; Administrative and Support Services; Public Administration, Defence and Compulsory Social Security.
- **Mixed work environments** – Wholesale and Retail Trade; Repair of Motor Vehicles and Motorcycles; Transportation and Storage; Education; Arts, Entertainment and Recreation; and Other Service Activities.

Table 11.18: Employers' views on when employees should return to work following sickness absence of any length, by sector

	Column Percentages				
		Sector			
	Total	**Agriculture and Energy**	**Public Admin, Education and Health**	**Construction**	**Distribution, Hotels and Restaurants**
Employees should return to work when they can do…					
…some of their work	47%	42%	49%	36%	47%
…most of their work	25%	27%	24%	28%	23%
…all of their work	21%	22%	18%	31%	23%
Don't know	8%	9%	8%	5%	8%
Base	*2,564*	*107*	*283*	*225*	*572*
	Total	**Transport and Comms**	**Financial, Professional and Admin Services**	**Manufacturing**	**Other Services**
Employees should return to work when they can do…					
…some of their work	47%	49%	51%	48%	44%
…most of their work	25%	25%	27%	21%	26%
…all of their work	21%	20%	14%	21%	18%
Don't know	8%	7%	7%	10%	12%
Base	*2,564*	*220*	*657*	*351*	*149*

Base: All employers (unweighted)

Table 11.19: Type of sick pay offered, by sector

	Column Percentages				
	Sector				
	Total	**Agriculture and Energy**	**Public Admin, Education and Health**	**Construction**	**Distribution, Hotels and Restaurants**
Statutory Sick Pay	54%	43%	52%	57%	62%
Above SSP	28%	28%	38%	24%	24%
Neither	13%	22%	6%	14%	11%
Don't know	5%	7%	3%	6%	4%
Base	*2,564*	*107*	*283*	*225*	*572*
	Total	**Transport and Comms**	**Financial, Professional and Admin Services**	**Manufacturing**	**Other Services**
Statutory Sick Pay	54%	51%	47%	58%	56%
Above SSP	28%	35%	32%	31%	19%
Neither	13%	10%	15%	9%	20%
Don't know	5%	5%	6%	1%	5%
Base	*2,564*	*220*	*657*	*351*	*149*
Base: All employers (unweighted)					

Table 11.20: OSP rate reduction over time, by sector

	Column Percentages				
	Sector				
	Total	**Agriculture and Energy**	**Public Admin, Education and Health**	**Construction**	**Distribution, Hotels and Restaurants**
Does the rate at which you pay OSP to eligible employees reduce over time?					
Yes	29%	38%	52%	36%	23%
No	56%	56%	42%	57%	53%
No fixed policy	7%	*	2%	4%	14%
Don't know	8%	6%	4%	3%	10%
Base	*1,069*	*43*[162]	*108*	*68*[163]	*194*
	Total	**Transport and Comms**	**Financial, Professional and Admin Services**	**Manufacturing**	**Other Services**
Does the rate at which you pay OSP to eligible employees reduce over time?					
Yes	29%	20%	27%	34%	26%
No	56%	58%	59%	55%	67%
No fixed policy	7%	5%	7%	4%	7%
Don't know	8%	17%	6%	7%	1%
Base	*1,069*	*105*	*317*	*187*	*47*[164]
Base: All employers who offer OSP to their employees (unweighted)[165]					

[162] Caution: low base size (under 50). Results should be interpreted as indicative rather than statistically robust.

[163] Caution: low base size (under 100). Results should be interpreted with caution.

[164] Caution: low base size (under 50). Results should be interpreted as indicative rather than statistically robust.

[165] The following conventions are used in tables throughout the report: less than 0.5 per cent (*) and no observations (0).

Table 11.21 OSP rate reduction over time, by whether any employees have a disability or long-term health condition (LTHC)

	Column Percentages			
	Whether employees have a disability or LTHC			
	Total	**No employees have a disability or LTHC**	**Some employees have a disability or LTHC**	**Don't know**
Does the rate at which you pay OSP to eligible employees reduce over time?				
Yes	29%	23%	37%	25%
No	56%	59%	53%	44%
No fixed policy	7%	9%	4%	0
Don't know	8%	9%	6%	31%
Base	*1,069*	*269*	*764*	*41*[166]
Base: who offer OSP to their employees (unweighted)				

[166] Caution: low base size (under 50). Results should be interpreted as indicative rather than statistically robust.

Table 11.22: Provision of OH services, by sector

	Column Percentages				
	Sector				
	Total	**Agriculture and Energy**	**Public Admin, Education and Health**	**Construction**	**Distribution, Hotels and Restaurants**
Yes	21%	22%	44%	22%	14%
No	76%	71%	54%	76%	83%
Don't know	3%	7%	3%	2%	2%
Base	*2,564*	*107*	*283*	*225*	*572*
	Total	**Transport and Comms**	**Financial, Professional and Admin Services**	**Manufacturing**	**Other Services**
Yes	21%	17%	21%	26%	24%
No	76%	81%	74%	69%	74%
Don't know	3%	3%	5%	5%	2%
Base	*2,564*	*220*	*657*	*351*	*149*

Base: All employers (unweighted)

Table 11.23: Type of OH provider, by sector (multicode)

		Sector			
	*** Total**	**Agriculture and Energy**	**Public Admin, Education and Health**	**Construction**	**Distribution, Hotels and Restaurants**
Private contractor (case-by-case basis)	46%	52%	32%	42%	49%
Private contractor (long-term contract)	26%	19%	23%	23%	23%
Public sector[167]	20%	4%	43%	26%	19%
In-house provider[168]	12%	19%	9%	6%	13%
Don't know	6%	15%	6%	9%	8%
Base	*1,059*	*46*	*149*	*86*	*180*
	Total	**Transport and Comms**	**Financial, Professional and Admin Services**	**Manufacturing**	**Other Services**
Private contractor (case-by-case basis)	46%	47%	50%	54%	38%
Private contractor (long-term contract)	26%	28%	34%	27%	22%
Public sector	20%	8%	17%	22%	10%
In-house provider	12%	10%	12%	12%	31%
Don't know	6%	12%	4%	4%	*
Base	*1,059*	*84*	*273*	*188*	*53*

Base: All employers who provide OH services (unweighted) [169]

**Employers could select more than one response, therefore column percentages do not add to 100%*

[167] For example, NHS Health at Work Service.

[168] For example, OH specialist on site.

[169] The following conventions are used in tables: less than 0.5 per cent (*) and no observations (0).