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Understanding Occupational Health Provision 2023-24

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A report of research carried out by IFF Research on behalf of the Joint Work and Health Directorate (Department for Work and Pensions and Department of Health and Social Care).

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Executive summary

The Joint Work and Health Directorate, a joint unit between Department for Work and Pensions (DWP) and Department of Health and Social Care (DHSC), commissioned IFF Research to undertake research with Occupational Health (OH) providers to understand the structure, attitudes, and behaviour of the OH market. The research examines: the capacity of the OH services market, its workforce composition, and skills shortages; use of, and enablers and barriers to using multidisciplinary teams; engagement with, and enablers and barriers to working with Small and Medium-sized Enterprises (SMEs) and the self-employed as customers; engagement with, enablers and barriers to innovation; and pricing strategies. The research, which took the form of a telephone survey of 200 NHS, in-house and private OH providers, and 20 in-depth interviews, was designed to provide:

- New baseline information on the OH market in order to monitor change over time.
- Updated findings from the previous survey on OH provision carried out in 2019.
- New evidence to support policy development.

The research findings cover the following topics:

Workforce composition and recruitment: The research found that, on average, OH providers are relatively small and still face significant challenges in recruiting skilled staff. The most acute staffing challenges in the sector are around nurses with an OH Specialist Community Public Health Nursing (SCPHN) qualification, registered nurses with (or training towards) other OH postgraduate qualifications, physiotherapists, and doctors registered with the General Medical Council (GMC) as an Occupational Medicine (OM) specialist. The sector is receptive to using newly-qualified OH professionals without experience to meet its staffing needs; and OH providers with unfilled vacancies are particularly likely to be open to this.

Multidisciplinary teams: The sector is positive about using multidisciplinary teams, and better patient care is the motivation driving this, while their use is constrained by the availability of appropriately skilled OH staff; provider access to finance; and the extent to which customers accept their use.

Training: OH providers commonly engage with training but want to do more. Staffing challenges suggest that the sector would benefit most from training that would help meet the shortfall in nurses with an SCPHN OH qualification.

Demand for OH services and provider capacity: It may be more common for demands to exceed provider capacity than it was in 2019. Providers are mostly open to seizing the opportunity to expand, but some are constrained by recruitment challenges.

Pricing: Most specific OH services asked about tended to be charged at £51-£200 per person, per use. Pricing is most often shaped by the complexity of the services required and the costs of delivery; though three in ten tailor their prices to specific groups or types of customers and qualitatively, providers sought to balance attractive prices against not devaluing their services.

SMEs and the self-employed as customers: Despite positive provider attitudes, SMEs continue to be significantly under-represented in the customer base; and providers report a lack of demand from the self-employed.

Data collection, knowledge sharing and innovation: Almost all OH providers collected at least some data for their own central analysis; and the majority invested resource or staff capacity in keeping up to date with new OH research. Providers tend to innovate but do not have the funds or staff capacity to innovate as much as they would like to.

Accreditations: Awareness of, and favourability towards, SEQOHS (Safe, Effective Quality, Occupational Health Service) accreditation is high, and it is perceived as a way of establishing credentials and enhancing reputation.

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Glossary of terms

Assessment of fitness for work	Assessments designed to make sure an individual is fit to effectively perform the tasks of their job role without risk to their own or others' health and safety.
Access to Work	A publicly funded employment support programme that aims to help more disabled people start or stay in work. It can provide practical and financial support if an individual has a disability or mental health condition.
Commercial Occupational Health Providers Association (COHPA)	A non-profit non-regulatory membership association for Occupational Health and wellbeing providers.
Continuing Professional Development (CPD)	Learning activities that professionals engage in to develop and enhance their work-related skills and knowledge in a pro-active manner.
Customer	'Customer' refers to employers seeking Occupational Health (OH) services on behalf of their employees.
Employee assistance programmes (EAP)	A service offered by employers to their employees to assist with personal or work-related issues that may impact on their job performance, health, or emotional wellbeing.
The Faculty of Occupational Medicine (FOM)	A charity focused on improving health at work; and the professional and educational body for occupational medicine in the UK.
Fit notes	Issued by doctors to provide evidence of advice a patient has been given about their fitness for work, including details of functional effects of patient's condition to allow the employer to consider ways to help them return to work, and sometimes suggest reasonable adjustments.
Full-time work	There is no specific number of hours that make work full-time, but full-time workers will usually work 35 hours or more a week.
General Medical Council (GMC)	The independent regulator of doctors in the UK, formed in 1858. Works with doctors, patients, and other stakeholders to support good, safe patient care across the UK.
Health surveillance	A system of ongoing health checks to detect ill-health at an early stage to enable employers to introduce

	interventions to prevent issues from getting worse; particularly for people working in hazardous roles.
In-house provider	'In-house provider' refers to Occupational Health departments or teams within organisations who deliver OH services internally to their employees.
Management referral	The process through which employees are referred for OH support.
Multidisciplinary teams (MDTs)	This is where OH services are delivered by two or more members of staff from different disciplines, alongside a nurse and a doctor, including both clinical and non-clinical patient-facing staff.
Musculoskeletal (MSK) provision	Health services commissioned to treat conditions that affect the joints, bones and muscles.
NHS provider	'NHS provider' refers to departments or teams within the NHS who provide OH services within the NHS or externally. It included NHS providers in England, Scotland and Wales.
Nursing & Midwifery Council (NMC)	The Nursing and Midwifery Council is the independent regulator for nurses and midwives in the United Kingdom, and nursing associates in England. It maintains the register of professionals eligible to practise.
Occupational Health (OH) services	Advisory and support services which help to maintain and promote employee health and wellbeing. OH services support organisations to achieve these goals by providing direct support and advice to employees and managers, as well as support at the organisational level e.g., to improve work environments and cultures.
Occupational Medicine (OM)	Medical support and advice provided to both employers and employees on the relationship between work and health.
OH Specialist Community Public Health Nursing (OH SCPHN)	The part of the Nursing & Midwifery Council register which is for registered nurses and midwives working in specialist public health roles, in this case, Occupational Health (OH).
Part-time work	A part-time worker is someone who works fewer than 35 hours per week.
Patient	'Patient' refers to the individual receiving OH support and/or treatment.

Private provider	‘Private provider’ refers to private organisations or individual practitioners providing OH services on a commercial basis.
Royal College of Occupational Therapists	A registered charity that has been working to promote the Occupational Therapists profession for over 90 years.
Safe, Effective Quality, Occupational Health Service (SEQOHS) accreditation	An accreditation scheme launched in 2010, intended to provide independent recognition that an OH service provider has demonstrated competence, as defined by a set of standards, to a team of trained assessors.
Self-employed customer	‘Self-employed customer’ refers to individuals who are seeking OH services without being employed by an organisation.
Small and Medium-sized Enterprises (SMEs)	Enterprises which have fewer than 250 employees, and which have an annual turnover not exceeding £25 million.
The Society of Occupational Medicine (SOM)	The Society of Occupational Medicine is the UK organisation for healthcare professionals working in, or with an interest in, Occupational Health.
Vocational rehabilitation (VR)	Process which enables persons with functional, psychological, developmental, cognitive, and emotional disabilities or impairments or health disabilities to overcome barriers to accessing, maintaining, or returning to employment.
Workplace adjustments	Making changes to the working environment to allow an employee to remain in a role. These can include changes to the physical working environment, for example modifying furniture or tools, or by changing working arrangements, for example a change of working hours or providing help with transport to or from the workplace.
The Vocational Rehabilitation Association (VRA)	The VRA is a multi-disciplinary UK-wide organisation supporting and promoting all those working in vocational rehabilitation and commissioning services whether in the public, private, voluntary or third sector.

Abbreviations

The following abbreviations are used in this report:

Abbreviation	Definition
COHPA	The Commercial Occupational Health Providers Association
CPD	Continuing Professional Development
DOccMed	Diploma in Occupational Medicine
DHSC	Department of Health and Social Care
DWP	Department for Work and Pensions
FOM	The Faculty of Occupational Medicine
GMC	General Medical Council
HAVS	Hand Arm Vibration Syndrome
MDTs	Multidisciplinary teams
NMC	Nursing and Midwifery Council
OH	Occupational Health
OH SCPHN	Occupational Health Specialist Community Public Health Nursing
OM	Occupational Medicine
SEQOHS	Safe, Effective, Quality Occupational Health Service
SMEs	Small and Medium-sized Enterprises
SOM	Society of Occupational Medicine
VR	Vocational Rehabilitation
VRA	Vocational Rehabilitation Association

Summary

Background and methodology (Chapter 1)

The Joint Work and Health Directorate, a joint unit between Department for Work and Pensions (DWP) and Department of Health and Social Care (DHSC) commissioned IFF Research to undertake research with Occupational Health (OH) providers to understand the structure, attitudes, and behaviour of the OH market. The research examines: the capacity of the OH services market, its workforce composition, and skills shortages; use of, and enablers and barriers to using multidisciplinary teams; engagement with, and enablers and barriers to working with Small and Medium-sized Enterprises (SMEs) and the self-employed as customers; engagement with, enablers and barriers to innovation; and pricing strategies and levels, and how these relate to delivery models. The research was designed to provide:

- New baseline information on the OH market in order to monitor change over time
- Updated findings from the previous survey on OH provision carried out in 2019.
- New evidence to support policy development.

This research was comprised of two components:

- Quantitative: a telephone survey of 200 NHS, in-house and private OH providers headquartered in Great Britain, conducted as an attempted census.
- Qualitative: 20 in-depth interviews with a subset of NHS, in-house and private OH providers who'd taken part in the survey.

Fieldwork took place between 23rd August 2023 and 19th January 2024.

The research findings refer to the following groups throughout:

- 'In-house providers': OH departments or teams within organisations, who deliver OH services internally to their employees.
- 'Private providers': private organisations or individual practitioners providing OH services on a commercial basis.
- 'NHS providers': departments or teams within the NHS who provide OH services within the NHS or externally.

Findings are drawn from the survey unless otherwise stated. The survey was semi-structured, gathering very detailed information from a relatively small sample (200 OH providers overall). This means that some of the findings are inevitably based on small numbers of interviews. For example, all of the findings for NHS providers are based on a sample of 43 providers. Results have been included in the report to allow comparisons but, in places, specific percentages should be treated with caution.

Some comparisons are made with previous research on OH provision conducted by IFF Research in 2019.

Workforce composition and recruitment (Chapter 2)

OH providers were asked how many staff they employed in various specific roles. The findings suggest that OH providers are generally relatively small, but that NHS providers tend to be bigger on average than other provider types. For NHS and in-house providers, the OH department or team sits within a much larger organisation; 93% of NHS provider organisations and 98% of in-house provider organisations had 250 or more employees overall, while their OH team or departments tended to be much smaller (most commonly between 10 and 49 employees for the NHS; and between 1 and 9 employees for in-house providers). Among private providers, around half (50%) were micro businesses with 1-9 employees and more than a quarter (27%) were small businesses with 10-49 employees.

Overall, the most common roles employed were admin staff, nurses registered with an OH Specialist Community Public Health Nursing (SCPHN) qualification, OH technicians or healthcare assistants, doctors registered with the General Medical Council (GMC) as an occupational medicine (OM) specialist, and nurses without any OH qualifications.[1]

Consistent with their greater average size, NHS providers had the broadest spread of roles, being significantly more likely than in-house and private providers to employ individuals in almost all roles. This was broadly consistent with 2019. In-house providers had the least diverse spread of roles, with private providers positioned between the two – less diverse than NHS providers but more diverse than in-house providers.

When asked about recruitment challenges, OH providers reported that nurses with OH Specialist Community Public Health Nursing (SCPHN OH), registered nurses training towards other OH postgraduate qualifications, physiotherapists and doctors registered with the GMC as an OM specialist had been the most difficult roles to recruit in the past three years. Having difficulty recruiting was slightly more common than in 2019.

In the in-depth interviews, providers reported that recruitment challenges arose from a lack of OH staff with the right qualifications and experience; coupled with a perceived lack of training, and funding for training, to equip prospective staff for roles.

Approaching four in ten (38%) had unfilled vacancies. This was significantly higher among NHS providers (53%). The unfilled vacancies broadly mirrored the roles that providers found difficult to recruit.

Two-thirds (66%) were at least somewhat favourable to hiring newly qualified OH professionals without experience, to deliver their OH services. Those with unfilled

[1] 'Nurses without OH qualifications' refers to nurses not registered under part 3 of the Nursing and Midwifery Council (NMC) register or without postgraduate qualifications in OH and without a Faculty of Occupational Medicine Diploma.

vacancies were more likely to be favourable, suggesting that provider-need may be driving open-mindedness towards the newly qualified as recruits.

Multidisciplinary teams (Chapter 3)

Multidisciplinary teams were defined as, 'where services are delivered by two or more members of staff from different disciplines, alongside a nurse and a doctor, including both clinical and non-clinical patient-facing staff'. Three-fifths of providers (60%) reported using multidisciplinary teams to deliver their OH services; NHS providers were the most likely to do so and in-house providers were the least likely.

Most OH providers (82%) were favourable towards using multidisciplinary teams, and this was consistent across different provider types. The findings suggest multidisciplinary teams were being used to provide patients with a holistic OH approach that addresses patient needs in a person-centred way. This is evident in the most common reasons for being favourable towards using multidisciplinary teams: to help customers benefit holistically from a wider range of OH specialisms (45%); clinical effectiveness / best practice (36%); and better outcomes for the patient (33%).

When asked what would encourage their organisation or OH department to make more use of multidisciplinary teams, OH providers most commonly mentioned: the availability of appropriately skilled staff (27%); access to finance (21%), and market education / acceptance / appetite (17%). This was broadly consistent with the barriers to using multidisciplinary teams that emerged from the in-depth interviews.

The in-depth interviews explored examples of how multidisciplinary teams operate. These typically involve a case manager who coordinates all professionals involved, and is the main client point of contact; alongside a range of other professionals including occupational therapists, OH technicians, physiotherapists, mental health workers and speech and language therapists, as well as the patient's line manager. Sometimes non-health professionals such as employability specialists were also involved. Typically, the patient encountered these various disciplines as part of a linear process, with each professional performing their role then passing the patient on, with the case manager coordinating this.

Training (Chapter 4)

It was very common for OH providers to fund access to training and qualifications for staff delivering their services, with 93% of OH providers doing so. Offering funding for *both* training and qualifications was more common amongst NHS providers; private providers were more likely not to fund access to either. Providers who had struggled to hire staff to fill roles, and providers with the Safe Effective Quality Occupational Health Service (SEQOHS) accreditation, were more likely to fund access to *both* training and qualifications.

OH providers most commonly funded access to: OH technician courses; audiometry training; training towards OH Specialist Community Public Health Nursing (OH SCPHN); and the Diploma in Occupational Health Practice (DipOHPrac).

The in-depth interviews identified motivations for funding training or qualifications; providers tended to do so as a means of providing quality OH services that met client needs and as a staff retention strategy.

Approaching a third of OH providers (30%) had additional training or qualifications that they would ideally like to access or fund access to but were not able to at present. This was more prevalent amongst NHS providers. Most commonly, providers wanted to access or fund access to: OH technician courses; training towards OH Specialist Community Public Health Nursing (OH SCPHN); or business and administration training.

The most commonly mentioned factors making it difficult to fund access to training and qualifications were: lack of funding (45%); staff finding time to attend (32%); and the cost of external provision (32%). Although a fifth of providers (20%) said that there were no barriers to funding access to training and qualifications. Overall, monetary factors were a barrier for three-fifths of providers: 60% of providers said either lack of funding and/or cost of provision was a barrier to funding access to training and qualifications. In the in-depth interviews, OH providers tended to suggest better availability of external training and subsidised rates for training, as a way of reducing barriers to training and qualification.

Demand for OH services, and provider capacity (Chapter 5)

OH providers identified four specific services that were both the most in-demand and the most-commonly offered by OH providers; these were: management referrals or assessments of fitness for work for ill or sick employees; pre-employment or post-offer of employment health assessments; ongoing health assessments for any employees, even if not ill or sick; and support with health surveillance.

When asked about their overall capacity, in terms of the maximum number of individuals a provider could provide services to at any one time, the median average capacity was 250 individuals. NHS providers had the highest median capacity (up to 1,000 individuals at once); while in-house and private providers could on average cater to a maximum of 200 individuals at once (median).[2]

OH providers of all types reported having been working near their maximum capacity, at maximum capacity or above full capacity in the past 12 months. A quarter (24%) had been operating at capacity, while a fifth (20%) had been operating beyond their maximum capacity. On average (median), providers reported 95% of their capacity having been used in the past 12 months. NHS and in-house providers were more likely to have been at capacity than private providers. Comparisons with broadly similar questions asked of private providers in 2019 suggested that demands exceeding capacity may now be more common.

Seven in ten OH providers (71%) were favourable towards the idea of expanding their capacity to increase the maximum number of customers they can provide their current services to at any one time, with private providers being more likely to be

[2] This is a median average, to avoid the average figures being distorted by a small number of outlying very high values.

‘extremely favourable’. Providers’ reasons for being favourable mostly revolved around grasping an apparent opportunity, although two-fifths (40%) mentioned the more altruistic motive of wanting to deliver the benefits of OH more widely.

Where providers were unfavourable towards expanding their capacity, this was most commonly due to a lack of interest in expansion (45%) and difficulty recruiting enough skilled staff to increase capacity (31%). Similarly, in the in-depth interviews, providers’ comments on their past efforts to expand capacity and their suggestions for making it easier to expand in future, tended to relate to their ability to recruit appropriately skilled, qualified and experienced staff.

Pricing (Chapter 6)

The majority (70%) of in-house providers did not charge for any OH services. Most NHS providers (88%) had sold services to external organisations in the past two years; most of these charged their services at a lower rate when delivered to NHS staff internally.

When asked how much they typically charge per employee for specific OH services, most of the services asked about (health surveillance; management referrals or assessment of fitness; ongoing health assessments; Cognitive Behavioural Therapy) were most commonly charged at between £51 and £200 per person, per use.

OH physiotherapy services were most commonly charged on a pay per use basis (49%, with these most often falling into the price range £51-£200 per use), or on a day, half-day or hourly rate basis (40%, with these most often falling into the price range £601-£800 a day). However, more than half (55%) of in-house providers did not charge for OH physiotherapy.

Three out of ten (29%) providers that charged for their services had customers that paid them a retainer; and this retainer would often, but not always, reduce the charges per person for their OH services.

Around a quarter (27%) of providers offered OH services via annual contracts, without any additional fees being charged when individual clients take up these services. The prices charged per year varied considerably by the size of customer, and providers commonly struggled to estimate a price band for customers with 1,000 employees or more.

Two-thirds (67%) of providers did not tailor their prices to specific groups or types of customers. Amongst providers that *did* tailor, 37% said that they considered the employer’s average level of utilisation of their services and 27% said that they considered the size of the employer.

Approaching four in ten providers (38%) considered the complexity of the contract or the interventions required and three in ten (30%) considered the real cost of servicing the contract, when determining their pricing. Qualitatively, providers emphasised the importance of balancing attractive prices while avoiding devaluing their services; however, a few discounted their services on ‘social value’ grounds, offering reduced rates to SMEs or self-employed individuals because they were perceived to be less able to afford OH services.

SMEs and self-employed as customers (Chapter 7)

Small and Medium Enterprises (SMEs) continue to be significantly under-represented in the OH provider customer base. On average, half the customer base for NHS and private providers was made up of SMEs (a median average of 50% overall, 50% for NHS providers and 60% for private providers). This is in the context of 99.8% of UK businesses being SMEs overall, as stated in the Business population estimates for the UK and regions 2024.

Most NHS and private providers (85%) were favourable towards working with SMEs as customers. Most commonly, this was because providers wanted to provide support to a typically neglected sector (35%), or the scale of OH providers' services was better suited to SMEs (34%), or there were stronger and more direct business relationships with SMEs (24%), or the providers could better provide tailored solutions to SMEs than larger organisations (20%).

Challenges in working with SMEs, which were explored in the in-depth interviews, were mainly financial, with OH providers noting SMEs' limited budgets, making for less profitable work. Although providers also reported a lack of awareness amongst SMEs of the benefits of OH.

The in-depth interviews also explored providers' views on working with the self-employed as customers. Providers were willing to work with the self-employed but reported a lack of demand, which they felt was due to a lack of legal requirement for the self-employed to use OH services and the self-employed being less likely to be able to afford OH services.

Data collection, knowledge sharing and innovation (Chapter 8)

Almost all providers (96%) collected at least some data for their own analysis. The most commonly collected types of patient data were on employee conditions or injuries (56%), employee fitness records from health surveillance (53%) and interventions used on employees (46%). The most commonly collected types of internal data were client satisfaction (61%), speed of seeing a case (53%), fees, invoicing or payment information; and referral numbers (each collected by 51%).

The majority of OH providers (82%) reported investing resources or staff capacity into keeping up to date with new OH research, and this was equally prevalent across all provider types. Most commonly, research was used to identify ways of improving provider practice (73%), by sharing findings in team meetings (55%) and to inform continuing professional development, revalidation or peer coaching (29%). By far the most common barrier to keeping up to date with the latest OH research was staff being too busy with day-to-day work (59%).

Around two-thirds (68%) reported innovating around their OH services ('innovation' was defined as: investment in new or improved services, delivery methods or technologies that benefit people's health, wellbeing and capacity to work; some of which might be termed 'Research and Development'). However, nearly half of providers (46%) said they did not innovate as much as they would like; NHS providers were more likely to say this. The most common barriers to innovation were

cost, followed by capacity, with similar responses emerging from the survey and the in-depth interviews.

Just over a third of providers (35%) had heard of the DWP and DHSC innovation fund, a £1 million fund for new ideas to boost health and welfare at work for SMEs and the self-employed.

Accreditations (Chapter 9)

OH providers discussed the SEQOHS (Safe Effective Quality Occupational Health) accreditation, in the context of other OH-relevant accreditations. A new SEQOHS standard was introduced in November 2023 but as this study's fieldwork was conducted between August 2023 and January 2024, findings will likely reflect attitudes towards the old, pre-2023 SEQOHS accreditation.

The vast majority (94%) of OH providers of all types were aware of SEQOHS; around a third (32%) were already SEQOHS accredited and nearly a fifth (17%) were working towards accreditation.

NHS providers were the most engaged with SEQOHS, with almost three quarters (74%) stating that they were SEQOHS accredited, compared with around one fifth of in-house (17%) and private providers (22%). A quarter (25%) of those not accredited or working towards SEQOHS accreditation, said they were likely to get it in the future.

Almost two-thirds of OH providers (65%) were favourable towards using SEQOHS accreditation. NHS providers were more likely to be favourable. Most commonly, providers were favourable towards SEQOHS to establish credentials and enhance their reputation amongst customers.

One in eight providers (13%) were unfavourable towards SEQOHS. Where providers had an unfavourable attitude towards SEQOHS, most commonly given reasons were because they felt SEQOHS provides minimal or no benefit to their business (77%), that the process for gaining the accreditation is complicated or time consuming (54%) and that it is expensive (42%). These same themes emerged when providers made suggestions regarding what would encourage them to become SEQOHS accredited, i.e. making it more beneficial to their business, making it less complicated and providing funding or reducing the cost.

Conclusions (Chapter 10)

The following conclusions can be drawn from this report:

- On average, OH providers are relatively small and still face significant challenges in recruiting skilled staff.
- The most acute staffing challenges in the sector are around nurses with OH SCPHN qualifications; and nurses with or training towards other OH postgraduate qualifications.
- The sector is receptive to using newly-qualified OH professionals to meet their staffing needs.
- The sector is positive about using multidisciplinary teams, and better patient care is the motivation driving this, while their use is constrained by the

availability of appropriately skilled OH staff, provider access to finance and the extent to which customers accept their use.

- OH providers commonly engage with training but want to do more. Staffing challenges suggest that the sector would benefit most from more training to help meet the shortfall in nurses with an OH SCPHN qualification.
- It may be more common for demands to exceed provider capacity than it was in 2019. Providers are mostly open to expanding capacity, but some are constrained by recruitment challenges.
- Most specific OH services asked about tended to be charged at £51-£200 per person per use.
- Despite positive provider attitudes, SMEs continue to be significantly under-represented in the customer base and providers report a lack of demand from the self-employed.
- OH providers tend to innovate but do not have the funds or staff capacity to innovate as much as they would like to.
- Awareness of and favourability towards SEQOHS accreditation is high, and it is perceived as a way of establishing credentials and enhancing reputation. However, only half were SEQOHS accredited or working towards SEQOHS accreditation.
- OH providers often seem to be influenced by altruistic motivations, including a commitment to high standards of patient care and a desire to spread the benefits of OH, over and above other factors.
- Recruitment and capacity challenges, stemming from a shortage of appropriately qualified, skilled, and experienced OH staff, recurs as a constraint on providers. This includes their ability to expand, to use multidisciplinary teams and to innovate.

1 Background and methodology

Introduction

This chapter describes the policy background and sets out the aims and objectives of the research. The chapter also describes the methodology and sets out the report structure.

Background to the research

Department for Work and Pensions (DWP) and Department of Health and Social Care (DHSC) occupational health (OH) reform programme has focused on increasing private market access and uptake of employer-led OH to help businesses, particularly small and medium-sized enterprises (SMEs), to support disabled employees and those with health conditions to get in and get on in work. This includes getting back into appropriate work as quickly as possible and enabling a sustainable workforce to support good quality provision across all sectors.

The programme has included:

- The launch of a £1m fund for innovation, on 30 January 2023 that focussed on increasing access to, and capacity in, OH. The fund has encouraged the development of new models of OH tailored to the self-employed and SMEs with a focus on better use of technology. Phase 1 was launched in January 2023 and projects finished January 24. Phase 2 launched on 4 December 2023 through a £1.5m fund, projects went live 1 April 2024 and completed in March 2025.
- The completion of a financial incentive and market navigation support pilot in Cumbria and Lancashire for small and medium-sized enterprises (SMEs) to test whether this helped in overcoming barriers to purchasing OH advice.
- The introduction of the Occupational Health Workforce Expansion Funding Scheme in July 2023, funding registered doctors and nurses to undertake Occupational Health training courses and qualifications.

The Joint Work and Health Directorate, a joint unit between DWP and DHSC, commissioned IFF Research to undertake research with OH providers to understand the structure, attitudes, and behaviour of the OH market in relation to the following areas:

- Market capacity, workforce composition, and skills shortages.
- Enablers of, and barriers to, using multidisciplinary teams.
- Enablers of, and barriers to, working with SMEs and the self-employed as customers.

- The extent of enablers of, and barriers to, innovation amongst providers.
- Pricing strategies and levels, and how these relate to delivery models.

The research was designed to provide:

- New baseline information on the OH market in order to monitor change over time to inform future policy.
- Updated findings from the previous survey on OH provision carried out in 2019.
- New evidence to support policy development.

In 2019, IFF Research carried out a study for DWP and DHSC's Work and Health Unit.to explore provision of OH and the commissioning of NHS work-related musculoskeletal (MSK) services to inform policy development. Where appropriate, findings from the 2019 report will be referenced in this report, however, it should be noted that the surveys are not directly comparable due to different survey methodologies and questionnaire content.

Methodology

This research was comprised of two components:

- **Quantitative:** a telephone survey with NHS, in-house and private OH providers.
- **Qualitative:** in-depth interviews with a subset of NHS, in-house and private OH providers who had taken part in the survey.

Telephone survey

A semi-structured telephone survey aimed to speak to as many OH providers based or headquartered in Great Britain as possible, as an attempted census. Due to the absence of a single authoritative sample, the sample was drawn from a range of sources, set out in Table 1.1.

A sample of 3,897 organisations was drawn for the telephone survey (excluding opt-ins). The sample included NHS, in-house, and private OH providers. Some of the organisations sampled were very likely to be providers of OH services (due to their details being sourced from OH sector bodies); while other organisations sampled needed screening to establish their relevance to the survey (for instance, large employers who were included in the sample because they *might* have an in-house OH team or department). In addition, there were 11 providers who opted in during fieldwork, as a result of publicity for the survey. The survey was aimed at senior executives who could answer questions on capacity, recruitment and resourcing, pricing structures, marketing strategies, innovation and learning.

The questionnaire was developed with input from a steering group of OH sector representatives and was cognitively tested ahead of fieldwork to ensure it was relevant and understood by a range of OH providers.

An email/letter with information about the study was sent to respondents ahead of an IFF telephone interviewer making contact.

In total 200 OH/VR[3] providers took part in the survey between 23rd August 2023 and 19th January 2024: 43 NHS providers, 54 in-house providers and 103 private providers.[4] The response rate varied considerably by sample source; likely due to variations in relevance of the sources of contact details used (Table 1.1). Some of the sample sources with higher response rates are related to sector bodies such as the Commercial Occupational Health Providers Association (COHPA) or sector accreditations such as Safe, Effective, Quality Occupational Health Service (SEQOHS) and, as such, OH providers who are more connected to others in their sector or more engaged with accreditations, may have been more likely to participate in the survey.

The research findings refer to the following groups throughout:

- **'In-house providers':** OH departments or teams who deliver OH services internally to their employees.
- **'Private providers':** private organisations or individual practitioners providing OH services on a commercial basis.
- **'NHS providers':** departments or teams within the NHS who provide OH services within the NHS or externally.

[3] Vocational rehabilitation (VR) is the process which enables persons with functional, psychological, developmental, cognitive, and emotional disabilities or impairments or health disabilities to overcome barriers to accessing, maintaining, or returning to employment.

[4] This may not necessarily be reflective of the split across Great Britain OH provision; and it is not possible to test this since there is no single authoritative sample source. As a result, when presenting the findings, this report makes clear the findings for each provider type separately.

Table 1.1. Sample sources, interviews achieved and response rates

Sample source	Type of provider sampled from this	Starting sample *(NB - may not all have been OH providers)*	Number of interviews achieved	Response rate as a percentage
Market Location	In-house	2771	44	2%
Market Location	Private	587	43	7%
Other sources of NHS providers	NHS	116	43	37%
Other sources of private providers	Private	144	41	28%
Other sources of in-house providers	In-house	31	10	32%
SOM listings	Private	103	9	9%
Office of Rail and Road public lists	Private	58	8	14%
ACPOHE listings	Private	103	2	2%

Notes: Market Location is a commercial primary data owner in the UK who independently verify and collect business data. SOM listings are publicly available listings from the Society of Occupational Medicine (SOM). Office of Rail and Road public lists are publicly available listings from the Office of Rail and Road (ORR). ACPOHE listings are publicly available listings from the Association of Chartered Physiotherapists in Occupational Health and Ergonomics (ACPOHE). The category 'other sources of NHS providers' includes: SEQOHS lists, which are publicly available lists of OH providers who had or were working towards a SEQOHS (Safe, Effective, Quality Occupational Health Service) accreditation; NHS Health at Work lists of OH teams working in the NHS; Market Location lists; Vocational Rehabilitation Association (VRA) Practitioner Direct lists of members; Health and Safety Commission (HSC) lists of OH providers; and Office of Rail and Road public lists. The category 'other sources of private providers' includes: COHPA public lists, SEQOHS public lists, VRA public lists, opt ins, and HSC public lists. COHPA lists are a publicly available list of OH providers registered with COHPA (the Commercial Occupational Health Providers Association). The category 'other sources of in-house providers' includes: SEQOHS public lists, Office of Rail and Road public lists, opt-ins, and SOM listings.

Depth interviews

To further understand the issues faced by OH providers, 20 in-depth interviews were carried out with NHS, in-house, and private OH providers who had taken part in the survey. Where appropriate, paired and triad interviews were undertaken to ensure a comprehensive overview of provision was provided. The interviews aimed to explore in depth: views on expanding capacity, recruitment and training; pricing strategies; experiences of working with SMEs and the self-employed; attitudes to accreditations; and the use of multidisciplinary teams in practice, including how different skills, professions and roles interact to deliver OH services.

Report Structure

The report takes the following structure:

- Chapter 2 looks at the current OH workforce composition and recruitment.
- Chapter 3 presents findings on attitudes towards using multidisciplinary teams and how OH providers use these in practice.
- Chapter 4 explores types of funded training, how providers fund access to training and barriers and enablers to training.
- Chapter 5 sets out the current demand for OH services and provider capacity; and explores views on expanding capacity.
- Chapter 6 looks at pricing strategies for OH providers.
- Chapter 7 provides findings on attitudes towards SMEs and the self-employed as customers.
- Chapter 8 explores data collection and innovation, looking at data collected and attitudes towards innovation and knowledge development.
- Chapter 9 sets out attitudes towards the Safe Effective Quality Occupational Health Service (SEQOHS) accreditation, including benefits and barriers, in the context of other OH accreditations.
- Final chapter includes the conclusions drawn from the research conducted.

Notes

The survey was semi-structured, gathering very detailed information from a relatively small sample (200 OH providers overall). This means that some of the findings are inevitably based on small numbers of interviews. For example, all of the findings for NHS providers are based on a sample of 43 providers. Results based on fewer than 50 interviews have been included in parts of the report to allow comparisons but, where this is the case, specific percentages should be treated with caution.

In some of the charts included in this report, the figures do not add up to 100%. For some charts, this is due to OH providers being able to give more than one response to the question, and for other charts, this is due to rounding.

2 Workforce composition and recruitment

This chapter provides an overview of the Occupational Health (OH) workforce employed by OH providers based or headquartered in England, Wales and Scotland. It shows which roles providers employ, and the recruitment challenges experienced in finding employees for these roles. Findings are drawn from both the survey of OH providers and the in-depth qualitative interviews.

General composition

This section gives an overview of current composition, including the roles providers employ and how many individuals they employ in each role.

Tables 2.1, 2.2 and 2.3 show the proportion of providers that employed at least one individual in each role, by provider type. Where a staff member had multiple qualifications, providers were asked to answer about the role according to the staff member's highest level of qualification. Figures with an asterisk (*) next to them are significantly higher than average, meaning that type of provider is more likely to employ someone in that role than providers overall.

NHS providers were significantly more likely than average to employ at least one staff member in most roles; the only exceptions being:

- OH technicians or health care assistants.
- Occupational therapists.
- Doctors not registered with General Medical Council (GMC as an Occupational Medicine (OM) specialist and without a Diploma in Occupational Medicine (DOccMed).
- Other roles.

A broadly similar question was asked of NHS and private providers in 2019, although more focused on clinical staff. These results are broadly consistent with 2019, where NHS providers were significantly more likely than private providers to directly employ individuals in almost all OH roles.

Table 2.1: Proportion of NHS providers employing at least one of each job role

	At least one full time employee	At least one part time	At least one of either
Admin staff	*93%	*74%	*98%
Nurses with an SCPHN OH qualification	*81%	*84%	*95%
Nurses without OH qualifications[5]	*56%	*72%	*81%
Doctors registered with GMC as an OM specialist	*42%	*47%	*67%
Counsellors	*23%	*47%	*51%
OH technicians or healthcare assistants	33%	28%	49%
Physiotherapists	*37%	*30%	*47%
Nurses training towards OH SCPHN	*28%	*23%	*44%
Registered nurses with or training towards other OH postgrad qualifications	*30%	*28%	*42%
Registrars training towards GMC registration as OM specialists	*19%	*26%	*30%
Mental Health nurses	*19%	*14%	*26%
Clinical psychologists with speciality in OH	*14%	*21%	*26%
Doctors with DOccMed	7%	*23%	*26%
Occupational therapists	9%	9%	12%
Doctors not registered with GMC as an OM specialist and without DOccMed	2%	7%	9%
Other roles[6]	26%	33%	42%

A1. How many of your OH department / organisation's staff are employed on a full-time basis, and how many are employed on a part-time basis? Please give your answer in terms of headcount, that is the number of employees occupying each role. Please include yourself if you occupy one of these roles. Base: 43 providers. Note the relatively small base sizes for NHS providers, meaning specific percentages should be treated with caution.

[5] 'Nurses without OH qualifications' refers to nurses not registered under part 3 of the Nursing and Midwifery Council (NMC) register or without postgraduate qualifications in OH and without a Faculty of Occupational Medicine Diploma.

[6] Unprompted roles mentioned by providers. Individually these roles were employed by a very small proportion of providers, they include psychiatrists; holistic therapists; business managers; sports therapists; paramedics.

Table 2.2: Proportion of In-house providers employing at least one of each job role

	At least one full time employee	At least one part time	At least one of either
Admin staff	54%	44%	72%
Nurses with an SCPHN OH qualification	59%	57%	*83%
Nurses without OH qualifications[7]	20%	13%	30%
Doctors registered with GMC as an OM specialist	13%	13%	22%
Counsellors	11%	7%	19%
OH technicians or healthcare assistants	44%	15%	54%
Physiotherapists	2%	0%	2%
Nurses training towards OH SCPHN	7%	0%	7%
Registered nurses with or training towards other OH postgrad qualifications	15%	13%	22%
Registrars training towards GMC registration as OM specialists	0%	0%	0%
Mental Health nurses	0%	0%	0%
Clinical psychologists with speciality in OH	2%	0%	2%
Doctors with DOccMed	2%	0%	2%
Occupational therapists	0%	2%	2%
Doctors not registered with GMC as an OM specialist and without DOccMed	2%	0%	2%
Other roles[8]	28%	4%	31%

A1. How many of your OH department / organisation's staff are employed on a full-time basis, and how many are employed on a part-time basis? Please give your answer in terms of headcount, that is the number of employees occupying each role. Please include yourself if you occupy one of these roles. Base: 54 providers. Note the relatively small base sizes for in-house providers, meaning specific percentages should be treated with caution.

[7] 'Nurses without OH qualifications' refers to nurses not registered under part 3 of the Nursing and Midwifery Council (NMC) register or without postgraduate qualifications in OH and without a Faculty of Occupational Medicine Diploma.

[8] Unprompted roles mentioned by providers. Individually these roles were employed by a very small proportion of providers, they include psychiatrists; holistic therapists; business managers; sports therapists; paramedics.

Table 2.3: Proportion of private providers employing at least one of each job role

	At least one full time employee	At least one part time	At least one of either
Admin staff	48%	51%	69%
Nurses with an SCPHN OH qualification	42%	37%	55%
Nurses without OH qualifications[9]	15%	16%	21%
Doctors registered with GMC as an OM specialist	18%	22%	38%
Counsellors	5%	10%	13%
OH technicians or healthcare assistants	34%	23%	42%
Physiotherapists	9%	11%	16%
Nurses training towards OH SCPHN	5%	3%	8%
Registered nurses with or training towards other OH postgrad qualifications	13%	5%	14%
Registrars training towards GMC registration as OM specialists	1%	3%	4%
Mental Health nurses	5%	5%	8%
Clinical psychologists with speciality in OH	3%	6%	8%
Doctors with DOccMed	5%	8%	10%
Occupational therapists	8%	4%	9%
Doctors not registered with GMC as an OM specialist and without DOccMed	1%	3%	4%
Other roles[10]	21%	16%	31%

A1. How many of your OH department / organisation's staff are employed on a full-time basis, and how many are employed on a part-time basis? Please give your answer in terms of headcount, that is the number of employees occupying each role. Please include yourself if you occupy one of these roles. Base: 103 providers.

[9] 'Nurses without OH qualifications' refers to nurses not registered under part 3 of the Nursing and Midwifery Council (NMC) register or without postgraduate qualifications in OH and without a Faculty of Occupational Medicine Diploma.

[10] Unprompted roles mentioned by providers. Individually these roles were employed by a very small proportion of providers, they include psychiatrists; holistic therapists; business managers; sports therapists; paramedics.

Table 2.4, 2.5, 2.6 show the mean and median average number of employees employed in each role. This shows that:

- Among NHS providers, admin staff made up the greatest number of employees as both a mean and median average, followed by nurses with an OH SCPHN qualification and then nurses without OH qualifications.
- Among in-house providers, slightly more nurses with an OH SCPHN qualification were employed on average than admin staff but, as with NHS providers, nurses without OH qualifications made up the third largest number of employees within the workforce.
- Among private providers, the two most employed professions were also admin staff and nurses with an OH SCPHN qualification, however, nurses with other OH postgrad qualifications or training towards these qualifications made up the third largest number of employees.

The tables also show the total average number of employees, by provider type (see bottom rows). Taking the sum of the average of each of these roles:

- NHS providers had 33 employees (sum of mean averages; the sum of median averages was 17).[11]
- In-house providers had nine employees (sum of mean averages; the sum of median averages was four).
- Private providers had 26 employees (sum of mean averages; the sum of median averages was three).

These findings suggest that OH providers are generally relatively small, but that NHS providers tend to be bigger on average than other provider types. The large disparity between the mean and median sizes of private providers shows that there is a greater range in size among private providers than NHS or in-house providers.

[11] The median average is the middle number in a set of values when those values are arranged from smallest to largest. It is useful as, unlike a mean average, it is not distorted by a small number of outlying very high values.

Table 2.4: Average number of NHS employees in each job role

	Mean number employed full time or part time	Median number employed full time or part time
Admin staff	10	8
Nurses with an SCPHN OH qualification	6	4
Nurses without OH qualifications[12]	4	3
Counsellors	2	1
Registered nurses with or training towards other OH postgrad qualifications	2	0
Doctors registered with GMC as an Occupational Medicine (OM) specialist	1	1
Physiotherapists	1	0
OH technicians or healthcare assistants	1	0
Clinical psychologists with speciality in OH	1	0
Nurses training towards OH SCPHN	1	0
Registrars training towards GMC registration as OM specialists	1	0
Mental Health nurses	1	0
Doctors with DOccMed	1	0
Occupational therapists	<1	0
Doctors not registered with GMC as an OM specialist and without DOccMed	<1	0
Other roles[13]	2	0
Sum of average for all professions[14]	**33**	**17**

A1. How many of your OH department / organisation's staff are employed on a full-time basis, and how many are employed on a part-time basis? Base: 43 NHS providers. Note the relatively small base sizes for NHS providers, meaning specific numbers of employees should be treated with caution.

Results showing <1 indicate the result was more than 0 but less than 0.5 (values between 0.5 and 0.9, have been rounded up to 1 here).

[12] 'Nurses without OH qualifications' refers to nurses not registered under part 3 of the Nursing and Midwifery Council (NMC) register or without postgraduate qualifications in OH and without a Faculty of Occupational Medicine Diploma.
[13] This row sums those saying 'other roles' as well as some other specific roles that were relatively uncommon.
[14] Note that this is the sum of the rounded figures presented in this table.

Table 2.5: Average number of in-house provider employees in each job role

	Mean number employed full time or part time	Median number employed full time or part time
Admin staff	2	1
Nurses with an SCPHN OH qualification	3	2
Nurses without OH qualifications[15]	1	0
Counsellors	<1	0
Registered nurses with or training towards other OH postgrad qualifications	<1	0
Doctors registered with GMC as an Occupational Medicine (OM) specialist	<1	0
Physiotherapists	0	0
OH technicians or healthcare assistants	1	1
Clinical psychologists with speciality in OH	<1	0
Nurses training towards OH SCPHN	<1	0
Registrars training towards GMC registration as OM specialists	0	0
Mental Health nurses	0	0
Doctors with DOccMed	0	0
Occupational therapists	0	0
Doctors not registered with GMC as an OM specialist and without DOccMed	0	0
Other roles[16]	2	1
Sum of average for all professions[17]	**3**	**2**

A1. How many of your OH department / organisation's staff are employed on a full-time basis, and how many are employed on a part-time basis? Base: 54 in-house providers. Note the relatively small base sizes for in-house providers, meaning specific numbers of employees should be treated with caution.

Results showing <1 indicate the result was more than 0 but less than 0.5 (values between 0.5 and 0.9, have been rounded up to 1 here).

[15] 'Nurses without OH qualifications' refers to nurses not registered under part 3 of the Nursing and Midwifery Council (NMC) register or without postgraduate qualifications in OH and without a Faculty of Occupational Medicine Diploma.
[16] This row sums those saying 'other roles' as well as some other specific roles that were relatively uncommon.
[17] Note that this is the sum of the rounded figures presented in this table.

Table 2.6: Average number of private provider employees in each job role

	Mean number employed full time or part time	Median number employed full time or part time
Admin staff	8	2
Nurses with an SCPHN OH qualification	6	1
Nurses without OH qualifications[18]	1	0
Counsellors	1	0
Registered nurses with or training towards other OH postgrad qualifications	<1	0
Doctors registered with GMC as an Occupational Medicine (OM) specialist	1	0
Physiotherapists	1	0
OH technicians or healthcare assistants	3	0
Clinical psychologists with speciality in OH	<1	0
Nurses training towards OH SCPHN	<1	0
Registrars training towards GMC registration as OM specialists	<1	0
Mental Health nurses	<1	0
Doctors with DOccMed	<1	0
Occupational therapists	<1	0
Doctors not registered with GMC as an OM specialist and without DOccMed	0	0
Other roles[19]	1	0
Sum of average for all professions[20]	**26**	**3**

A1. How many of your OH department / organisation's staff are employed on a full-time basis, and how many are employed on a part-time basis? Base: 103 private providers.

Results showing <1 indicate the result was more than 0 but less than 0.5 (values between 0.5 and 0.9, have been rounded up to 1 here).

[18] 'Nurses without OH qualifications' refers to nurses not registered under part 3 of the Nursing and Midwifery Council (NMC) register or without postgraduate qualifications in OH and without a Faculty of Occupational Medicine Diploma.
[19] This row sums those saying 'other roles' as well as some other specific roles that were relatively uncommon.
[20] Note that this is the sum of the rounded figures presented in this table.

Table 2.7 shows the self-reported total number of employees within OH providers' organisations. For NHS and in-house providers, figures are given for the whole organisation as well as the OH team or department specifically. This suggests that, for NHS and in-house providers, the OH department or team sits within a much larger organisation. Indeed, 93% of NHS provider organisations and 98% of in-house provider organisations had 250 or more employees overall, while their OH team or departments tended to be much smaller (most commonly between 10 and 49 employees for the NHS; and between 1 and 9 employees for in-house providers). However, among private providers around half (50%) were micro businesses, more than a quarter (27%) were small businesses and 12% were sole traders.

Table 2.7: Size of OH organisation, by type

	NHS providers (all staff)	NHS providers (OH team / department)	In-house providers (all staff)	In-house providers (OH team / department)	Private providers (all staff)
0 (sole trader)	0%	0%	0%	0%	12%
1-9 (micro)	0%	9%	0%	74%	50%
10-49 (small)	2%	72%	0%	26%	27%
50-249 (medium)	5%	19%	2%	0%	9%
250+ (large)	93%	0%	98%	0%	2%
Mean number of employees	11,092	32	6,469	8	32
Median number of employees	10,000	26	4,250	5	7

J3. Overall, how many individuals are directly employed by your organisation? Base: NHS providers (43); In-house providers (54); Private providers (103). Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages and numbers of employees should be treated with caution.

NHS

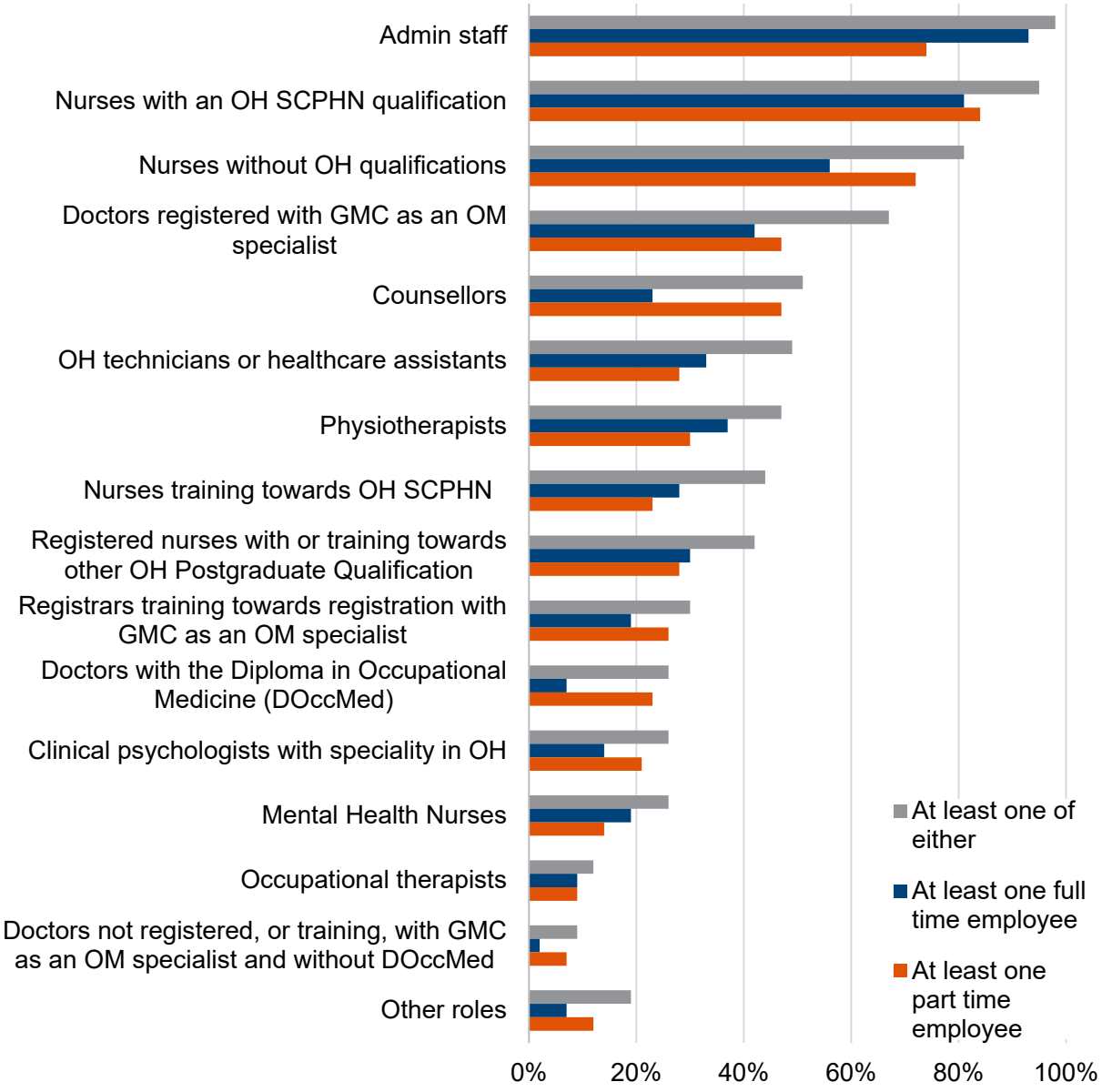
Figure 2.1 (and Table A.1 in Annex) shows the proportion of NHS providers that employed at least one member of staff in each role. Almost all NHS providers employed at least one member of admin staff (98%) and at least one nurse with an SCPHN OH qualification (95%). A large majority (81%) employed nurses without OH qualifications.[21] Two-thirds (67%) employed at least one doctor registered with the GMC as an OM specialist and around half employed at least one counsellor (51%) or OH technician or healthcare assistant (49%).

As already mentioned, NHS providers employed a wider range of roles than in-house or private providers, and even occupational therapists and doctors not registered with

[21] Again, 'nurses without OH qualifications' refers to nurses not registered under part 3 of the Nursing and Midwifery Council (NMC) register or without postgraduate qualifications in OH and without a Faculty of Occupational Medicine Diploma.

the GMC as an OM specialist and without DOccMed – the least frequently employed roles – were still employed by around one in ten NHS providers (12% and 9% respectively).

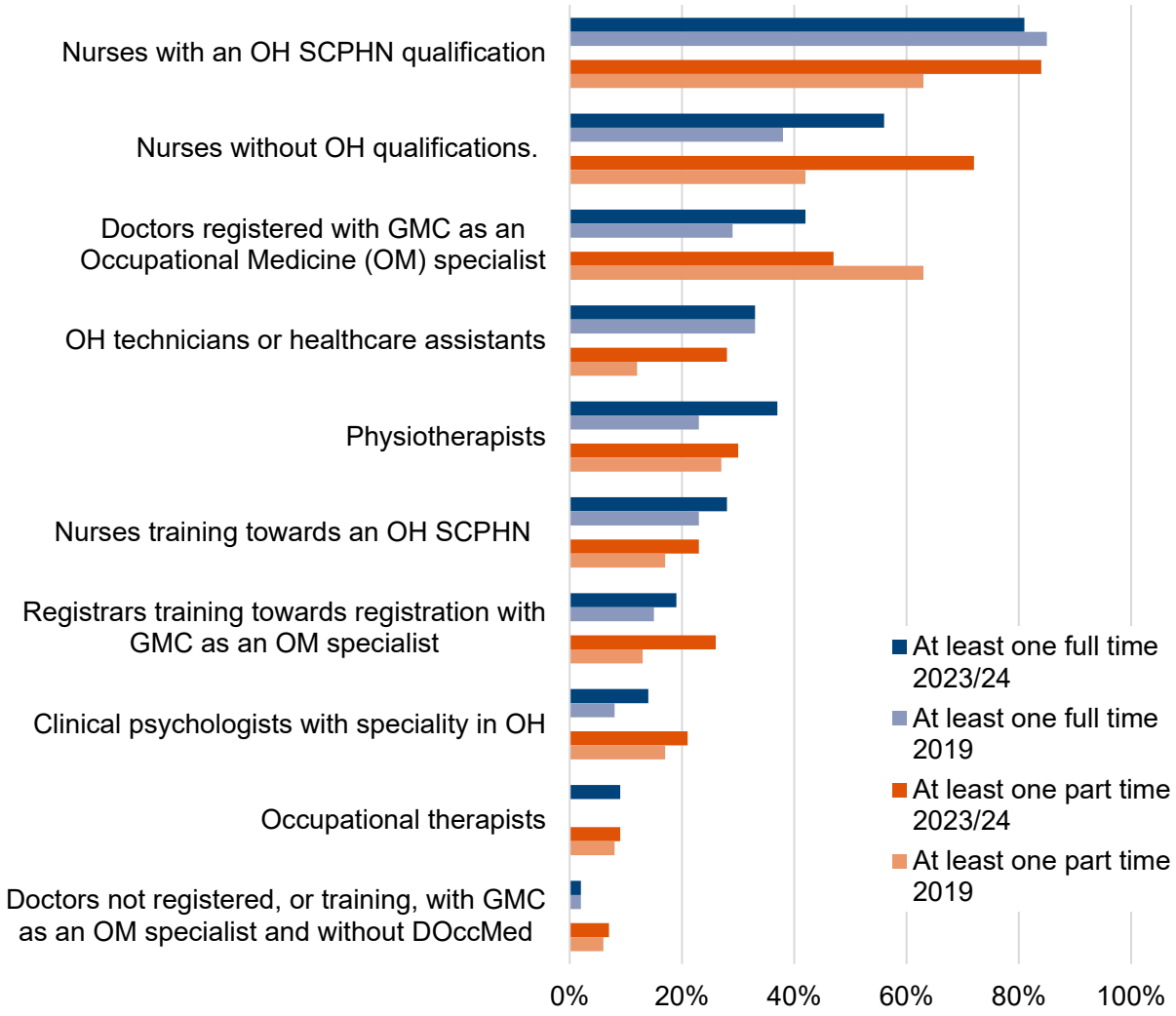
Figure 2.1: Proportion of NHS providers that employed at least one member of staff in each role



A1. How many of your OH department / organisation's staff are employed on a full-time basis, and how many are employed on a part-time basis? Base: NHS providers (43). Note the relatively small base size for NHS providers, meaning specific percentages should be treated with caution.

As already noted, a broadly similar question was asked in 2019, although it focused more on clinical staff. The general composition of clinical staff among NHS providers has remained broadly consistent since 2019 (Figure 2.2 and Table A.2 in Annex).

Figure 2.2: Proportion of NHS providers that employed at least one member of staff in each role in 2023-24 and 2019



A1. How many of your OH department / organisation's staff are employed on a full-time basis, and how many are employed on a part-time basis? Base: NHS providers 2023-24 (43); NHS providers 2019 (52). Note the relatively small base sizes for NHS providers, meaning specific percentages should be treated with caution.

As in 2023-24 the most commonly employed profession in 2019 was nurses with an SCPHN OH qualification (85% full time and 63% part time). Similarly, in 2019, the second most employed profession full time was nurses without OH qualifications[22] (38%), the same as in 2023-24 (56%); and the joint-most employed profession on a part-time basis was doctors registered with GMC as an OM specialist (63%), which was the third highest in 2023-24.

[22] Again, 'nurses without OH qualifications' refers to nurses not registered under part 3 of the Nursing and Midwifery Council (NMC) register or without postgraduate qualifications in OH and without a Faculty of Occupational Medicine Diploma.

There were, however, some notable changes between the two studies:[23]

- In 2023-24, NHS providers were more likely to employ on a part time basis at least one nurse with an OH SCPHN qualification, than was the case in 2019 (84% compared to 63%).
- In 2023-24, NHS providers were more likely to employ on a part time basis at least one nurse without OH qualifications, than was the case in 2019 (72% compared to 42%).

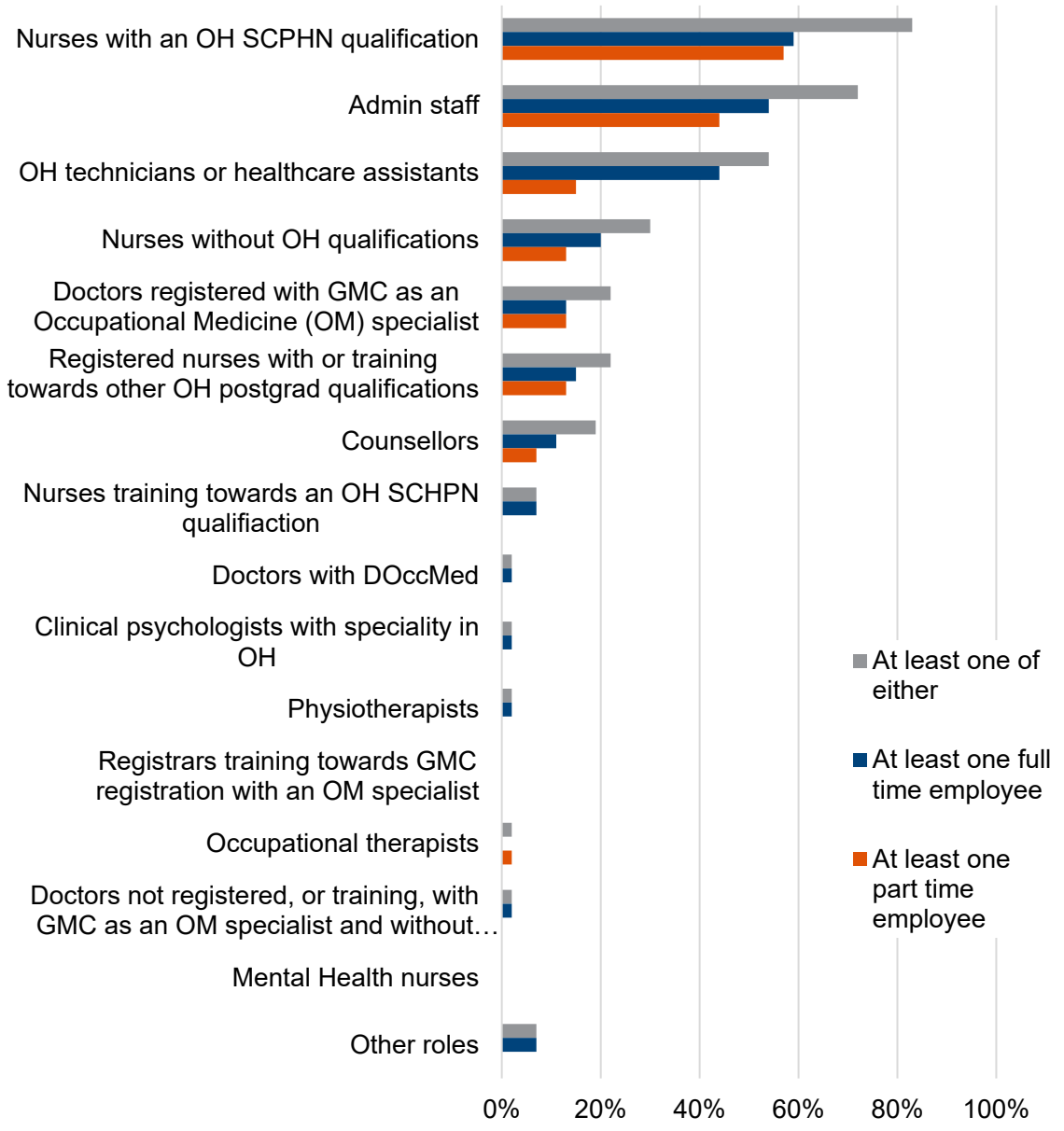
In-house providers

Figure 2.3 (and Table A.3 in Annex) shows the proportion of in-house providers that employed at least one member of staff in each role.

Similarly to NHS providers, most in-house providers employed at least one nurse with an SCPHN OH qualification (83%) and almost three-quarters (72%) employed at least one member of admin staff. Over half (54%) employed at least one OH technician or healthcare assistant and three in ten (30%) employed at least one nurse without OH qualifications. Unlike NHS providers and private providers, a number of roles were employed by very few in-house providers (less than 5%); and none of them employed mental health nurses or registrars training towards GMC registration as OM specialists.

[23] However, it should be noted that differences in results may be at least partly due to difference in the survey sampling methodology or question wording.

Figure 2.3: Proportion of in-house providers that employed at least one member of staff in each role



A1. How many of your OH department / organisation's staff are employed on a full-time basis, and how many are employed on a part-time basis? Base: In-house providers (54). Note the relatively small base size for in-house providers, meaning specific percentages should be treated with caution.

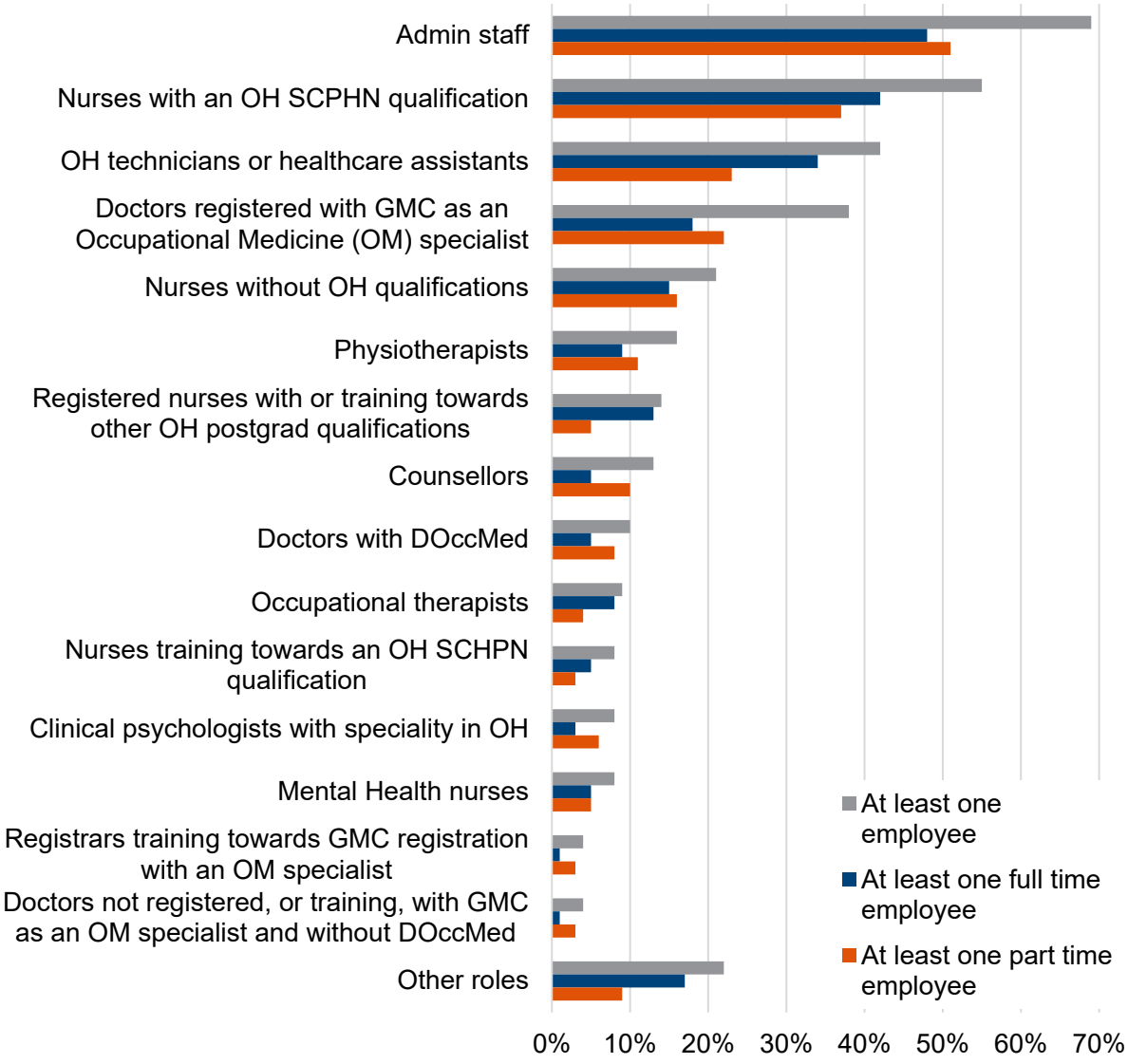
Private providers

Figure 2.4 (and Table A.4 in Annex) shows the proportion of private providers that employed at least one member of staff in each role. Almost seven in ten (69%) employed at least one member of admin staff and more than half (55%) employed nurses with an SCPHN OH qualification. Around four in ten employed at least one OH technician or healthcare assistant (42%) or at least one doctor registered with the GMC as an OM specialist (38%).

The spread of job roles employed by private providers lies somewhere in-between NHS and in-house providers. At least *some* private providers employ the least

employed job roles, such as registrars training towards GMC registration as OM specialists and doctors not registered with the GMC as an OM specialist and without DOccMed (both 4%).

Figure 2.4: Proportion of private providers that employed at least one member of staff in each role



A1. How many of your OH department / organisation's staff are employed on a full-time basis, and how many are employed on a part-time basis? Base: Private providers (103).

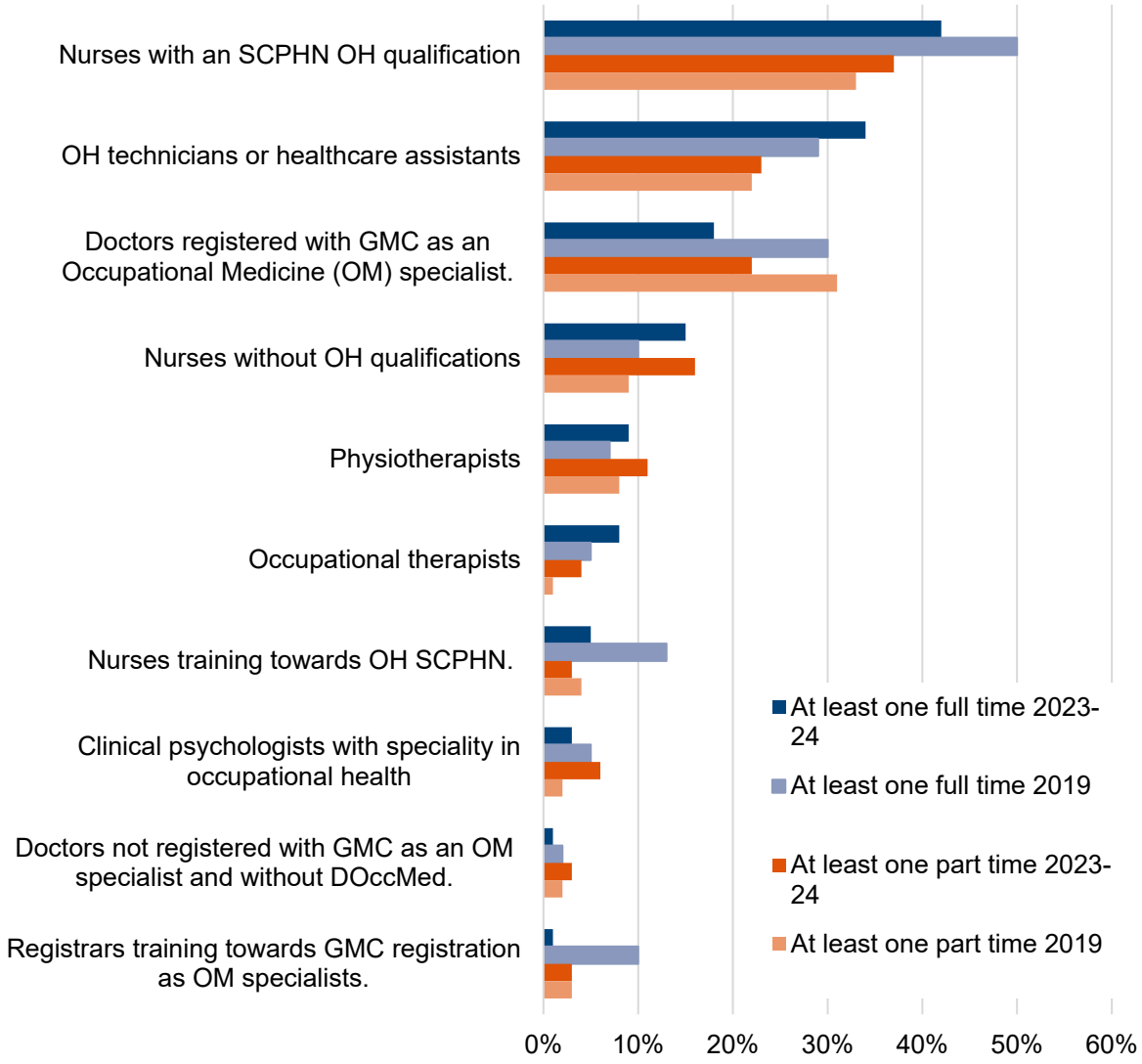
Figure 2.5 (and Table A.5 in Annex) compares the proportion of private providers employing at least one member of staff in each role, in 2023-24 and 2019.

In both 2023-24 and 2019, the most common role employed by private providers was a nurse with an SCPHN OH qualification, both on a full-time basis (42% in 2023-24; 50% in 2019) and on a part time basis (37% in 2023-24; 33% in 2019).

There were, however, some notable changes between the two studies:[24]

- In 2023-24, fewer private providers employed on a full-time basis at least one doctor registered with the GMC as an OM specialist than in 2019 (18% compared to 30%)
- In 2023-24, fewer private providers employed on a full-time basis at least one nurse training towards OH SCPHN (5% compared to 13%).
- In 2023-24, fewer private providers employed on a full-time basis at least one registrar training towards GMC registration as OM specialists (1% compared to 10%).

Figure 2.5: Proportion of private providers that employed at least one member of staff in each role in 2023-24 and 2019



A1. How many of your OH department / organisation's staff are employed on a full-time basis, and how many are employed on a part-time basis? Base: Private providers 2023/24 (103); Private providers 2019 (104).

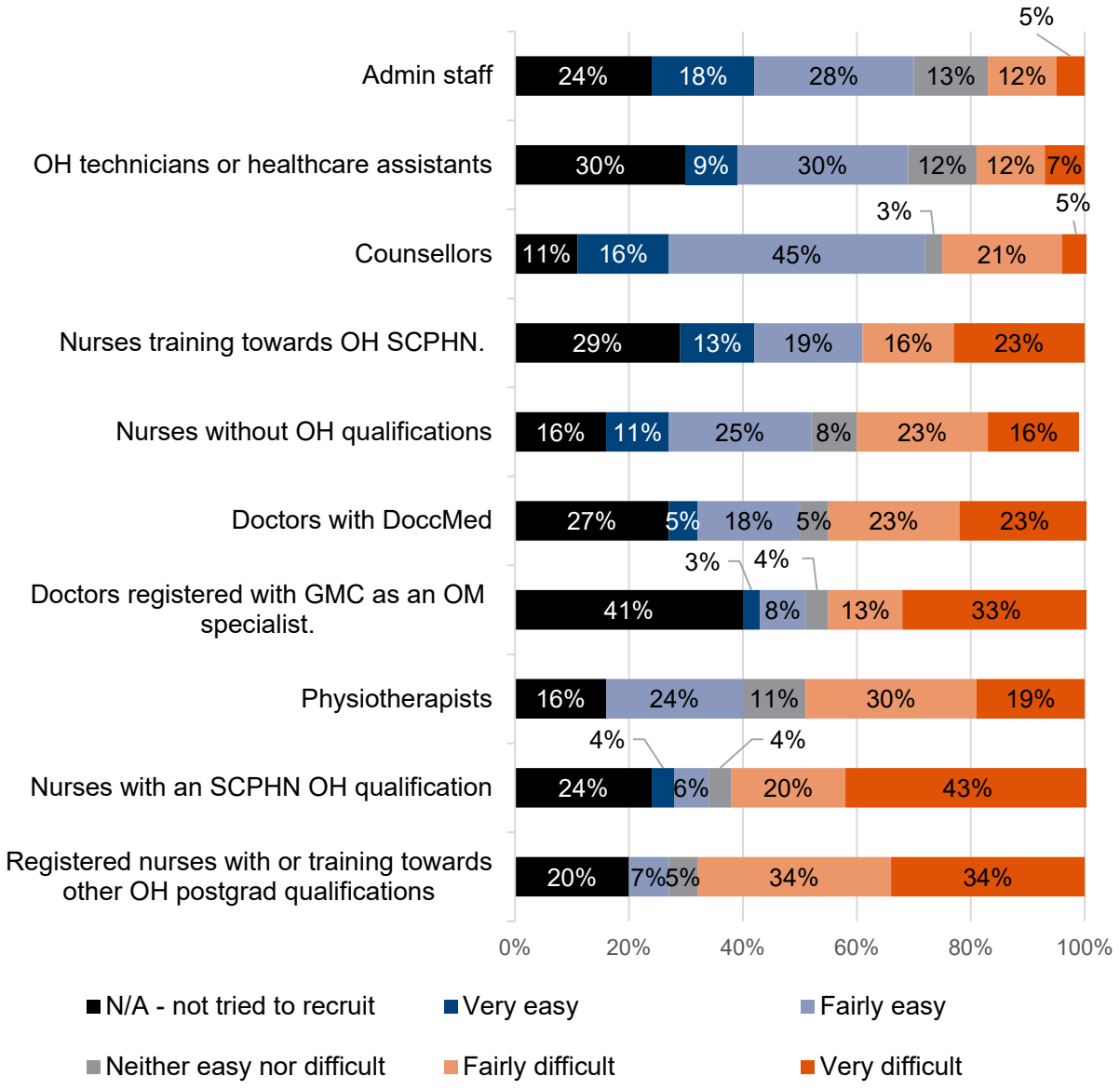
[24] However, note that differences in results may be at least partly due to difference in the survey sampling methodology or question wording.

Recruitment challenges

Roles that are difficult to recruit

OH providers that employed at least one member of staff in each role, were asked how easy or difficult these roles had been to recruit for, in the past three years (Figure 2.6).

Figure 2.6: Ease / difficulty for OH providers in recruiting for roles, in the past 3 years



A2. Now thinking about the past three years, how easy or difficult has your OH department / organisation found recruiting the following types of staff? Base: All providers who employ at least one of each role - Registered nurses training towards other OH postgrad qualifications (44); Nurses with an SCPHN OH qualification (142); Doctors with DOccMed (22); Physiotherapists (37); Doctors registered with GMC as an OM specialist (79); Nurses without OH qualifications (73); nurses training towards registration (31); Counsellors (38); OH technicians or healthcare assistants (81); Admin staff (152). Note the relatively small base sizes for many of the job roles, meaning specific percentages should be treated with caution.

Nurses had been the most difficult roles to recruit, with more than two-thirds (68%) reporting that registered nurses with, or training towards, other OH postgraduate qualifications had been difficult to recruit and a similar proportion (63%) saying nurses with an SCPHN OH qualification had been difficult to recruit. Slightly less than half said that physiotherapists (49%), doctors registered with the GMC as an OM specialist (46%) and doctors with a DOccMed diploma (45%) had been difficult to recruit.

The least difficult to recruit roles were admin staff (17%), OH technicians or healthcare assistants (20%) and counsellors (26%).

By provider type, the three most difficult roles to recruit for NHS providers were:

- Nurses with an OH SCPHN qualification (76%).
- Doctors registered with GMC as an OM specialist (55%).
- Physiotherapists (45%).

For private providers the three most difficult roles to recruit for were[25]:

- Nurses with an OH SCPHN qualification (46%).
- Doctors registered with GMC as an OM specialist (38%).
- Nurses without OH qualifications[26] (36%).

NHS providers were more likely than private providers to say it was difficult to recruit nurses with an OH SCPHN qualification (76% compared to 46%) and private providers were more likely than average to find recruiting OH technicians difficult (31% compared to 20%).

In the 2019 survey, for most role types, slightly fewer providers found those roles were difficult to recruit for. As was the case in 2023-24**,** in 2019 nurses were the most difficult to recruit, with half of providers (51%) saying nurses with an OH SCPHN qualification and four in ten (41%) saying nurses with other OH postgraduate qualifications were difficult roles to recruit for. In 2019**,** the third most difficult to recruit role was doctors registered with the GMC as an OM specialist (37%), while in 2023-24 this was the fourth most difficult to recruit, although the proportion of providers saying it was difficult was higher (46%). It is important to note that comparisons with 2019 should be treated with some caution; because of changes in sampling approach and the job roles included, and the way questions were phrased has changed slightly.

The qualitative in-depth interviews explored OH providers' challenges in recruiting staff needed to deliver their OH services. Commonly, providers reported challenges arising from a lack of OH staff with the right qualifications and years of experience.

> *"[There's a] lack of availability of suitable staff. Once the business finds a good employee, they do all they can to keep them."*

[25] The majority of roles were not employed by more than 20 providers.

[26] Again, 'nurses without OH qualifications' refers to nurses not registered under part 3 of the Nursing and Midwifery Council (NMC) register or without postgraduate qualifications in OH and without a Faculty of Occupational Medicine Diploma.

(Private provider, 1-9 employees, North East)

“There's only a handful of AMEs [Aeromedical Examiners[27]] in the country, so for us to get one on our books is near impossible.”

(Private provider, 1-9 employees, North East)

This was coupled with a perceived lack of training, and funding for training, to equip prospective staff for the roles needing filling.

“We could easily use technicians but again it's getting them on the courses, it's finding those right courses for the right people. …again, there's so many general nurses who want to get into Occupational Health, but to try and get them on the training, they're cutting courses left, right and centre.”

(Private provider, 1-9 employees, East of England)

“There's not many training courses, actual recognised ones at universities.”

(Private provider, 10-49 employees, Yorkshire and Humber)

A few providers mentioned an increase in the number of OH professionals who are seeking self-employed roles, which thus makes them unavailable to recruit as salaried employees.

"I've had people interviewing [for the role] recognising that I was offering more than the going rate, but I still couldn't get folks to commit to an employed role. They want to have the whole summer off with their kids and want to enjoy that self-employed flexibility."

(Private provider, 1-9 employees, South East)

Furthermore, the more technical roles came with high salary costs. One provider noted that due to the shortage of qualified staff, candidates were placing high demands on salary and flexible working, while others said they were struggling to meet the market salaries.

“Recruiting the right staff, usually the experienced Occupational Health Advisors…partly due to a lack of experienced OHAs in the market and secondly because of the rate of salaries we can afford.”

(Private provider, 1-9 employees, North West)

“Shortage of staff, shortage of qualified staff, salaries …we can’t compete in the free market with salaries…and they are demanding.”

(In-house, 50+ employees, North East)

OH providers that had experienced recruitment challenges were asked how they had tried to overcome these issues. Some providers had tried to offer higher wages or reviewed their salaries and benefits.

[27] These are specialist healthcare professionals who specialise in evaluating the health and fitness of individuals involved in aviation.

"I have flexible working arrangements, child-friendly hours, half the staff work remotely so they don't have to be in the geographical area, and they don't have to commute. I've pushed for salaries [to be in line with the NHS]."

(In-house, 50+ employees, North East)

Others had changed their recruitment methods, either going through private recruitment, tapping into personal networks, or recruiting through social media.

"Only things that have worked was tapping into my personal networks, the people I know from training courses …Vocational Rehabilitation training…and people hearing about our vacancies via word of mouth."

(In-house, 1-9 employees, South East England)

"Trying to find our own ways of doing private advertisements, either through our own website or on LinkedIn."

(In-house, 1-9 employees, East of England)

Some of the providers who had not had recruitment issues, said that this had been avoided by having good networks to draw upon.

"We have a dedicated OH nurse/physician/technician coordinator, who has spent time building a database of suitably qualified staff and we have essentially tried to manage their diaries and fill their diaries with as much work as possible to keep them on board."

(Private, 10-49 employees, North West)

Similarly, a few providers mentioned they used a database to help them search for staff for specific OH roles.

"I don't actually advertise. People either contact me with their CV and ask me if they can be involved. And I look at what their CV looks like. But I also go to the Independent Practice Occupational Therapy database."

(In-house, 1-9 employees, East of England)

A few practitioners mentioned that they had spent time reviewing the skillsets required for different OH services and re-assessing what types of staff could undertake each service. For instance, one provider was exploring the idea of upskilling general nurses and technicians to deliver OH services; another had reviewed using OH technicians to undertake health surveillance and was piloting a scheme where a technician-led team went into the work force as opposed to a nurse or physician-led team; and another provider had considered using student nurses to deliver OH technician work. As well as resolving staffing issues, these approaches were perceived to have the potential to upskill existing OH staff.

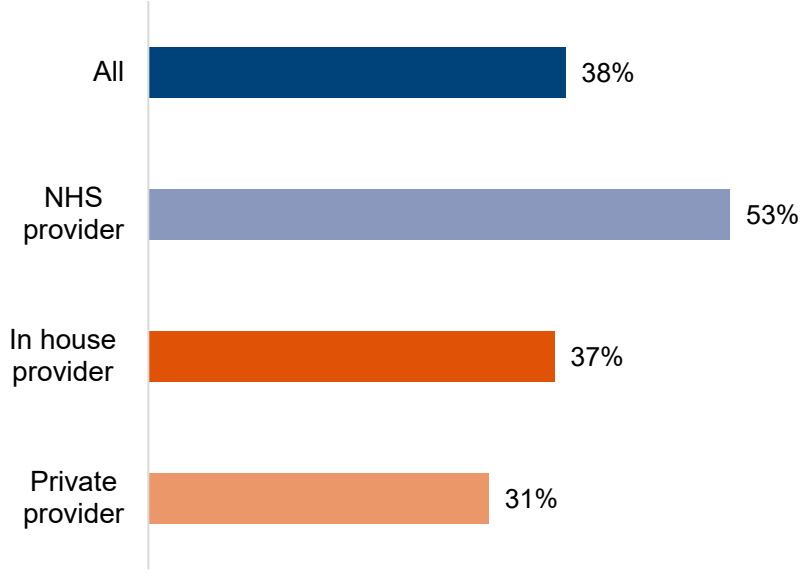
"[We] have considered in the past getting student nurses in to do the OH Technician work as this would build up their knowledge base about OH."

(In-house, 1-9 employees, East of England)

Unfilled vacancies

In the survey, OH providers were asked whether there were any roles that they would like to hire staff to fill but have been unable to fill. Approaching four in ten (38%) providers had roles that they would like to hire staff for but have been unable to fill. This was higher among NHS providers, more than half (53%) of whom had roles they were unable to fill (Figure 2.7).

Figure 2.7: Proportion of OH providers with unfilled vacancies



A3 Are there any roles that you would like to hire staff to fill, but have been unable to fill? Base: All (200); NHS provider (43); In-house provider (54); Private provider (103). Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages should be treated with caution.

There were no differences in prevalence of having unfilled vacancies, by geographic area that the OH provider delivers services to; or by the country in Great Britain in which the OH provider is based or headquartered.

A broadly similar question was asked of private providers in 2019, when the proportion with roles they were unable to fill was higher. Just under half (44%) of private providers in 2019 had roles that they were unable to fill, compared with 31% in 2023-24.

The roles that these providers were unable to fill broadly mirror the roles that providers found difficult to recruit, seen in Figure 2.6 earlier. A quarter (24%) of providers with unfilled roles had vacancies for doctors registered with GMC as an OM specialist, rising to a half (52%) among NHS providers, significantly higher than for the other two provider types. For in-house providers and private providers, the most commonly vacant role was nurses without OH qualifications[28] (25% and 31%

[28] Again, 'nurses without OH qualifications' refers to nurses not registered under part 3 of the Nursing and Midwifery Council (NMC) register or without postgraduate qualifications in OH and without a Faculty of Occupational Medicine Diploma.

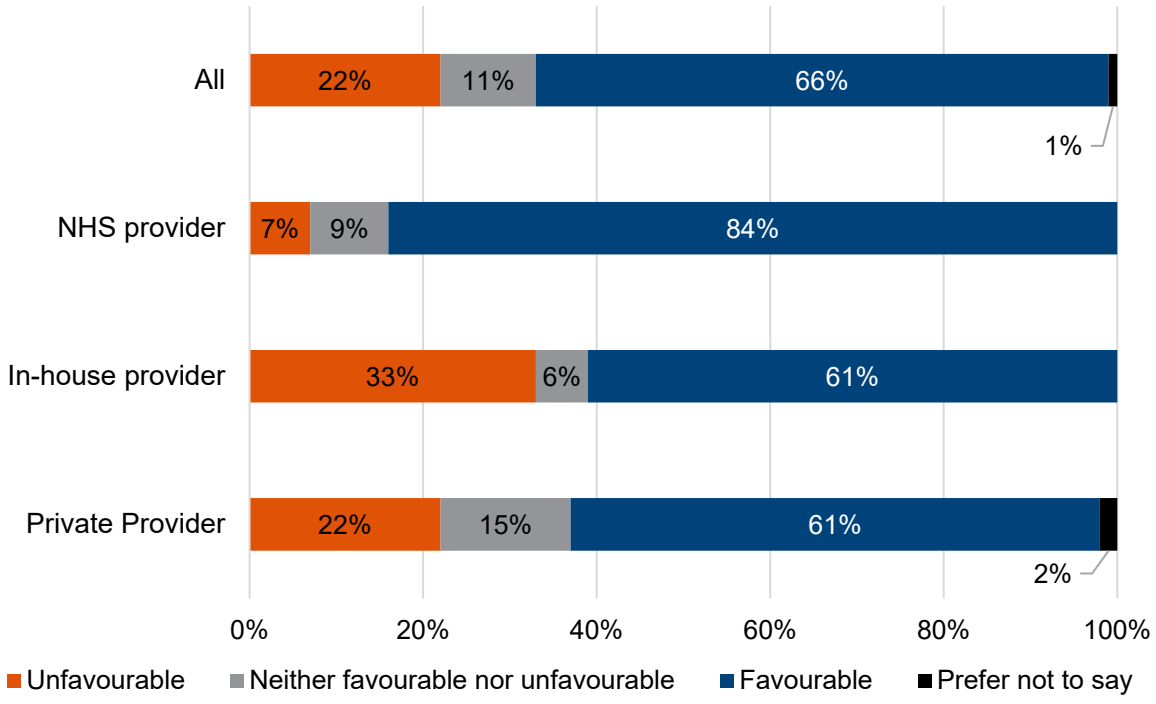
respectively). Three in ten NHS providers (30%) and a quarter of in-house providers (25%) had unfilled vacancies for a nurse with an SCPHN OH qualification.

In 2019 a broadly similar question was asked. In 2019, the role in which providers most commonly had vacancies was nurses with an SCPHN OH qualification followed by doctors registered with GMC as an OM specialist; these were also amongst the most commonly vacant roles in 2023-24. It should be noted that the specific roles asked about and the base definition used for the question in 2019 are not directly comparable, so specific figures have not been included here.

Favourability towards hiring newly qualified recruits

OH providers were asked what was their OH department or organisation's attitude to hiring newly-qualified OH professionals without experience, to deliver their OH services (Figure 2.8). Two-thirds (66%) were at least somewhat favourable to hiring newly qualified OH professionals. Around a fifth (22%) were unfavourable. NHS providers were more likely than in-house and private providers to say that they were favourable (84% compared to 61% and 61% respectively).

Figure 2.8: Favourability towards using newly-qualified OH professionals



A10 On balance, what is your OH department's / organisation's attitude to hiring newly-qualified OH professionals without experience, to deliver its services? Base: All (200); NHS providers (43); In-house providers (54); Private providers (103). Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages should be treated with caution.

OH providers with unfilled vacancies were more likely to be favourable to using newly-qualified recruits (76% of those with unfilled vacancies were favourable,

compared with 60% of those without). This suggests that provider need may be driving open-mindedness towards the newly qualified as recruits.

Providers that used multidisciplinary teams were more likely to be favourable towards hiring newly qualified recruits than providers that did not (72% compared with 57%). Similarly, providers that were SEQOHS accredited were also more likely to be favourable compared to providers that were not working towards accreditation (83% compared to 54%).

Summary

On average, OH providers are relatively small and still face significant challenges in recruiting skilled staff – approaching four in ten have unfilled vacancies, and this is more common for NHS providers.

The most acute staffing challenges in the sector are around nurses with SCPHN OH qualifications and nurses with or training towards other OH postgraduate qualifications. As in 2019, nurses with an SCPHN OH qualification or with or training towards other OH postgraduate qualifications are seen as hardest to recruit; and nurses with an SCPHN OH qualification are also amongst the most common vacant roles. Workforce composition data suggests that nurses with an SCPHN OH qualification are also – along with admin staff – the ‘backbone’ of the OH workforce.

Overall, providers tend to be relatively favourable to hiring newly-qualified OH staff without experience to deliver their OH services. Those with unfilled vacancies are more likely to be favourable, suggesting that provider need may be driving open-mindedness.

3 Multidisciplinary teams

This chapter discusses the extent to which Occupational Health (OH) providers use multidisciplinary teams to deliver their OH services. It describes OH providers' attitudes to using multidisciplinary teams and both their reasons for using them; and the perceived barriers to doing so. It also gives examples of how OH providers use multidisciplinary teams in practice. Findings are drawn from both the survey of OH providers and the in-depth qualitative interviews.

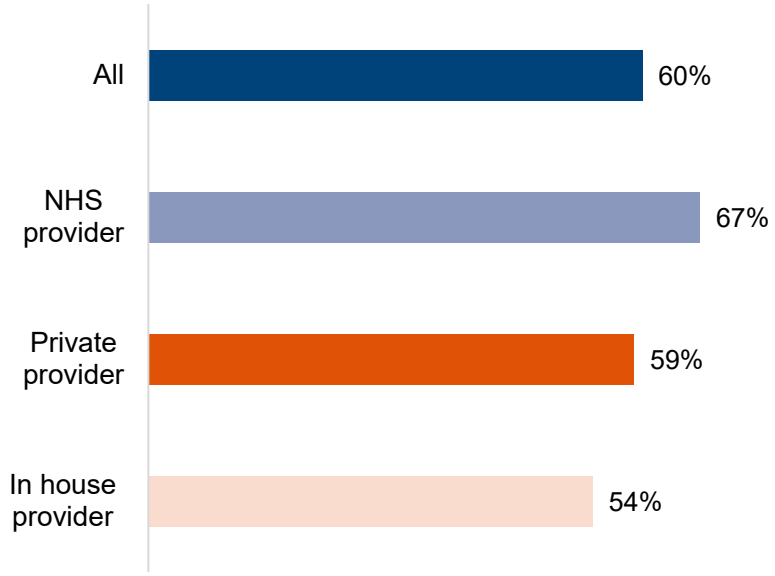
When discussing multidisciplinary teams, OH providers were responding to the following definition:

> *By multidisciplinary teams, we mean where services are delivered by two or more members of staff from different disciplines, alongside a nurse and a doctor, including both clinical and non-clinical patient-facing staff.*

Extent of use of multidisciplinary teams

Three-fifths of providers (60%) reported using multidisciplinary teams to deliver their OH services (Figure 3.1). NHS providers were the most likely to do so (67%) and in-house providers were least likely (54%).

Figure 3.1: Proportion of OH providers' use of multidisciplinary teams



A12. Does your OH department / organisation ever use multidisciplinary teams to deliver its services?
Base: All respondents (200); NHS providers (43); In-house providers (54); Private providers (103).
Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages should be treated with caution.

Broadly speaking, the larger the provider, the more likely they were to report using multidisciplinary teams to deliver their services (Table 3.1).

Table 3.1. OH department / organisation use of multidisciplinary teams to deliver its services

	All OH providers
	%
Sole practitioner / sole trader	42
Micro (1-9 employees)	46
Small (10-49 employees)	77
Medium (50-249 employees)	71

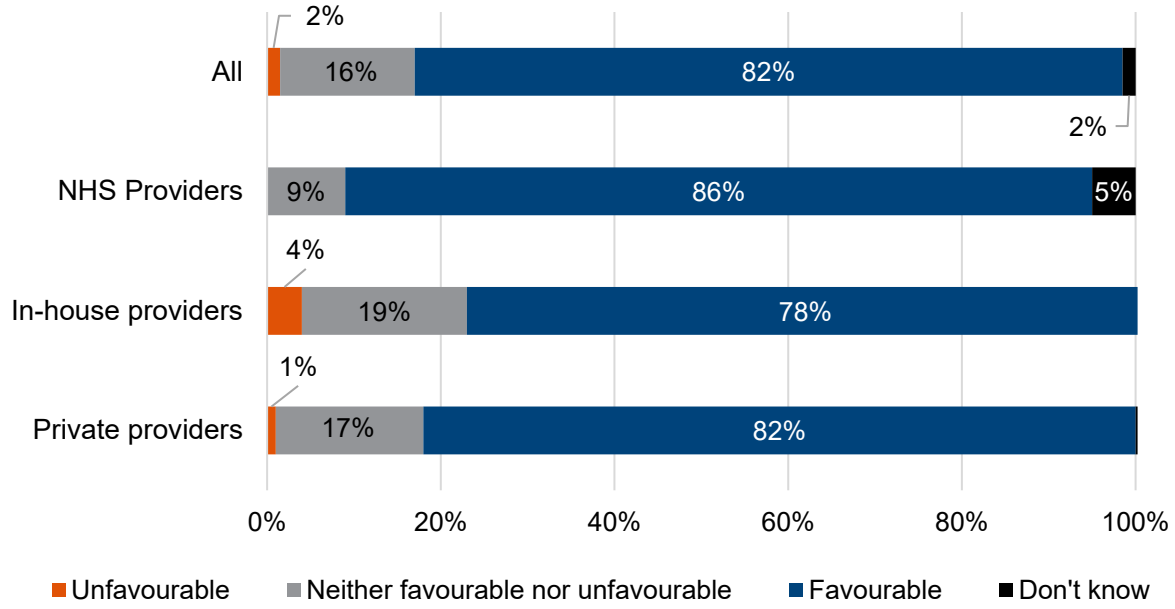
Base: All respondents (200), sole practitioner / sole trader (12), micro (96), small (73), medium (17). Note the relatively small base sizes for many of the provider size bands, meaning specific percentages should be treated with caution; only two providers fell into the 'large' category so this has been excluded from the table. In this table, total provider size is based on OH team or department for NHS and in-house providers, and the whole organisation for private providers. All sole practitioners/sole traders who responded were from private providers.

There were no significant differences in use of multidisciplinary teams by geographic area that the OH provider delivers services to.

Attitudes towards using multidisciplinary teams

Most OH providers reported positive attitudes towards the use of multidisciplinary teams. When asked how favourable or unfavourable their OH department or organisation was to using multidisciplinary teams to deliver their services, over four-fifths (82%) were favourable towards doing so, being 'extremely', 'very' or 'somewhat' favourable, on a seven-point scale from 'extremely favourable' to 'extremely unfavourable' (Figure 3.2). Over four in five NHS providers (86%) and private providers (82%) were favourable towards using multidisciplinary teams, compared to 78% of in-house providers.

Figure 3.2: Favourability among OH providers towards using multidisciplinary teams



A14. On balance, what is your OH department's / organisation's attitude to using multidisciplinary teams to deliver its services? Base: All respondents (200); NHS providers (43); In-house providers (54); Private providers (103). Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages should be treated with caution.

OH providers who were more favourable towards using multidisciplinary teams were more likely to be already using them. Of those 'extremely favourable' towards using multidisciplinary teams, 77% were currently using them; and of those 'very favourable' towards using multidisciplinary teams, 76% were currently using them (compared with only 51% of those 'somewhat favourable' and none of those who were unfavourable).

There were no significant differences in attitudes towards multidisciplinary teams by geographic area that the OH provider delivers services to, by the country in Great Britain in which the OH provider is based or headquartered; or by size of OH provider.

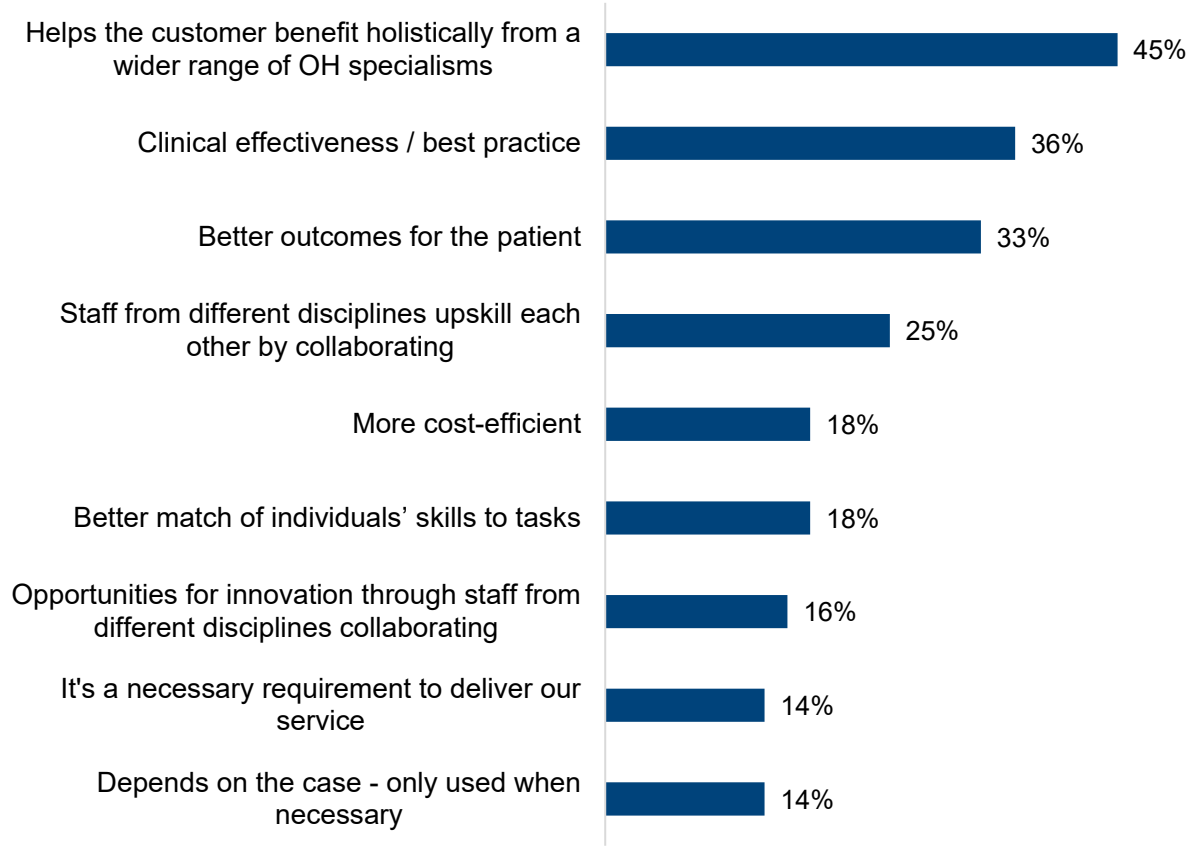
Benefits and drivers of using multidisciplinary teams

One hypothesis that was considered when designing the research was that OH providers might be using multidisciplinary teams as a solution to staff recruitment challenges in the sector. Research findings suggest that, instead, multidisciplinary teams were being used to provide patients with a holistic OH approach that addresses patient needs in a person-centred way.

In the survey, OH providers who were favourable towards using multidisciplinary teams were asked why this was the case (Figure 3.3). The most common reasons for being favourable towards using multidisciplinary teams were: to help customers

benefit holistically from a wider range of OH specialisms (45%); clinical effectiveness / best practice (36%); and better outcomes for the patient (33%).

Figure 3.3: Reasons for OH providers being favourable towards multidisciplinary teams



A15. Why is your attitude to your OH department / organisation using MDTs to deliver services favourable? Base: All respondents favourable to using MDTs (163). Figure 3.3 includes only those responses mentioned by 10% or more.

Similar themes emerged within the in-depth interviews. OH providers were using multidisciplinary teams as a means of:

- Accessing more specialist OH services (such as mental health specialists, speech and language therapists or neurodiversity consultants).
- Using a mix of specialists to better assess patient needs and deliver better patient outcomes. This in turn better meets the needs of the customer (i.e. the patient's employer).

  "The remit of our role is wide and we cannot be experts in everything. I would triage to get the right person to resolve the problem and to ensure the client gets the right help and support. Clients benefit holistically from a wider range of OH specialisms."

  (Private provider, sole trader, Yorkshire and Humber)

“The department looks at the whole holistic health needs of its members and external patients and we aren’t able to meet the needs if we work in isolation with just one clinician. That means we have one or more specialist [provide] input or support…in order to be able to get the best outcome for that patient.”

(NHS provider, sole trader, North West)

- Enabling different disciplines to work alongside each other and sharing knowledge, which would benefit the professional development of the staff involved.

  “Because you can't be good at everything – better match of skills. People upskill each other and innovate and people think differently and have different priorities.”

  (Private provider, sole trader, South East of England)

Barriers to using multidisciplinary teams

The perceived barriers to using multidisciplinary teams were explored with OH providers in the in-depth interviews. The barriers most commonly mentioned were:

- Internal staff capacity issues – a shortage of suitably skilled staff within the organisation means that providers don’t have enough capacity to form multidisciplinary teams.

  “Occupational Health nurses, technicians and physicians; the availability of them, the number of them, there aren’t enough around.”

  (Private provider, 10-49 employees, North West England)

- Concern that use of multidisciplinary teams would lead to increased costs for the customer.
- The OH provider feeling that multidisciplinary teams are not compatible with their own organisational structure or approach (for instance, if a provider only offers one-to-one appointments, or feels their organisation is too small to adopt multidisciplinary teams).
- Customers not seeing the benefit of multidisciplinary teams or not wanting to use them (for instance, two providers mentioned that larger customer organisations perceived it to be easier to refer their employees to a single individual, so that they only had to deal with a single point of contact within the OH provider).

  "You've got to really sell the benefits of why they need a MDT; in smaller organisations you may not need to, but larger organisations just like to refer employees to individuals, or separately. They think it's easier."

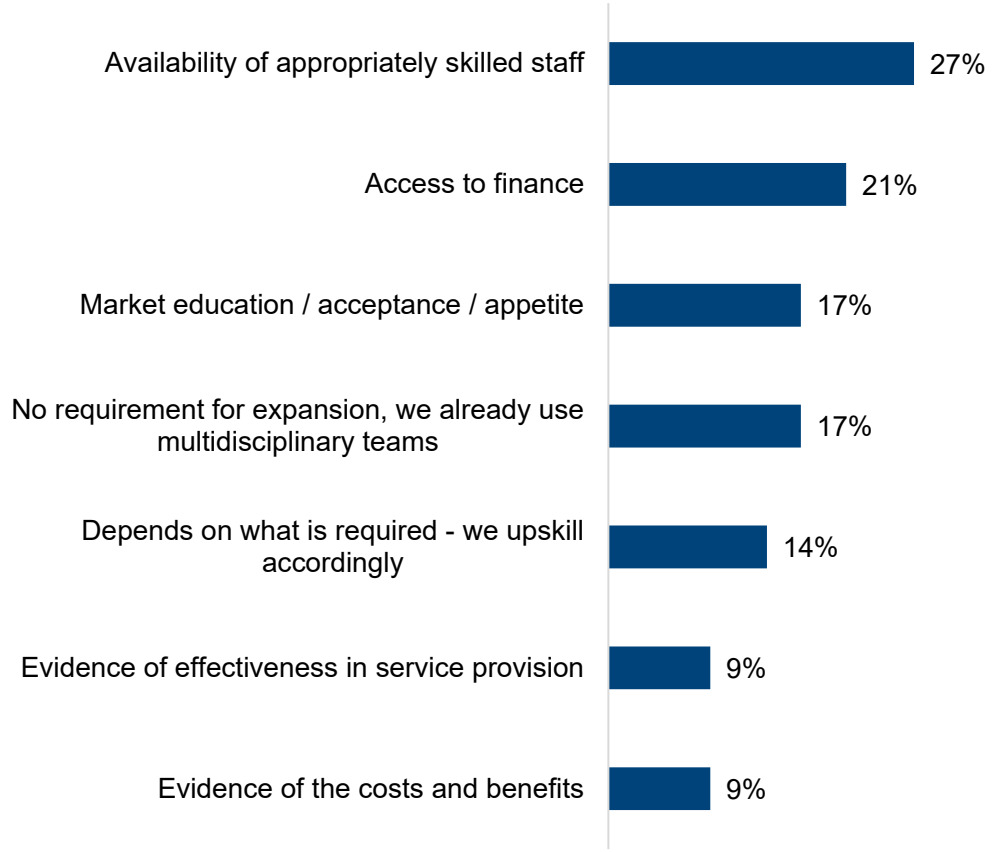
  (Private provider, sole trader, Wales)

One provider felt that technology was a barrier, as they were concerned about their ability to securely share files amongst professionals working within a multidisciplinary team.

Factors that would encourage take up of multidisciplinary teams

In the survey, OH providers were asked what would encourage their organisation or OH department to make more use of multidisciplinary teams (Figure 3.4). The most common factors mentioned were: the availability of appropriately skilled staff (27%); access to finance (21%), and market education / acceptance / appetite (17%).

Figure 3.4: Factors that would encourage OH providers' use of multidisciplinary teams



A16. What would encourage your OH department / organisation to make more use of multidisciplinary teams to deliver its services (if anything)? Base: All respondents (200). Figure 3.4 includes only those responses mentioned by 5% or more.

NHS providers and in-house providers were more likely to mention access to finance (37% and 31% respectively, compared with only 9% of private providers). NHS providers were also more likely to mention the availability of appropriately skilled staff (40%, compared with 24% of private providers and 20% of in-house providers).

How multidisciplinary teams are used in practice

In the in-depth interviews, OH providers were asked to describe how their multidisciplinary teams operate, including the mix of skills and professions involved and how they work together.

OH providers noted that their multidisciplinary teams typically involve:

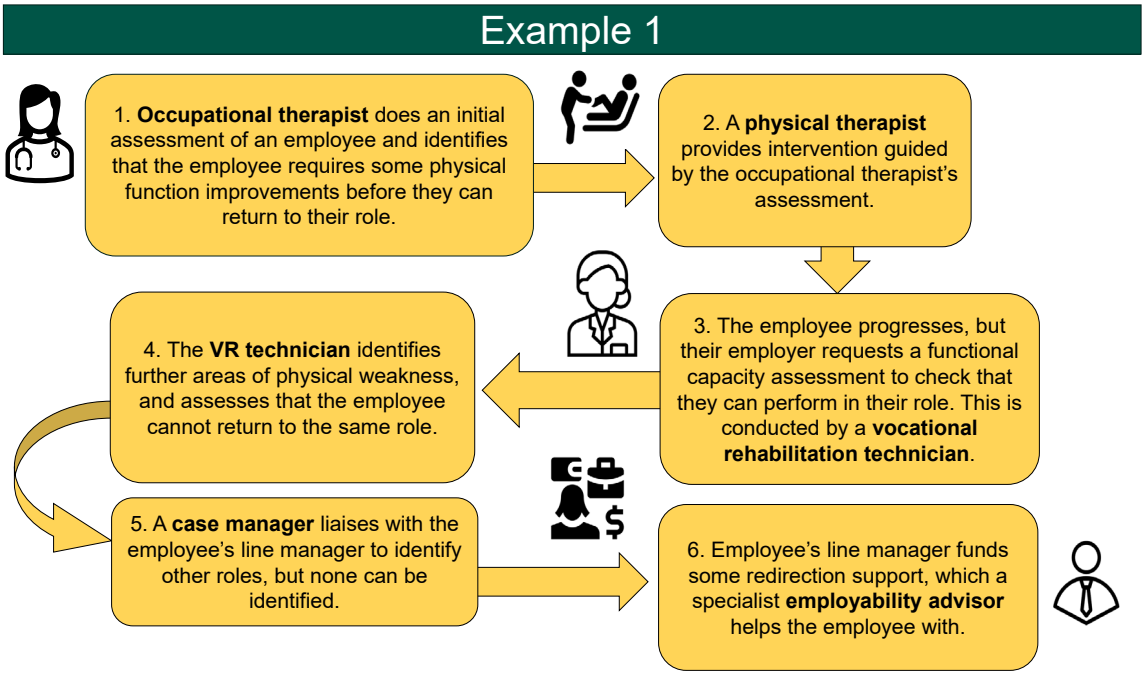
- A case manager who coordinates all professionals involved, and is the main client point of contact.
- A range of other relevant professionals as needed, including occupational therapists, OH technicians, physiotherapists, mental health workers (such as counsellors, psychologists, psychiatrists), radiographers, speech and language therapists, and non-health professionals such as employability specialists.
- The patient's line manager and, in some instances, social workers and housing departments.

Typically, the patient encountered these various disciplines as part of a linear process. Each member of staff would perform their respective role – providing bespoke assessments and advice for an employee – then pass the patient onto the next practitioner, with the case manager coordinating this.

> *"The case manager ensures that things happen in the right order; for instance, checking that the functional assessment for a job role happens before determining the optimal function or correct intervention."*
>
> (Private provider, 1-9 employees, South East England)
>
> *"[The case manager is] the person liaising with the business, liaising with the manager, liaising with the person concerned and liaising with these other professionals."*
>
> (Private provider, 1-9 employees, Yorkshire and Humber)

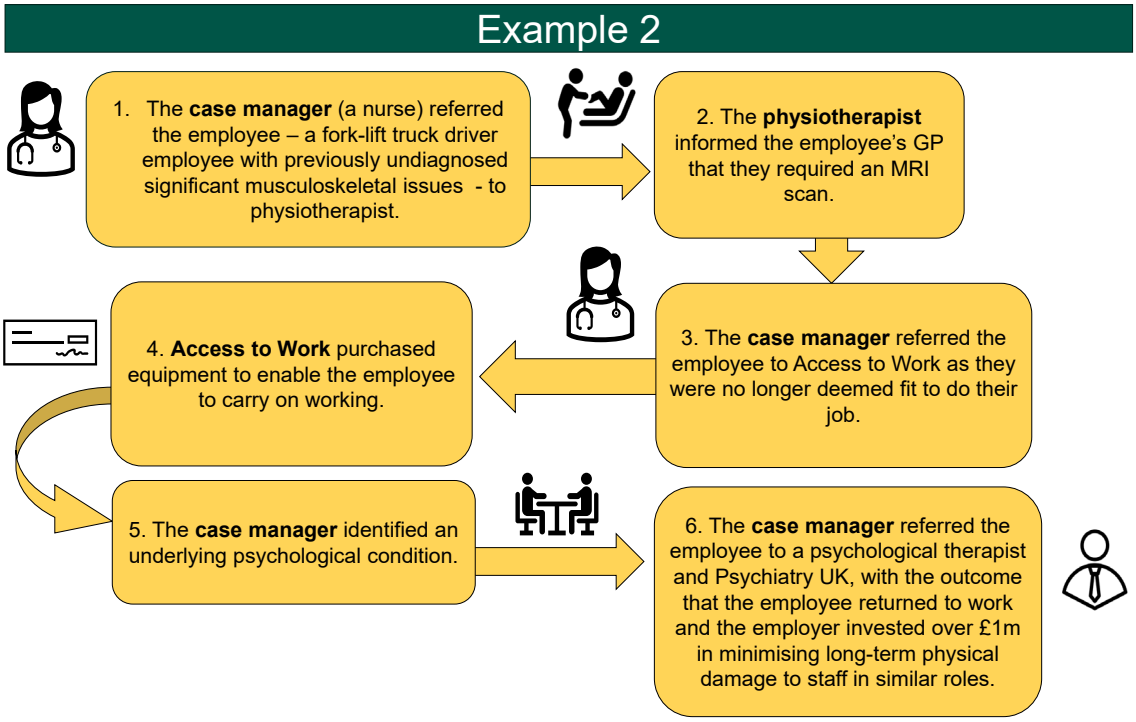
OH providers were also asked to describe some specific good practice examples of using multidisciplinary teams. Examples are shown in Figures 3.5 to 3.7:

Figures 3.5 to Figure 3.7: Examples of OH providers using multidisciplinary teams



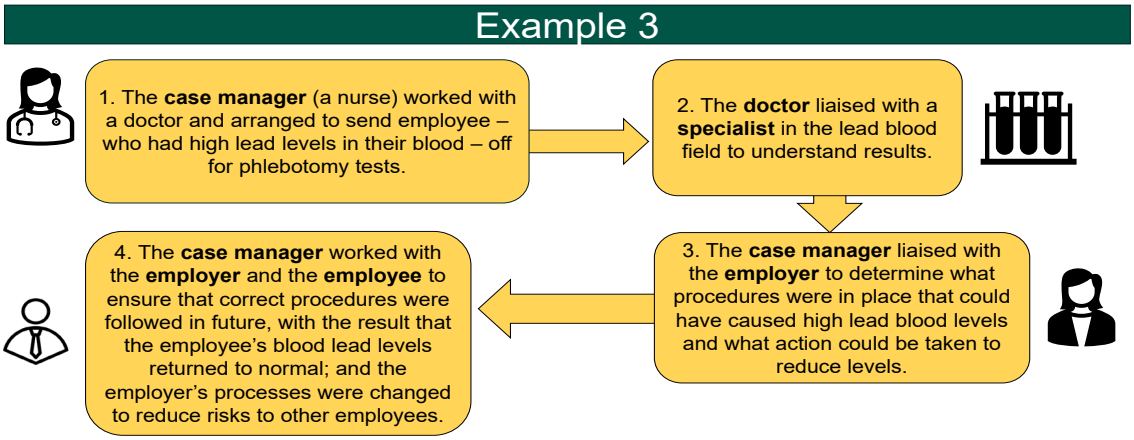
The diagram above shows an example of OH providers using multidisciplinary teams broken down into the different steps.

- Step 1: Occupational therapist does and initial assessment of an employee and identifies that the employee requires some physical function improvements before they can return to their role.
- Step 2: A physical therapist provides intervention guided by the occupational therapist's assessment.
- Step 3: The employee progresses, but their employee requests a functional capacity assessment to check that they can perform their role. This is conducted by a vocational rehabilitation (VR) technician.
- Step 4: The VR technician identifies further areas of physical weakness and assess that the employee cannot return to the same role.
- Step 5: A case manager liaises with the employee's line manager to identify other toles, but none can be identified.
- Step 6: Employee's line manager funds some redirection support, which a specialist employability advisor helps the employee with.



The diagram above shows another example of OH providers using multidisciplinary teams broken down into the different steps.

- Step 1: The case manager (a nurse) referred the employee – a fork-lift truck driver employee with previous undiagnosed significant musculoskeletal issues – to physiotherapist.
- Step 2: The physiotherapist informed the employee's GP that they required an MRI scan.
- Step 3: The case manager referred the employee to Access to Work as they were no longer deemed fit to do their job.
- Step 4: Access to Work purchased equipment to enable the employee to carry on working.
- Step 5: The case manager identified an underlying psychological condition.
- Step 6: The case manager referred the employee to a psychological therapist and Psychiatry UK, with the outcome that the employee returned to work and the employer invested over £1m in minimising long-term physical damage to staff in similar role.



The diagram above shows another example of OH providers using multidisciplinary teams broken down into the different steps.

- Step 1: The case manager (a nurse) worked with a doctor and arranged to send employee – who had high lead levels in their blood – off for phlebotomy tests.
- Step 2: The doctor liaised with a specialist in the lead blood field to understand the results.
- Step 3: The case manager liaised with the employer to determine what procedures were in place that could have caused high lead blood levels and what action could be taken to reduce levels.
- Step 4: The case manager worked the employer and the employee to ensure that correct procedures were followed in future, with the result that the employee's blood lead levels returned to normal; and the employer's processes were changed to reduce the risks to other employees.

Summary

The sector is positive about using multidisciplinary teams, and better patient care is the motivation driving this. OH providers are mostly favourable to using multidisciplinary teams and they're fairly commonly used, by two-fifths. Rather than being used as a solution to capacity and recruitment challenges, providers use multidisciplinary teams to draw on multiple disciplines to better meet patient needs. However, the use of multidisciplinary teams is currently constrained by the availability of appropriately skilled OH staff; provider access to finance; and the extent to which customers accept their use.

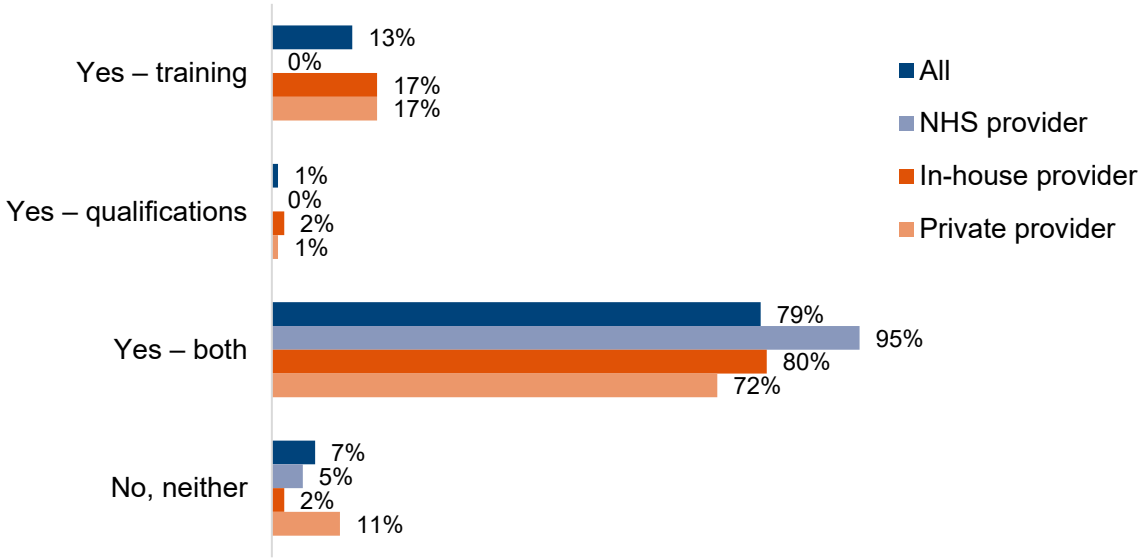
4 Training

This chapter discusses the extent to which Occupational Health (OH) providers fund access to training and qualifications for staff delivering their services, and the types of training that are funded. It also describes the barriers and enablers to funding access to training and qualifications. Findings are drawn from both the survey of OH providers and the in-depth qualitative interviews. It should be noted fieldwork was undertaken at a time when the Government was offering funding for a number of OH courses as part of a workforce expansion scheme.

Prevalence and types of funded training

There were high levels of funding for staff to access training and qualifications with 93% of OH providers funding access to training and/or qualifications (Figure 4.1). Offering funding for *both* training and qualifications was more common amongst NHS providers with 95% of NHS providers offering funding for both compared to 80% of in-house providers and 72% of private providers. Private providers were more likely not to fund access to either training or qualifications with one in ten (11%) not providing any form of funding.

Figure 4.1: Whether OH providers fund access to training or qualifications for staff delivering services



B1. Does your OH department / organisation fund access to any training or qualifications for the staff you use to deliver your services? / Can you use funding from your OH department / organisation to personally access training or qualifications? Base: All respondents (200); NHS providers (43); In-house providers (54); Private providers (103). Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages should be treated with caution.

Broadly speaking, the larger the provider, the more likely they were to fund access to both training and qualifications (Table 4.1).

Table 4.1. Whether providers fund access to *both* training and qualifications by size of provider

	All OH providers
	%
0 (Sole practitioner / sole trader)	50
Micro (1 – 9 employees)	75
Small (10 – 49 employees)	88
Medium (50 – 249 employees)	82

Base: All respondents (200); sole practitioner / sole trader (12), micro (96), small (73), medium (17). Note the relatively small base sizes for many of the provider size bands, meaning specific percentages should be treated with caution; only two providers fell into the 'large' category so this has been excluded from the table. In this table, total provider size is based on the OH team or department for NHS and in-house providers and the whole organisation for private providers.

OH providers who had struggled to hire staff to fill roles were more likely to offer funding to access *both* training and qualifications (87%) compared with providers who had not had recruitment problems (74%).

Nearly all OH providers with the Safe Effective Quality Occupational Health Service (SEQOHS) accreditation (92%) funded access to *both* training and qualifications. This compares with three quarters (76%) of providers working towards SEQOHS and 71% of providers who did not have or were not working towards SEQOHS accreditation (Table 4.2).

Table 4.2. Whether providers fund access to *both* training and qualifications by accreditation status

	All OH providers
	%
SEQOHS accredited	92
Working towards SEQOHS accreditation	76
Neither	71

Base: All respondents who fund access to *both* training and qualifications (158); those SEQOHS accredited (64), working towards SEQOHS accreditation (34), neither (99). Note the relatively small base size for those working towards SEQOHS accreditation, meaning the specific percentage should be treated with caution.

Overall, the more favourable the provider to hiring newly-qualified OH professionals without experience, the more likely they were to provide access to funding for *both* training and qualifications: 87% of providers who were extremely favourable compared with 57% who were very unfavourable.

There were no significant differences in the provision of funding to access training or qualifications by the country in Great Britain in which the OH provider is based or headquartered.

A range of training and qualifications were funded by OH providers (Table 4.3). The following were most commonly funded:

- OH technician courses (47% of all providers fund access to this training). This type of training was most prevalent amongst NHS and in-house providers (56% and 57% respectively compared with 37% of private providers).
- Audiometry (35% of all providers).
- Training towards OH Specialist Community Public Health Nursing (OH SCPHN) (33%). This training was more common amongst NHS providers (65% compared with 33% for in-house providers and 18% for private providers).
- Diploma in Occupational Health Practice (DipOHPrac) (31%). NHS providers were most likely to fund this diploma (53% compared with 33% for in-house providers and 20% for private providers).

Table 4.3 Types of training and / or qualifications funded and accessed

	All	NHS providers	In-house providers	Private providers
	%	%	%	%
OH technician courses	47	56	57	37
Audiometry[29]	35	35	41	32
Training towards OH SCPHN (OH Specialist Community Public Health Nursing)	33	65	33	18
DipOHPrac (Diploma in Occupational Health Practice)	31	53	33	20
Spirometry[30]	31	33	33	28
Revalidation / CPD	30	28	41	25
Psychologist or counselling course/training/qualifications (e.g. British Association for Counselling and Psychotherapy-accredited)	25	26	22	26
Hand arm vibration (HAVS)[31]	24	23	26	22
Business management / administration	20	37	17	14
Occupational Medicine Postgraduate Degree	19	37	11	16
DOccMed (Diploma in Occupational Medicine)	16	33	6	14
Vocational rehabilitation practitioner course/training/qualifications	14	16	13	13
Immunisations / vaccinations	13	26	17	6
Training towards CCT (Certificate of Completion of Training) in Occupational Medicine	13	23	7	11
Physiotherapy course/ training/ qualifications	13	26	6	11
Mental Health first aid	11	14	17	7

[29] Measurement of the range and sensitivity of a person's hearing.
[30] Measurement of lung function, by examining how much air someone can breathe out, in one forced breath.
[31] Hand Arm Vibration Syndrome (HAVS) is damage caused by exposure to vibration at work.

CESR (Certificate of Eligibility for Specialist Registration) in Occupational Medicine	11	21	6	9

B2 What types of training and/or qualifications do you fund your staff in accessing / are you able to access? Base: All respondents (200); NHS providers (43); In-house providers (54); Private providers (103). Table 4.3 includes only those responses mentioned by 10% or more. Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages should be treated with caution.

Benefits and drivers of funding access to training and qualifications

The in-depth interviews allowed OH providers to discuss in more detail their views on training and qualifications. Providers discussed the need for and benefits of funding access.

Training was seen as necessary to provide quality OH services and to ensure staff were up-to-date on learning and development. This in turn increased staff skills and enabled staff to meet client needs.

> *"The benefits [of training] are that you're forever keeping up to date, you're not stagnant, you're open, you're curious, open to suggestion. You're much more challenging."*
>
> (Private provider, 1-9 employees, Yorkshire and the Humber)

OH providers also reported that funding to access training and qualifications was viewed as a staff retention strategy.

> *"By supporting our team with additional training, we're showing them that we value them."'*
>
> (Private provider, 1-9 employees, East of England)

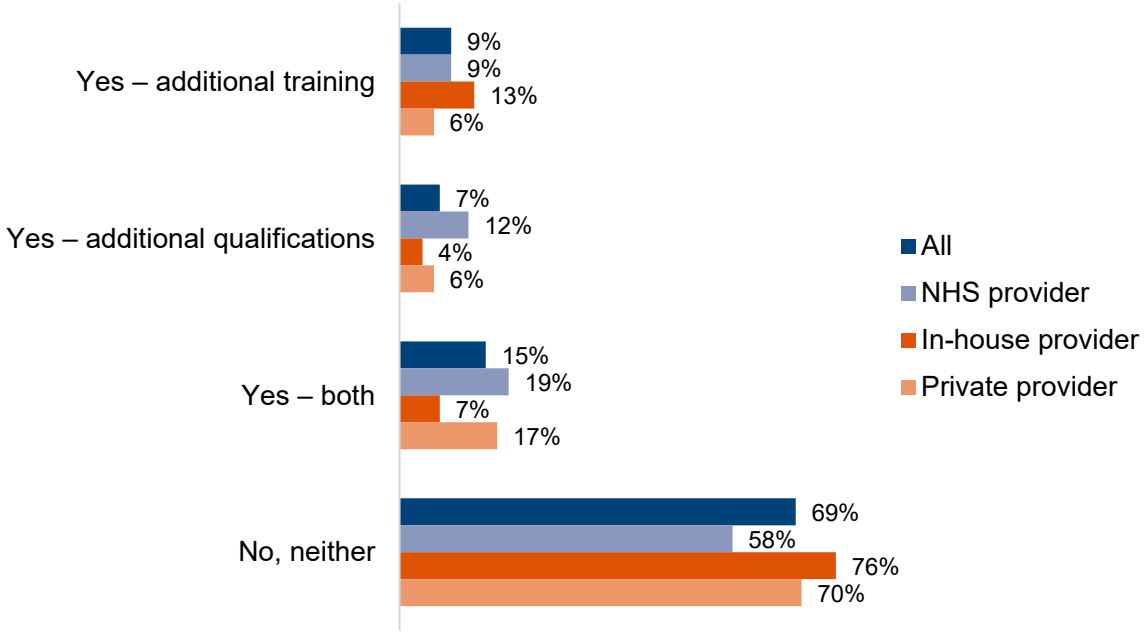
Providers also discussed the ways they funded access to training and qualifications as part of the in-depth interviews. Funding was provided in a variety of ways. Most commonly, providers set a budget to pay for the training and noted they needed to carefully review their training budget and ensure they took on higher-value work to be able to provide funds for training and qualifications. One provider forewent bonuses to be able to fund access to training and qualifications.

> *"It's one of those [where] we're having to scrimp and save… just to get our staff trained. It is something that we prioritise because we have to, but it's something that has taken away …our bonuses."*
>
> (Private provider, 1-9 employees, East of England)

Barriers to funding access to training and qualifications

OH providers were asked whether there were additional staff training or qualifications that they would ideally like to access or fund access to but are not able to at present. Around seven in ten OH providers (69%) did not want to provide access to additional training and funding, while approaching a third (30%) did want to do so (Figure 4.2).

Figure 4.2: Whether OH providers would like to fund access to additional training or qualifications

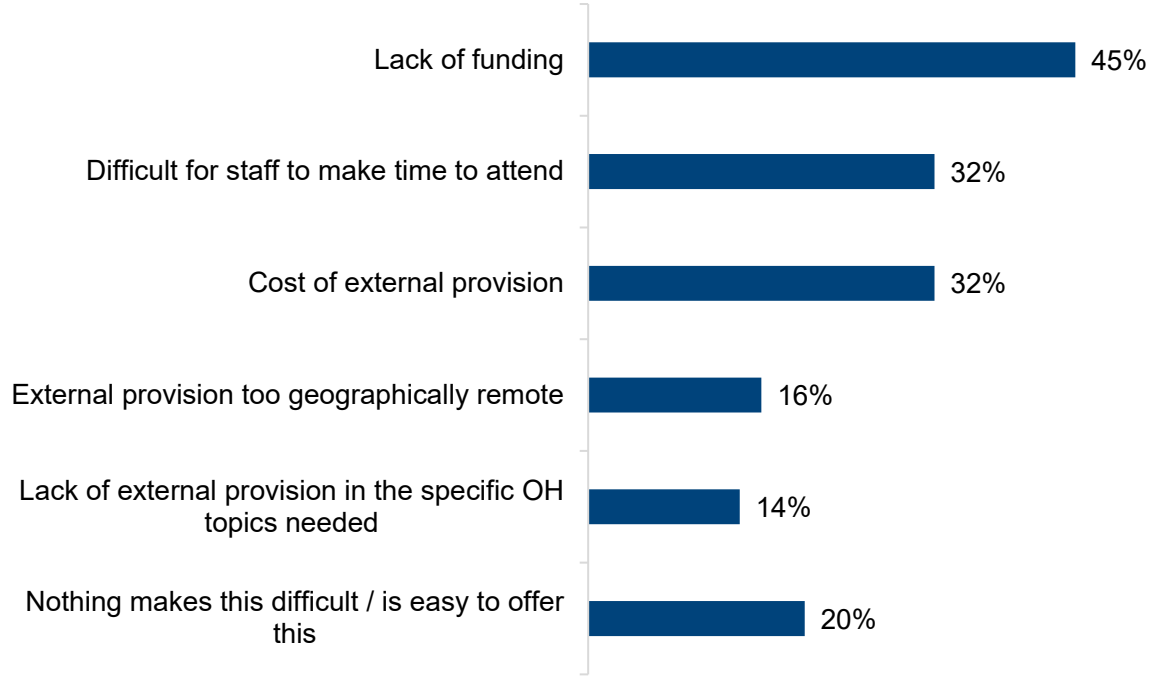


B3. Is there any additional staff training or qualifications that you'd ideally like to fund access to / that you'd ideally like to access, but are not able to at present? Base: All providers (200); NHS providers (43); In-house providers (54); Private providers (103). Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages should be treated with caution.

The types of additional training and qualifications that providers would most like to fund were: OH technician courses (35% of OH providers who wanted to fund access to additional training and qualifications); training towards OH Specialist Community Public Health Nursing (OH SCPHN) (28%) and business and administration (22%).

In the survey, OH providers were asked what made it difficult to fund access to training and qualifications. The most common factors mentioned were: the lack of funding (45%); difficulty for staff to find time to attend (32%); and the cost of external provision (32%) (Figure 4.3). Overall, monetary factors were a barrier for three fifths of providers: 60% of providers said either lack of funding and/or cost of provision was a barrier to funding access to training and qualifications. A fifth of providers (20%) said that there were no barriers to funding access to training and qualifications.

Figure 4.3: Barriers to funding access to training and qualifications



B5. What makes it difficult for your OH department / organisation to fund access to training and qualifications for staff delivering your services? / What makes it difficult for you to access training and qualifications? Base: All providers (200). The chart includes only those responses mentioned by 10% or more.

Similar barriers emerged in the in-depth interviews.

> *"We are massively squeezed in our training budget... Some external provision is also costly."*
>
> (In-house provider, 50+ employees, South West England)

> *"[The issue is] capacity and demand and being able to release staff to attend training."*
>
> (NHS provider, 200+ employees, South West England)

The in-depth interviews highlighted that some providers did not want to provide funding to access training, as they worked with contracted staff who may work at the organisation for a relatively short period of time and therefore it was perceived there was limited organisational benefit in training these staff.

> *"Unfavourable [to funding access to training] because the majority of staff we use are freelance. Training is their responsibility, and not the business's."*
>
> (Private provider, 10-49 employees, North West)

One OH provider noted they did not have sufficient lead-in time to fund training as their current need was for already-qualified staff.

In the in-depth interviews, providers were asked to give more detail on barriers to funding additional training or qualifications and how these barriers might be overcome.

The most common response was better availability of external training and subsidised rates for training. The length of training was noted as a barrier, particularly for nurse training and qualifications. A few providers commented on the shorter training period for OH technicians and how this training could be undertaken in-house.

Location was also noted as barrier and some providers noted training was not provided in their local area and as a result, costs to attend training increased as there were travel and accommodation costs in addition to the cost of training. One provider suggested onsite training would help to avoid additional costs and minimise staff time away from the business.

> *“Locations of the training [would make it easier to fund training], so more closer to us would be better, so we wouldn't have to pay for accommodation and travel.”*
>
> (Private provider, 1-9 employees, North West England)

Summary

OH providers commonly engage with training but want to do more. Provider funding for staff training and/or qualifications is commonplace but nearly a third would like to fund more of this than they’re currently able to. Lack of funding, difficulty making time for staff to attend, and external provision costs and locations are the main barriers.

5 Demand for Occupational Health services, and provider capacity

This chapter discusses the specific services most commonly offered by Occupational Health (OH) providers and how this compared with demand for these services. It examines the overall capacity of OH providers, in terms of the maximum number of individuals a provider could provide services to at any one time; and the extent to which this overall capacity has been used in the past 12 months. It describes how OH providers respond, when demand for their services exceeds their overall capacity; and the extent to which providers' services interact with other provision. Finally, it explores OH provider attitudes to the idea of expanding their capacity. Findings are drawn from both the survey of OH providers and the in-depth qualitative interviews.

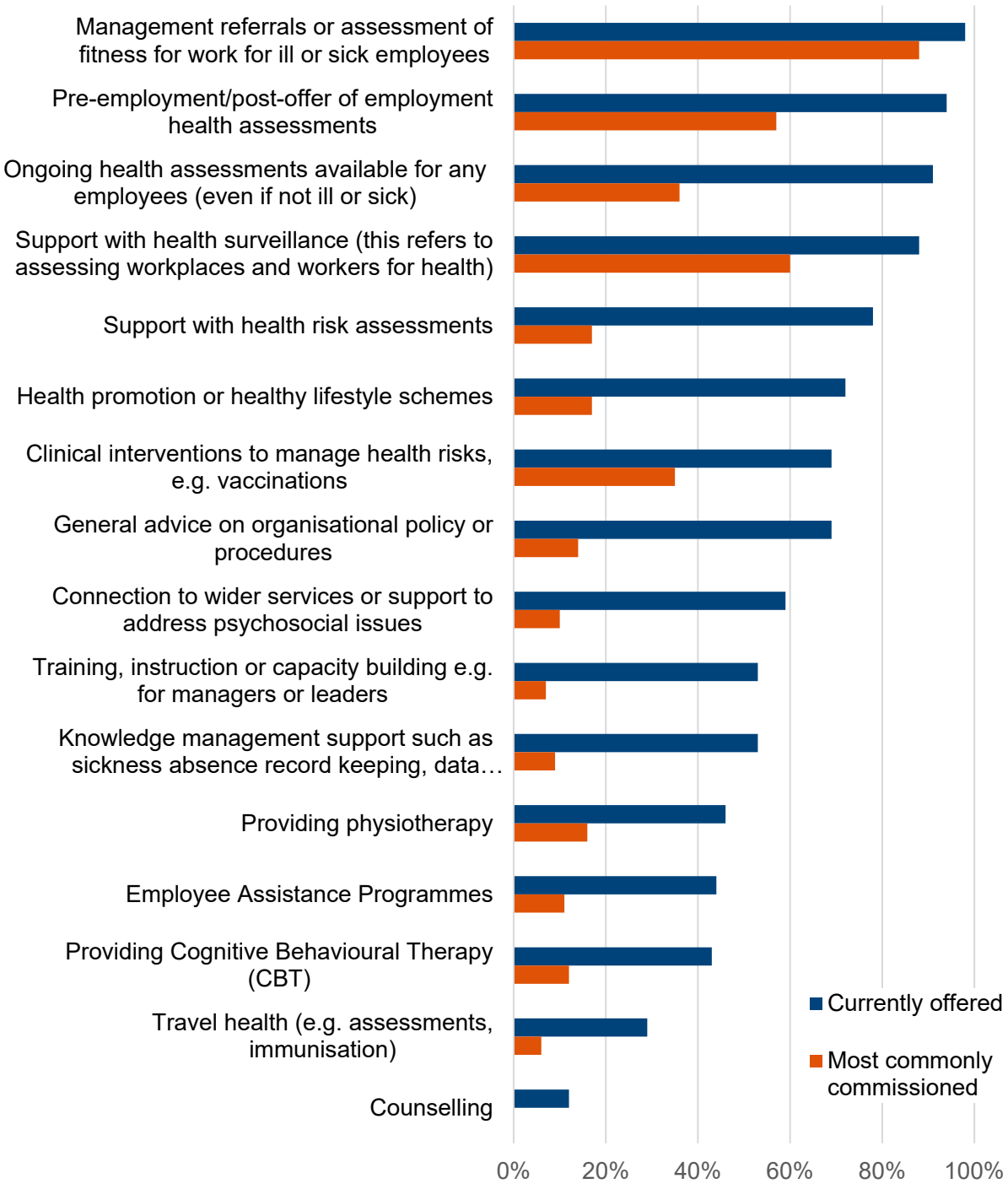
Current demand for Occupational Health services

Commissioned services

OH providers were asked about the specific services that they currently offer; and which of these services were most commonly used or commissioned by customers. When discussing the services most commonly used or commissioned, providers were asked to select up to ten specific services.

Unsurprisingly, the four most in-demand services were also the most-offered by OH providers (Figure 5.1 and Table A.6 in Annex).

Figure 5.1: OH Services most commonly offered and most commonly used



E1. Which of the following types of Occupational Health support or interventions does your organisation offer? E3. Which of your services are most commonly used or commissioned? Please pick up to ten of the most common. Base: All respondents (200). Figure 5.1 includes only those responses mentioned by 10% or more.

The most commonly offered services were:

- **Management referrals or assessment of fitness for work for ill or sick employees** (this was both the most offered service and the most commonly used or commissioned).
- **Pre-employment or post-offer of employment health assessments** (this was the second most commonly offered and the third most commonly used or commissioned).
- **Ongoing health assessments for any employees, even if not ill or sick** (this was the third most commonly offered and the fourth most commonly used or commissioned).
- **Support with health surveillance** (this was the fourth most commonly offered and the second most commonly used or commissioned).

There were some significant differences by OH provider type:

- NHS providers were more likely than average to *offer* clinical interventions to manage health risks, e.g. vaccinations (98%, compared with 69% of all providers) but less likely than average to offer training, instruction or capacity building, e.g. for managers or leaders (40%, compared with 53%). They were also more likely to report the following being amongst their *most used* services
    - Management referrals or assessment of fitness for work (95%, compared with 88% of all providers),
    - Pre-employment/post-offer of employment health assessments (86%, compared with 57%) and
    - Clinical interventions to manage health risks (79%, compared with 35%).
- In-house providers were more likely than average to *offer* several services:
    - General advice on organisational policy or procedures to help with legal compliance and business (87%, compared with 69% of all providers);
    - Employee Assistance Programmes (80%, compared with 44%);
    - Connections to wider services or support to address psychosocial issues, e.g. debt counselling (72%, compared with 59%);
    - Knowledge management support such as sickness absence record keeping and data analysis (72%, compared with 53%); and
    - Cognitive Behavioural Therapy (63%, compared with 43%).

  They were also more likely to report knowledge management support being amongst their *most used* services (19%, compared with 9% of all providers).
- Private providers were less likely than average to *offer* several services:
    - Pre-employment/post-offer of employment health assessments (89%, compared with 94% of all providers);

- Support with health surveillance, which refers to regular checks for people working in hazardous roles (83%, compared with 88%);
- Clinical interventions to manage health risks, e.g. vaccinations (59%, compared with 69%);
- General advice on organisational policy or procedures to help with legal compliance and business (59%, compared with 69%);
- Knowledge management support such as sickness absence record keeping and data analysis (45%, compared with 53%);
- Employee Assistance Programmes (28%, compared with 44%); and
- Cognitive Behavioural Therapy (35%, compared with 43%).

For several of these, they were also less likely to report them being amongst their *most used* services: this was the case for pre-employment/post-offer of employment health assessments; clinical interventions to manage health risks; knowledge management support; and Employee Assistance Programmes.

In the 2019 survey of OH provision a broadly similar question was asked of private providers only and there has been no change in the two most commonly offered and most commonly used services:

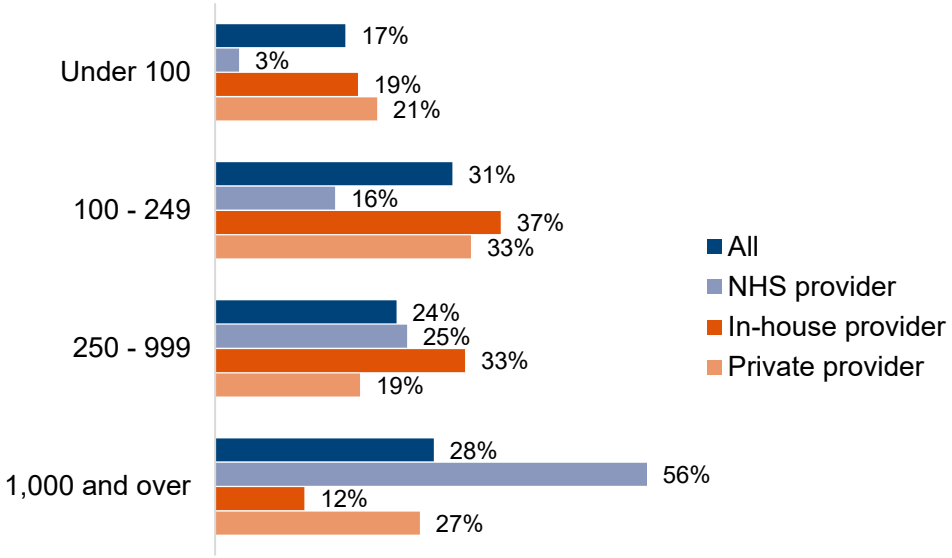
- The most commonly offered services in 2019 were advice about workplace adjustments or return to work plans (94%) and assessments of fitness for work for ill employees (90%) – now collapsed into one category ('management referrals or assessments of fitness for work') which is the most offered service in 2023-24. The second most mentioned service was pre-employment or post-offer employment health assessments (88%) which is again the second most mentioned in 2023-24.
- When asked about the most frequently used services in 2019, two were notably more common: support with health surveillance (33%) and assessments of fitness for work (24%). These are again the two most used or commissioned in 2023-24.

Private providers were also asked in the current survey, what types of overall services their organisation delivers to its clients. Responses were prompted by a list, and providers could pick more than one option. Nearly all (95%) categorised their services as Occupational Health services; a third (33%) categorised their services as OH Physiotherapy; and nearly as many (29%) categorised their services as Vocational Rehabilitation. It should be noted that results may at least be partly due to the survey sampling methodology and sampling sources and may not represent the OH provider population as a whole.

Overall capacity and demand

In the survey, OH providers were asked about their overall capacity, in terms of the maximum number of individuals a provider could provide services to at any one time. NHS providers had the highest capacity (being able to cater to an average of up to 1,000 individuals at once);[32] and 56% of NHS providers could cater to 1,000 individuals or more (Figure 5.2). By contrast, in-house and private providers could on average cater to a maximum of 200 individuals at once. Across all provider types, the median capacity was 250 individuals.

Figure 5.2: Maximum number of individuals OH providers can provide services to



C1. What is your capacity for providing Occupational Health services, i.e. what is the maximum number of individuals you could provide your services to at any one time? Base: All respondents excluding refusals / don't knows (165); NHS providers (32); In-house providers (43); Private providers (90). Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages should be treated with caution.

Capacity varies by size of OH provider, with medium-size organisations having the largest capacity with a median capacity of 2,524 individuals (Table 5.1).

The capacity of OH providers tended to be relatively consistent by region. OH providers catering to the East of England had the highest capacity with a median capacity of 310. This was followed by London, North East and North West England, Northern Ireland and Wales, each with a median capacity of 300.

[32] This is a median average, to avoid the average figures being distorted by a small number of outlying very high values.

Table 5.1. Maximum number of individuals OH providers can provide services to by size of provider

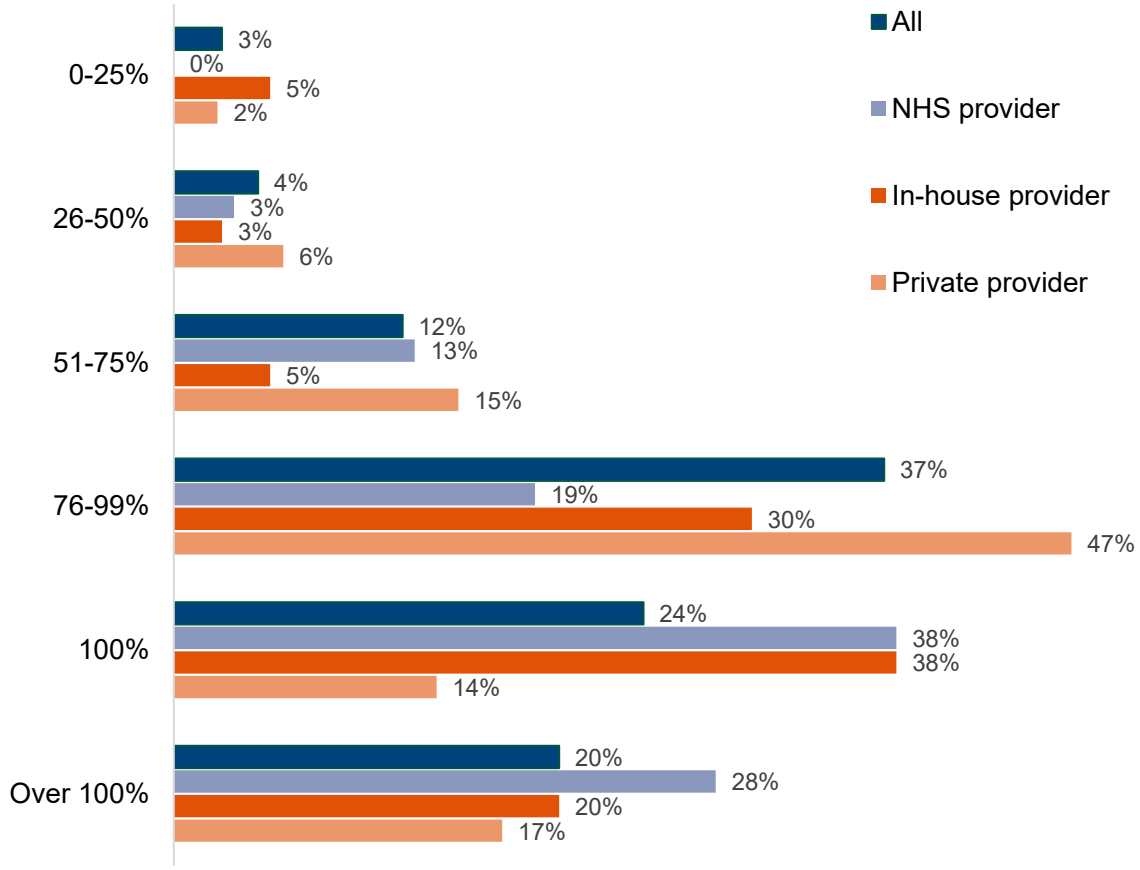
	All OH providers	Sole practitioner	Micro	Small	Medium
No of individuals can cater to:					
Median average	250	120	160	928	2524
Mean average	1677	105	476	1053	3690

C1. What is your capacity for providing Occupational Health services, i.e. what is the maximum number of individuals you could provide your services to at any one time? Base: All respondents excluding refusals / don't knows (165); sole practitioner / sole trader (11), micro (78), small (63), medium (11). Note the relatively small base sizes for many of the provider size bands, meaning specific percentages should be treated with caution; only two providers fell into the 'large' category so this has been excluded from the table. In this table, total provider size is based on the OH team or department for NHS and in-house providers and the whole organisation for private providers.

OH providers were asked what percentage of their overall capacity had been used in the past 12 months. They could give answers above 100%, i.e. to indicate that demand had been exceeding capacity in the past 12 months. OH providers of all types have been working near their maximum capacity or above their maximum capacity in the past 12 months (Figure 5.3). A quarter of all providers (24%) were at capacity, i.e. answering 100%; while a fifth (20%) were working above their maximum capacity, i.e. giving an answer of over 100%. Around a fifth of providers (19%) were working at 75% capacity or below. On average, providers reported that they were working at 95% of their maximum capacity over the last 12 months.[33]

[33] Again, this is a median average, to avoid the average figures being distorted by a small number of outlying very high values.

Figure 5.3: Percentage of OH providers' overall capacity taken in past 12 months



C2. And in the last 12 months, what percentage of this capacity was taken up? Base: All respondents excluding refusals / don't knows (160); NHS providers (32); In-house providers (40); Private providers (88). Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages should be treated with caution.

There were some differences by provider type:

- NHS and in-house providers were more likely to have been at capacity (each 38%) or above maximum capacity (28% and 20% respectively); and on average they each reported 100% of their capacity having been used in the past 12 months.
- Private providers were slightly less likely to have been at capacity (14%) or above maximum capacity (17%); and on average they reported 90% of their capacity having been used in the past 12 months.

In 2019, broadly similar questions were asked of private providers only. In 2019, only 1% of private providers indicated they had exceeded their capacity; this was 17% in 2023-24, suggesting that it may now be more common for demands to exceed provider capacity.

In the current survey, the relationship between size of provider and having been at maximum capacity or exceeding full capacity was not clear-cut (Table 5.2).

Table 5.2. Proportion of OH providers' capacity taken up in the last 12 months by size of provider

	All OH providers	Sole practitioner	Micro	Small	Medium	Large
	%	%	%	%	%	%
At capacity i.e. 100%	24	[10]	24	31	[9]	[0]
Above maximum capacity i.e. over 100%	20	[30]	18	20	[27]	[0]
Median average capacity used	*95*	*83*	*95*	*100*	*90*	*88*

C2. And in the last 12 months, what percentage of this capacity was taken up? Base: All respondents excluding refusals / don't knows (160); sole practitioner (10), micro (76), small (61), medium (11), large (2). Numbers in square brackets [ ] are percentages based on less than 50 observations. Note the relatively small base sizes for many of the provider size bands, meaning specific percentages for median average capacity used, and whether the provider was at or above maximum capacity, should be treated with caution. In this table, total provider size is based on OH team or department for NHS and in-house providers, and the whole organisation for private providers. All sole practitioners who responded were from private providers.

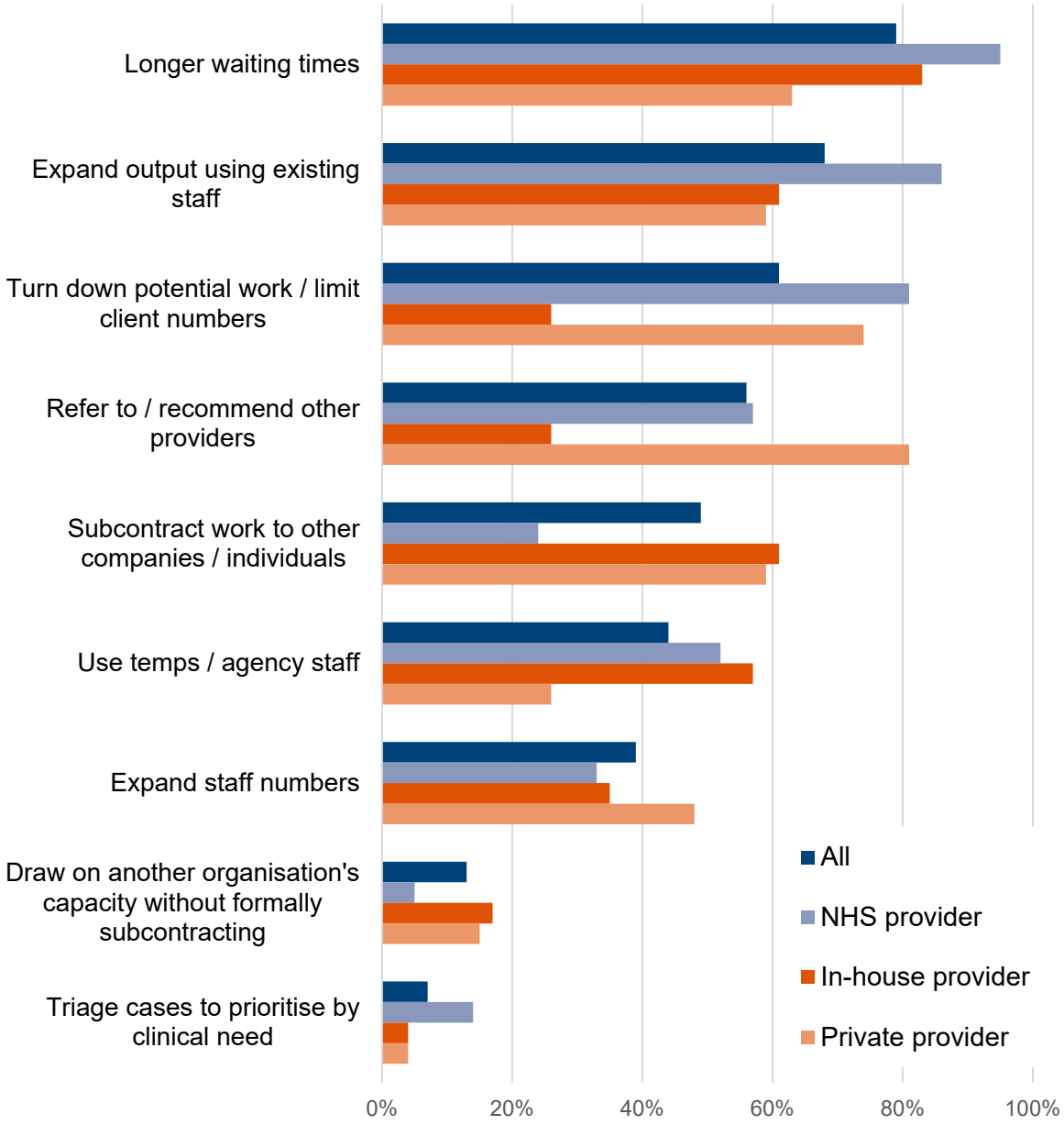
The extent to which the capacity of OH providers had been used, tended to be relatively consistent by region. Providers catering to most regions of England, and those catering to Northern Ireland, each reported a median of 90% of their capacity having been used in the past 12 months; those catering to Scotland and Wales each reported a median of 95% of their capacity having been used in this period.

Responses to being above maximum capacity

OH providers were asked how they respond if demand exceeds their maximum capacity. Responses were prompted with a list.

For OH providers who were at, or over, capacity, the most common responses to being above maximum capacity were longer waiting times (79%); expanding output using existing staff, e.g. by restructuring teams or workloads or upskilling staff (68%); and turning down potential capacity or limiting client numbers (61%). Around half will refer or recommend other OH providers (56%) or subcontract work to other companies (49%) (Figure 5.4 and Table A.7 in Annex). There were no statistically significant patterns by provider type.

Figure 5.4: OH provider responses to being above maximum capacity



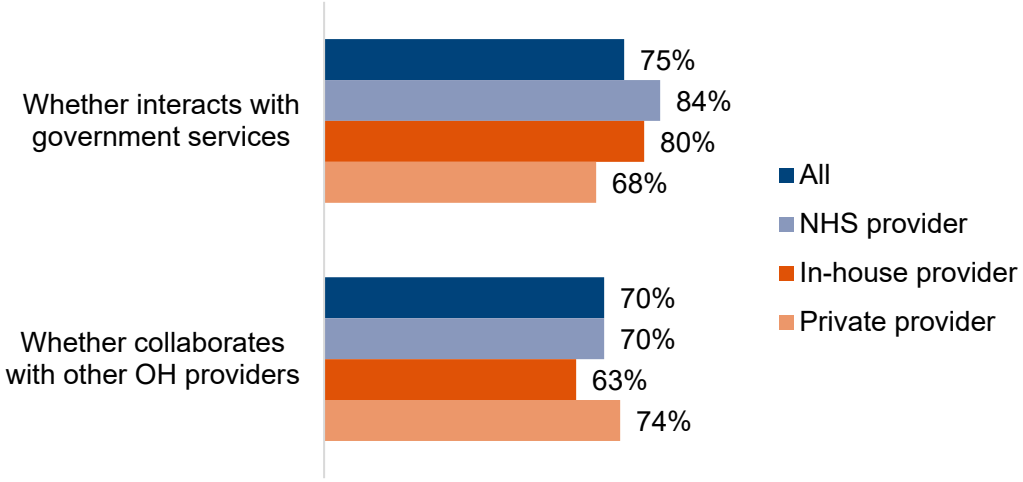
C3. How do you respond if demand for your services exceeds your capacity? Base: All respondents who were at, or over, capacity (71); NHS providers (21); In-house providers (23); Private providers (27). Note the relatively small base sizes for the individual provider types, meaning specific percentages should be treated with caution. Figure 5.4 includes only those responses mentioned by 5% or more.

Extent of interaction with NHS and government services

OH providers were asked whether their services interact with any government services such as Access to Work; and whether they collaborate with other OH providers as part of their service offer. In addition, in-house providers and private providers were asked whether what they deliver in OH interacts with NHS provision.

Interaction with other provision was common, with three quarters (75%) interacting with government services and seven in ten (70%) collaborating with other OH providers (Figure 5.5).

Figure 5.5: Interaction with government services and other OH providers

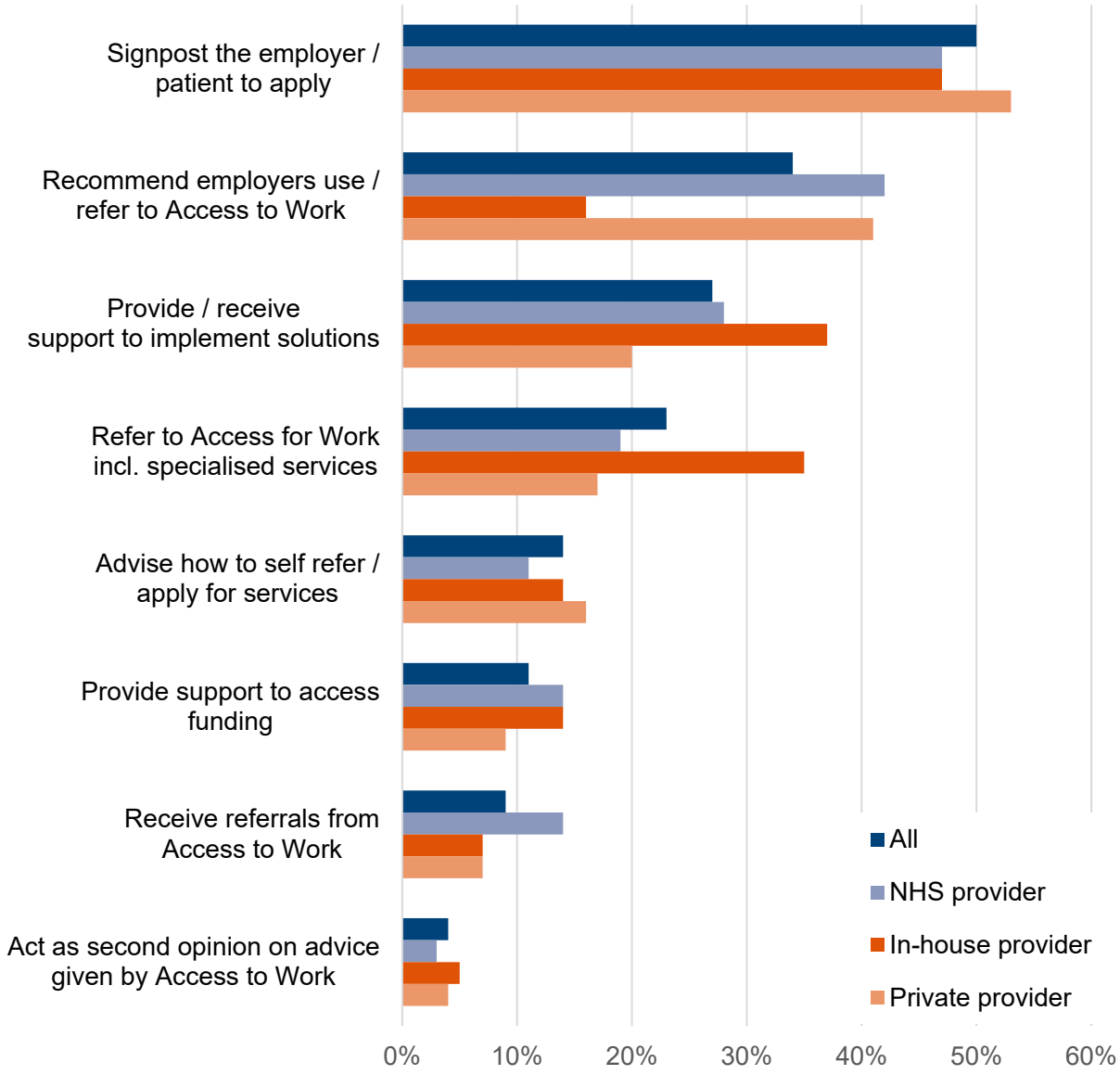


C9. Does what you deliver in OH interact with any government services such as Access to Work? C11 Do you currently collaborate with other OH providers as part of your service offer? Base: All respondents (200); NHS providers (43); In-house providers (54); Private providers (103). Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages should be treated with caution.

Private providers' services were less likely than average to interact with any government services (68%, compared with 75% of all providers).

Most commonly, those OH providers who interacted with government services such as Access to Work, said that they did so by signposting the employer or patient to apply (50%), or recommending that employers use or refer to Access to Work (34%, Figure 5.6 and Table A.8 in Annex). Results should be treated with caution due to the small base sizes.

Figure 5.6: Detail of OH providers' interaction with government services



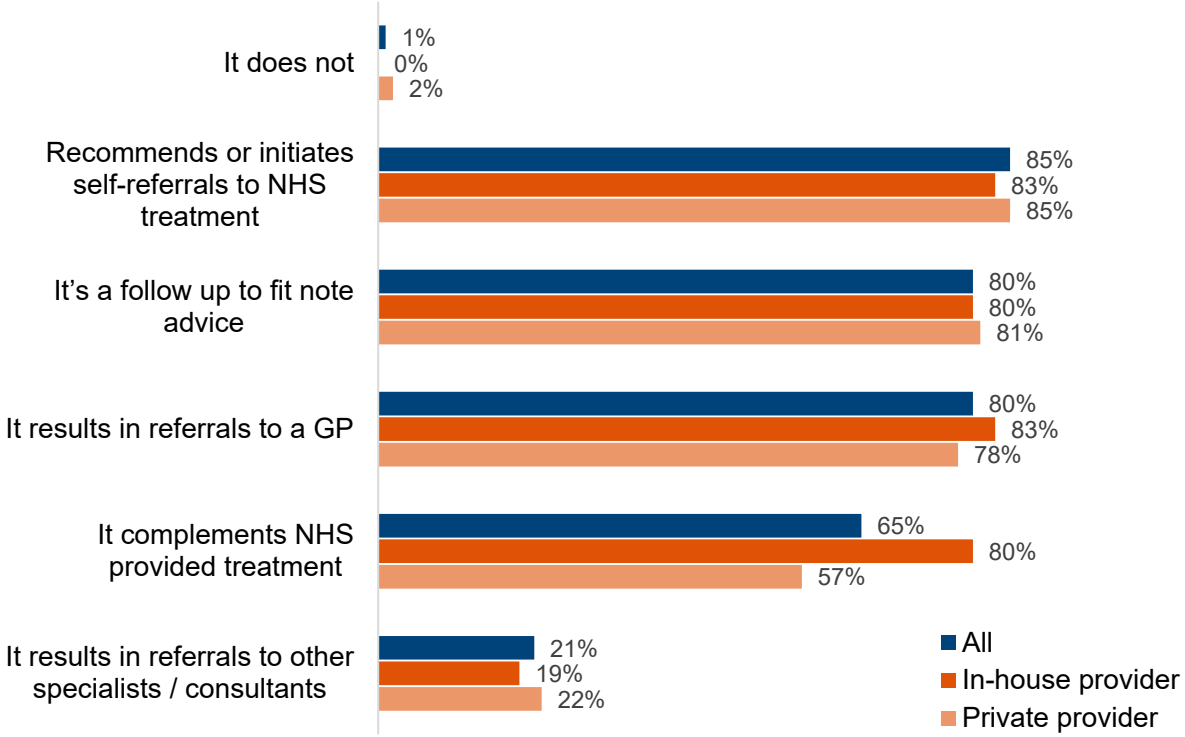
C10 Please can you say a bit more about how your services interact with Government services such as Access to Work? Base: Those whose services interact with government provision (149); NHS providers (36); In-house providers (43); Private providers (70). Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages should be treated with caution.

Those who collaborated with other OH providers most commonly said that they did so via passing on or receiving work that is out of scope (51%); sharing knowledge or discussing cases (37%); formally having work subcontracted to them (36%); informally providing peer-to-peer support (31%); or informal referral of customers to or from other providers (31%).

Nearly all in-house and private providers reported that what they deliver interacts with NHS provision in some way (Figure 5.7). Most commonly, this was by recommending or initiating self-referrals to NHS treatment (85%), as a follow up to fit note advice (80%) or via referrals to a GP (80%).

Two thirds (65%) reported that what they deliver complements NHS-provided treatment. In-house providers were more likely than average to say this (80%) whereas private providers were less likely than average to do so (57%).

Figure 5.7: In-house and private OH provider interaction with NHS provision



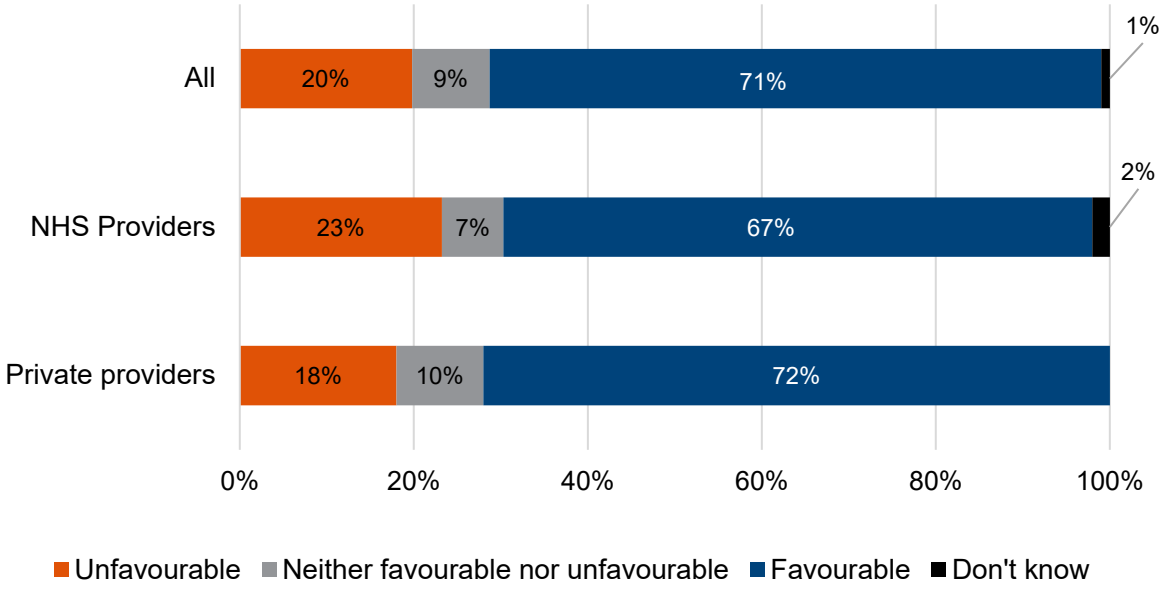
C7. Does what you deliver in OH interact with NHS provision in any of the following ways? Base: All in-house and private providers (157); In-house providers (54); Private providers (103). Note the relatively small base size for in-house providers, meaning specific percentages should be treated with caution.

A broadly similar question was asked of private providers in 2019, when – consistent with 2023-24 – nearly all (96%) said that their OH support interacted with NHS provision in some way (similarly this is 98% in 2023-24).

Attitudes to expanding capacity

Most OH NHS and private providers reported positive attitudes towards the idea of expanding their capacity, so they could increase the maximum number of customers they can provide their current services to at any one time. When asked how favourable or unfavourable their OH department or organisation was to expanding its capacity, seven in ten (71%) were favourable towards doing so (being 'extremely', 'very' or 'somewhat' favourable, on a seven-point scale from 'extremely favourable' to 'extremely unfavourable', Figure 5.8).

Figure 5.8: Favourability among OH providers towards expanding capacity



C4. On balance, what is your OH department's / organisation's stance on expanding its capacity, to increase the maximum number of customers you could provide your current services to at any one time? Base: All NHS and private providers (146); NHS providers (43); Private providers (103). Note the relatively small base size for NHS providers, meaning specific percentages should be treated with caution.

Private providers were more likely to be 'extremely favourable' towards expansion (44%, compared with 23% of NHS providers). There were no significant differences in attitudes to expansion by size of OH provider.

Enablers to expanding capacity

In the survey, those favourable towards expanding their capacity were asked why this was the case. The most commonly mentioned reasons revolved around grasping an apparent opportunity; 46% mentioned increased capacity as a way of increasing revenues and the same proportion mentioned high demand suggesting an expansion opportunity. In a similar vein, nearly a third (31%) mentioned increased capacity as a way of increasing market share. Altruistic motives were also relatively common, with two-fifths (40%) wanting to deliver the benefits of OH more widely (Figure 5.9).

Figure 5.9: Reasons for being favourable towards expanding capacity

C5. Why is your OH department's / organisation's stance on expanding capacity for your current services favourable? Base: All NHS and private providers favourable to expanding (103); NHS providers (29); Private providers (74). Note the relatively small base size for NHS providers, meaning specific percentages should be treated with caution. There were no significant differences by provider type. Figure 5.9 includes only those responses mentioned by 5% or more.

Similar motivations for expansion emerged in the in-depth interviews:

- **OH providers seeing an opportunity to grow their business.** In turn, some providers hoped that this business growth would deliver other internal benefits. These included enabling more investment in staff training; exposing staff to more varied types of OH work; making it possible to set up an internal Multidisciplinary Team; or reducing the hours worked by existing staff.

  "The more I can grow, the more I can then have an in-house Multidisciplinary Team as opposed to having to reach out to self-employed associates; then the more I can invest in my own staff's training and education so that I have the best team there is."

  (Private provider, 1-9 employees, South East)

  "It's about expanding into the community and working with small businesses; [expanding capacity] would give staff more variety to their day, allow them to build more experience of dealing with other things. We'd also be able to generate more revenue this way."

  (NHS provider, North West)

- **Wanting to spread the reach and benefits of OH services as widely as possible.** Within this, some providers hoped to cater to growing demand for specific types of OH services such as those catering to neurodiversity.

In the in-depth interviews, some OH providers also noted that, whilst they were favourable to expansion, it was difficult to know whether to expand their number of staff first or expand their client base first.

OH providers also discussed, in the in-depth interviews, the ways in which they had already attempted to expand their capacity and what might make it easier for them to expand in future.

Many of the responses related to their **ability to recruit appropriately skilled, qualified and experienced staff**. Providers reported that, in their attempts to expand, they used networking at conferences or professional databases to try to identify appropriate individuals to recruit. They also reported using self-employed associates and non-UK qualified nurses to meet their staffing needs. The recurring theme in providers' responses regarding what would make it easier for them to expand was improved availability of skilled staff with the right experience and qualifications.

Individual providers also suggested that expansion could be facilitated through subsidised OH training; and a fund to support providers to expand without taking on debt.

Barriers to expanding capacity

In the survey, those unfavourable towards expanding their capacity were asked why this was the case. The most commonly mentioned reasons were a lack of interest in expansion and difficulty recruiting enough skilled staff to increase capacity. Also relatively common was concerns about expansion negatively impacting quality of services. There were no significant differences by provider type.

Similar reasons for being unfavourable to expansion emerged in the in-depth interviews:

- **Lack of interest in expanding.** Several OH providers stated that they wanted to remain a small business; while one mentioned that they preferred to focus on the quality of their service offer rather than increasing the scale of delivery, and another mentioned that they did not wish to expand as they personally were nearing retirement.
- **A shortage of suitably skilled, qualified and experienced staff.** OH providers specifically cited a shortage of OH nurses, doctors and technicians as a reason for being unfavourable to expansion. Within this, some providers commented that they had observed a lack of knowledge of what OH work entails, amongst potential candidates for their roles. A few also mentioned that a desire to be self-employed amongst the OH talent pool was making it more difficult to recruit staff in order to expand; or mentioned that a talent shortage would mean that, if they were to expand, they would be burdened with the responsibility for training new staff.

“A lot of people have got the health experience, but this [OH] is a totally new field for them.”

(Private provider, 1-9 employees, East of England)

“OH is never mentioned in recruitment drives in the health sector.”

(Private provider, 1-9 employees, South East)

“It's a nightmare…there's a limit to the number of professionals with the right experience, then also a limit to the number of professionals who want an employed role.”

(Private provider, 1-9 employees, South East)

Larger private Occupational Health providers purchasing smaller providers

A further theme that emerged spontaneously from these discussions was that of acquisitions in the OH sector.

One small private OH provider commented they receive regular emails from larger providers interested in purchasing their business. They mentioned one particular company that previously was focused on winning large contracts but is now focusing on winning work by purchasing SMEs with smaller contracts. The provider was concerned about this reducing customer choice.

Another provider mentioned takeovers in relation to barriers to expansion, in that they feel that this creates uncertainty in the employment market for OH services, as OH providers may be subject to company takeovers and subsequent reorganisations.

Summary

It may be more common for demands to exceed provider capacity than it was in 2019. In the past 12 months, the majority of providers of all types have been working near maximum capacity or above maximum capacity. Whilst NHS providers have the highest capacity, they are also most likely to have been working above maximum capacity.

Providers are mostly open to seizing the opportunity to expand, but some are constrained by recruitment challenges. Seven in ten NHS and private providers are in favour of expanding; for those who are not, lack of interest and challenges recruiting skilled staff are the barriers.

6 Pricing

This chapter explores how Occupational Health (OH) providers price their services and the decisions they make to reach these prices. The chapter starts by discussing how providers price different OH services, before discussing the ways in which customers are charged (for instance, the use of retainers and annual contracts). It then covers the factors that are considered when price-setting and whether prices are tailored to specific groups of customers. The findings cover all private providers surveyed, as well as in-house providers that charge for their OH services and NHS providers that have sold OH services commercially to organisations outside of the NHS in the last two years. Findings are drawn from both the survey of OH providers and the in-depth qualitative interviews.

Charging by in-house and NHS providers

The majority (70%) of in-house providers did not charge for any of their services. While 30% did, this amounted to a total of 16 providers, therefore within this chapter in-house providers that charged for their services are mostly included in the figures for 'all providers' rather than being discussed as a separate group.

Most NHS providers (88%) had sold their services to organisations outside of the NHS in the past two years. This amounted to a total of 38 providers and as a result it is often possible to discuss them as a separate group. Where NHS providers are not mentioned separately this is because, for that particular figure or part of analysis, fewer than 20 NHS providers gave a response.

Among the NHS providers that had sold their services to organisations outside of the NHS, approaching seven in ten (68%) had different pricing for the OH services they delivered to NHS staff internally, and the OH services delivered to organisations outside of the NHS. Most (69%) charged their services at a lower rate when delivered to NHS staff internally and approaching a quarter (23%) did not know whether the cost would be higher or lower. None charged their services internally at a higher rate than externally.

Price per head for specific OH services

To explore pricing levels, OH providers were asked in the survey how much they would typically charge per employee for each of the following specific OH services:

- Support with health surveillance
- Management referrals or assessment of fitness for work for ill or sick employees
- Ongoing health assessments – available for any employees (even if not ill or sick) – regarding fitness for roles or fitness for tasks

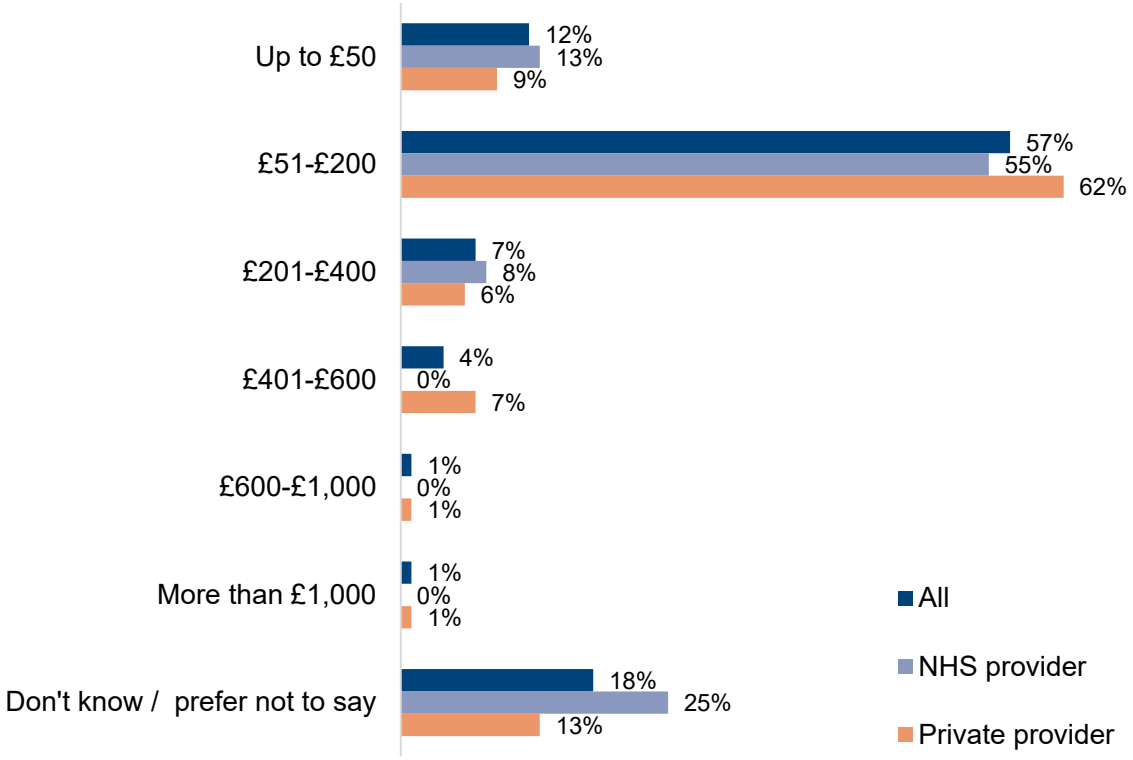
- Cognitive Behavioural Therapy (CBT)
- Employee Assistance Programmes

OH providers that offered these specific services were asked how much they would typically charge per employee for each service as well as how the service would typically be delivered. Providers tended to discuss pricing on 'per person per use' basis. In the following sections, specific provider types are sometimes omitted from figures and tables due to small base sizes. In places, breakdowns for specific groups of providers have been included, where it aids understanding of the findings, but caution is advised due to small base sizes. This includes all findings for NHS providers, where the base is less than 50 and specific percentages should be treated with caution.

Health surveillance

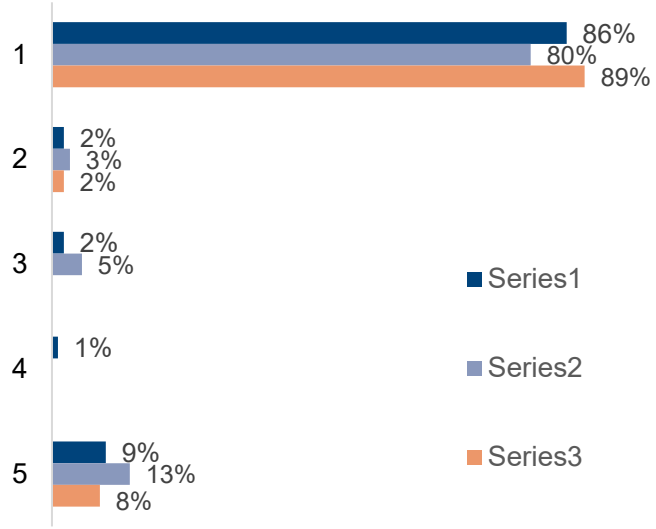
Firstly, providers were asked about health surveillance (Figure 6.1). Typically, health surveillance would cost between £51 and £200 per person (57%), though around one in eight (12%) charged £50 or less, and 7% charged between £201 and £400. Most commonly health surveillance was charged based on face-to-face delivery (86% of providers) and delivery by a nurse (51% of providers) (Figure 6.2.1 and Figure 6.2.2). A fifth of providers based the price of health surveillance on delivery by an OH technician (21%).

Figure 6.1: Price per person for health surveillance



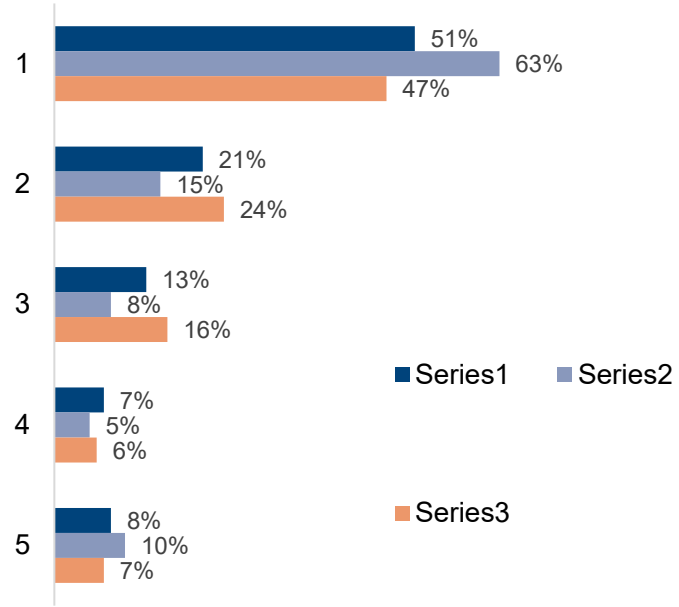
E4. What price do you charge per head for support with health surveillance? Base: All that charge for health surveillance (138); NHS providers (40); Private providers (85). Note the relatively small base size for NHS providers, meaning specific percentages should be treated with caution.

Figure 6.2.1: What type of delivery the price of health surveillance was based on



E4a/b. And was this price based on? Base: All that charge for health surveillance (138); NHS providers (40); Private providers (85). Note the relatively small base size for NHS providers, meaning specific percentages should be treated with caution.

Figure 6.2.2: What type of delivery the price of health surveillance was based on



E4a/b. And was this price based on? Base: All that charge for health surveillance (138); NHS providers (40); Private providers (85). Note the relatively small base size for NHS providers, meaning specific percentages should be treated with caution.

Table 6.1, 6.2 and 6.3 shows the average charge band for delivery of health surveillance for the most common delivery methods that providers based that cost on.[34] The average cost was consistently between £51 and £200 regardless of the delivery method. Note the relatively small base sizes for many of the provider types and delivery modes, meaning these specific findings should be treated with caution.

[34] These are median averages, to avoid the average figures being distorted by a small number of outlying very high values.

Table 6.1: Average price per person for health surveillance by delivery type for all OH providers

Pricing assumptions:	Median price for delivery	Number of providers
Method of delivery: Face-to-face	£51-£200	118
Delivery professional: By a nurse	£51-£200	71
Combinations of delivery (method and professional): Face to face and by a nurse	£51-£200	66
Overall	£51-£200	138

Table 6.2: Average price per person for health surveillance by delivery type for NHS providers

Pricing assumptions:	Median price for delivery	Number of providers
Method of delivery: Face-to-face	£51-£200	32
Delivery professional: By a nurse	£51-£200	25
Combinations of delivery (method and professional): Face to face and by a nurse	£51-£200	22
Overall	£51-£200	40

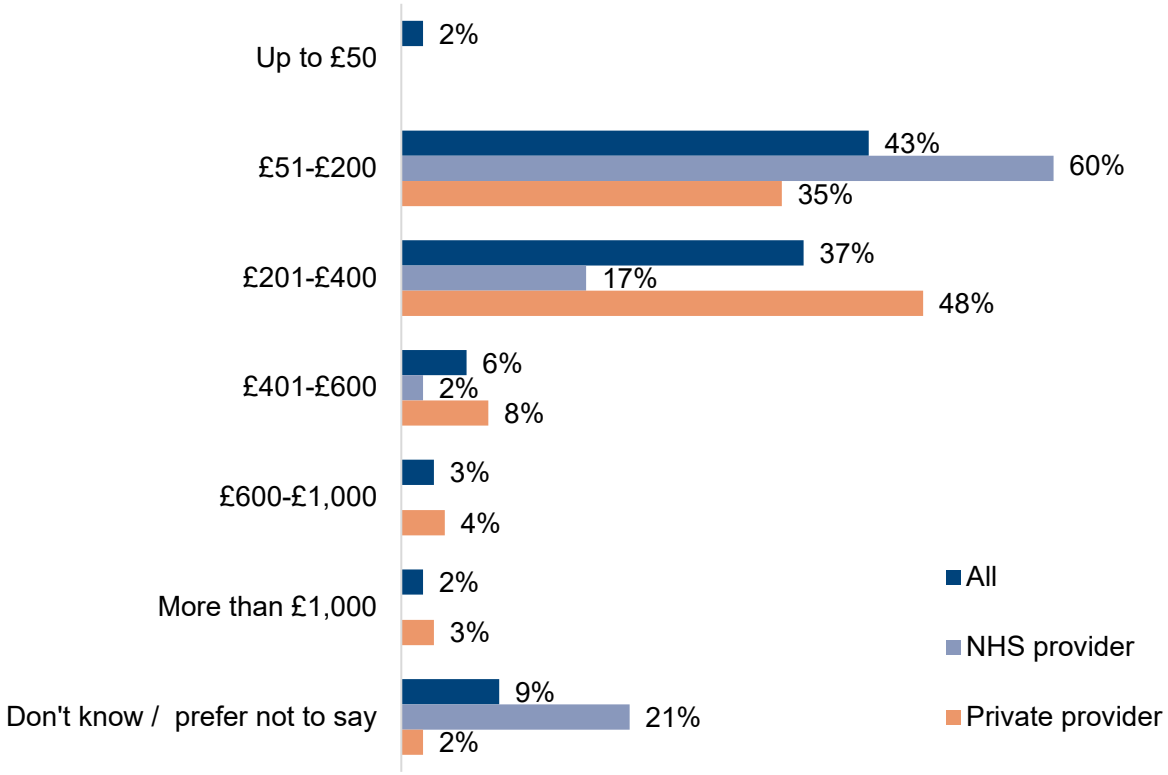
Table 6.3: Average price per person for health surveillance by delivery type for Private providers

Pricing assumptions:	Median price for delivery	Number of providers
Method of delivery: Face-to-face	£51-£200	76
Delivery professional: By a nurse	£51-£200	40
Combinations of delivery (method and professional): Face to face and by a nurse	£51-£200	39
Overall	£51-£200	85

Management referrals or assessment of fitness

Delivering management referrals or assessment of fitness for work most commonly cost between £51 and £200 per person, with 43% of all providers charging this amount (Figure 6.3). However, charging a higher price band of £201-£400 was also common (37%). NHS providers were most likely to charge £51-£200 (60% charged at this rate), while private providers were most likely to charge £201-£400 (48% charged at this rate).

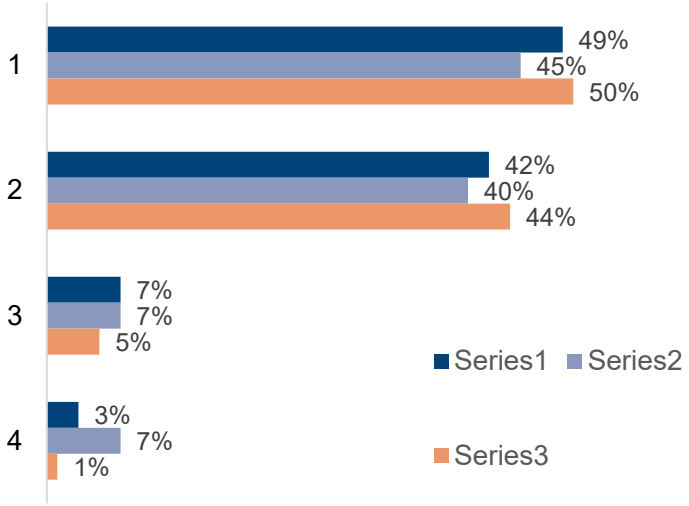
Figure 6.3: Price per person for management referrals or assessment of fitness



E5. What price do you charge per head for management referrals or assessment of fitness for work for ill or sick employees? Base: All that charge for management referrals or assessment of fitness for work for ill or sick employees (158); NHS providers (42); Private providers (100). Note the relatively small base size for NHS providers, meaning specific percentages should be treated with caution.

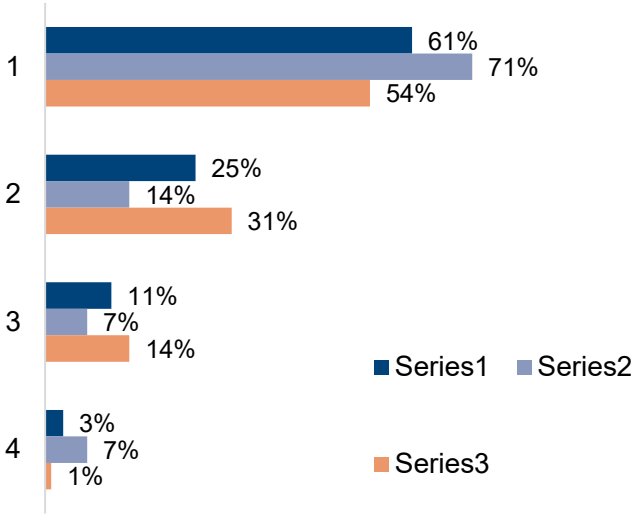
Pricing was equally likely to be based on face-to-face delivery (49% of providers) and virtual delivery (42%). Six in ten (61%) providers based the price on delivery by a nurse and a quarter (25%) based it on delivery by a doctor (Figure 6.4.1 and Figure 6.4.2).

Figure 6.4.1: What type of delivery the price of management referrals or assessment of fitness was based on



E5a/b. And was this price based on? Base: All that charge for management referrals or assessment of fitness for work for ill or sick employees (158); NHS providers (42); Private providers (100). Note the relatively small base size for NHS providers, meaning specific percentages should be treated with caution.

Figure 6.4.2: What type of delivery the price of management referrals or assessment of fitness was based on



E5a/b. And was this price based on? Base: All that charge for management referrals or assessment of fitness for work for ill or sick employees (158); NHS providers (42); Private providers (100). Note the relatively small base size for NHS providers, meaning specific percentages should be treated with caution.

Table 6.4, 6.5 and 6.6 show there was some variation in the pricing of management referrals or assessment of fitness for work, by different delivery methods. Private providers tended to price within the £201-£400 band, regardless of the delivery method (Table 6.6). Overall, however, nurses were more often costed in the £51-£200 price band, and doctors in the £201-£400 price band (figures for doctors tend to be influenced more by *private* providers' pricing, whereas figures for nurses tend to

be more equally influenced by both private and NHS providers). Note the relatively small base sizes for many of the provider types and delivery modes, meaning these specific findings should be treated with caution.

Table 6.4 Average price per person for management referrals or assessment of fitness for work by delivery type for all providers

Pricing assumptions:	Median price for delivery	Number of providers
Method of delivery: Face-to-face	£51-£200	77
Method of delivery: Virtual	£51-£200	66
Delivery professional: Doctor	£201-400	39
Delivery professional: Nurse	£51-£200	97
Overall	£201-£400	158

Table 6.5 Average price per person for management referrals or assessment of fitness for work by delivery type for NHS providers

Pricing assumptions:	Median price for delivery	Number of providers
Method of delivery: Face-to-face	-	19
Method of delivery: Virtual	-	17
Delivery professional: Doctor	-	6
Delivery professional: Nurse	£51-£200	30
Overall	£51-£200	42

Note the median price has been omitted (-) in some instances for NHS providers, due to the relatively small numbers of NHS providers

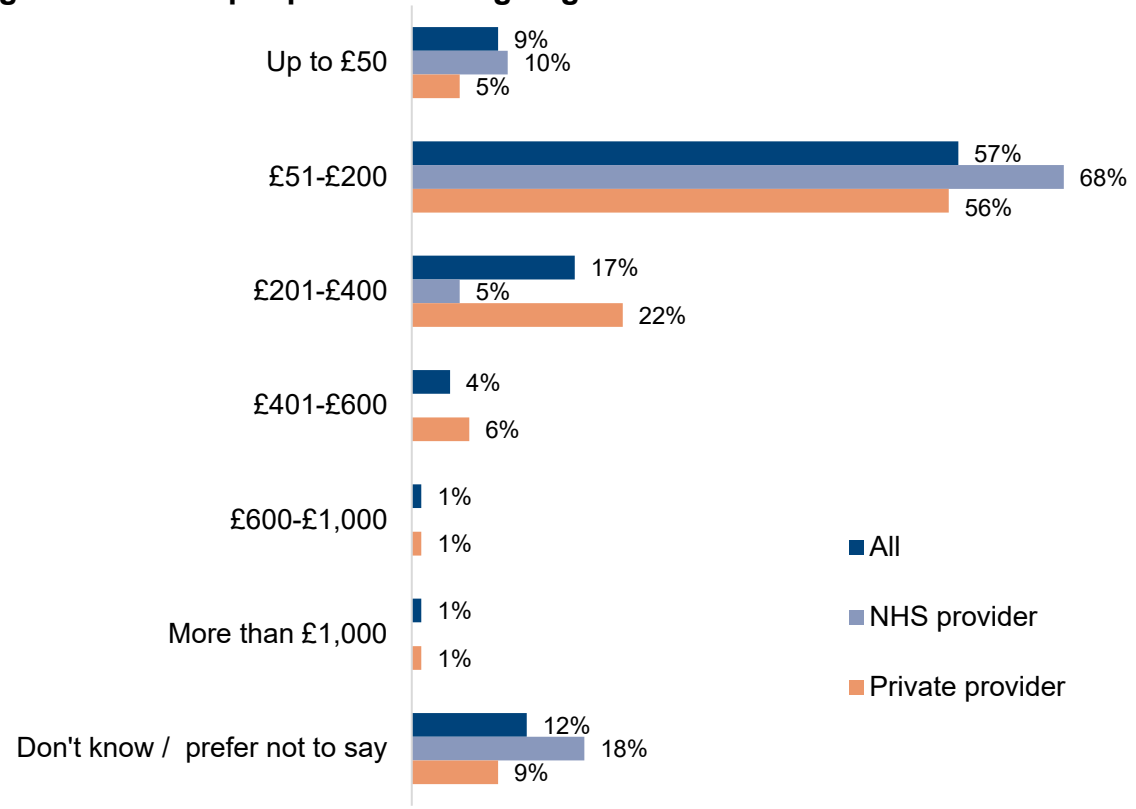
Table 6.6 Average price per person for management referrals or assessment of fitness for work by delivery type for private providers

Pricing assumptions:	Median price for delivery	Number of providers
Method of delivery: Face-to-face	£201-£400	50
Method of delivery: Virtual	£201-£400	44
Delivery professional: Doctor	£201-£400	31
Delivery professional: Nurse	£201-£400	54
Overall	£201-£400	100

Ongoing health assessments

OH providers most commonly charged ongoing health assessments at between £51 and £200 per person (Figure 6.5). Approaching six in ten providers (57%) charged between £51 and £200, while one in six (17%) charged £201-£400.

Figure 6.5: Price per person for ongoing health assessments

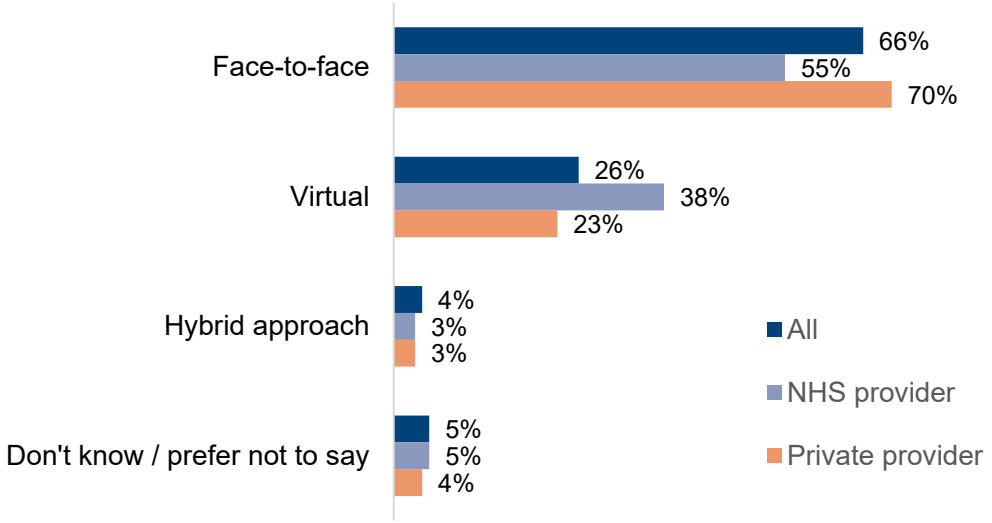


E6. And was this price based on? Base: All that charge for ongoing health assessments (145); NHS providers (40); Private providers (93). Note the relatively small base size for NHS providers, meaning specific percentages should be treated with caution.

Two-thirds (66%) based this price on face-to-face delivery, while a quarter (26%) based this on virtual delivery (Figure 6.6.1). Two-thirds (64%) based this price on delivery by a nurse, while 16% based it on delivery by a doctor (Figure 6.6.2).

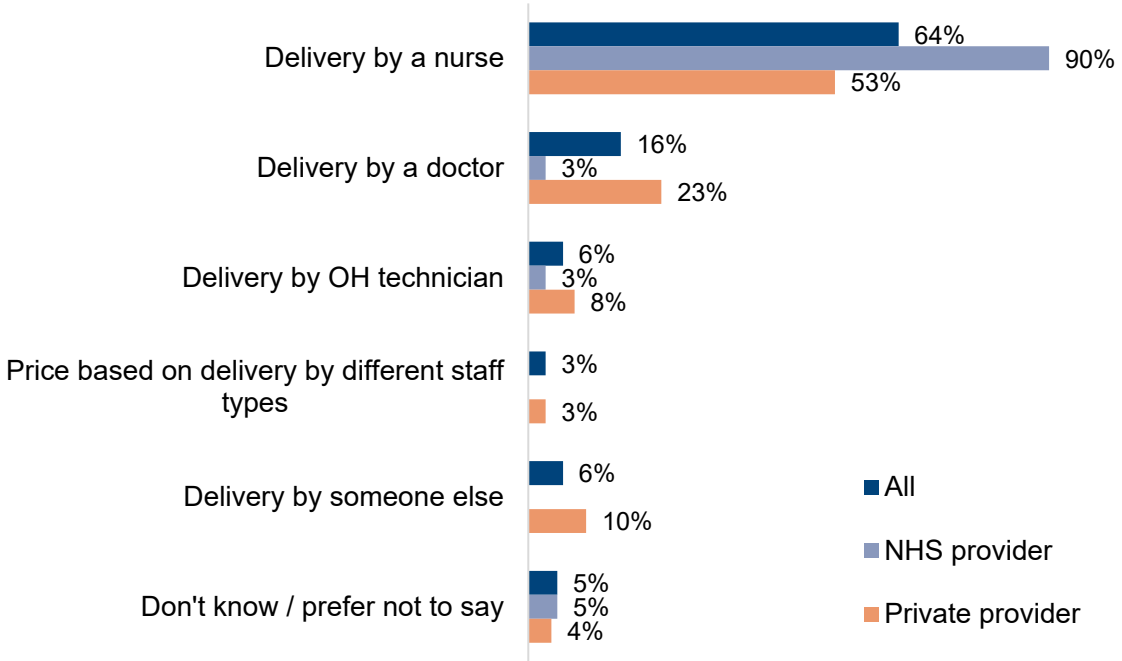
The cost of ongoing health assessments was mostly priced between £51 and £200 per person regardless of delivery method. Base sizes are too small to break these findings down in further detail.

Figure 6.6.1: What type of delivery the price of ongoing health assessments was based on



E6a/b. And was this price based on? Base: All that charge for ongoing health assessments (145); NHS providers (40); Private providers (93). Note the relatively small base size for NHS providers, meaning specific percentages should be treated with caution.

Figure 6.6.2: What type of delivery the price of ongoing health assessments was based on

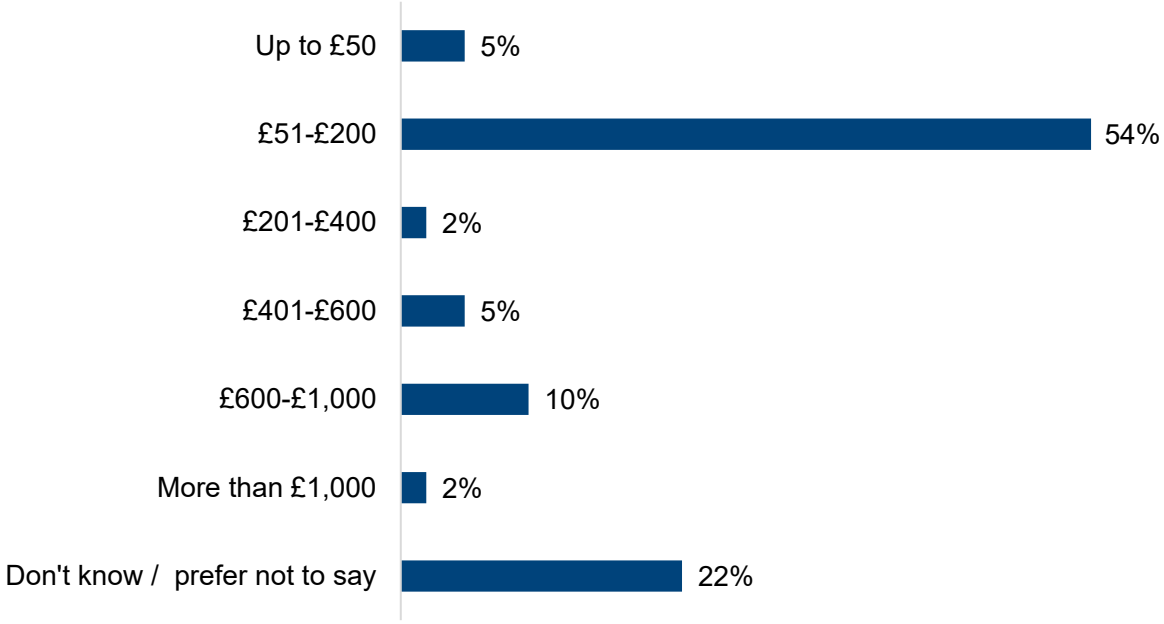


E6a/b. And was this price based on? Base: All that charge for ongoing health assessments (145); NHS providers (40); Private providers (93). Note the relatively small base size for NHS providers, meaning specific percentages should be treated with caution.

Cognitive Behavioural Therapy (CBT)

OH providers most commonly charged for Cognitive Behavioural Therapy (CBT) at between £51 and £200 per person (Figure 6.7). More than half (54%) charged at this level. This was the case irrespective of the method of delivery.

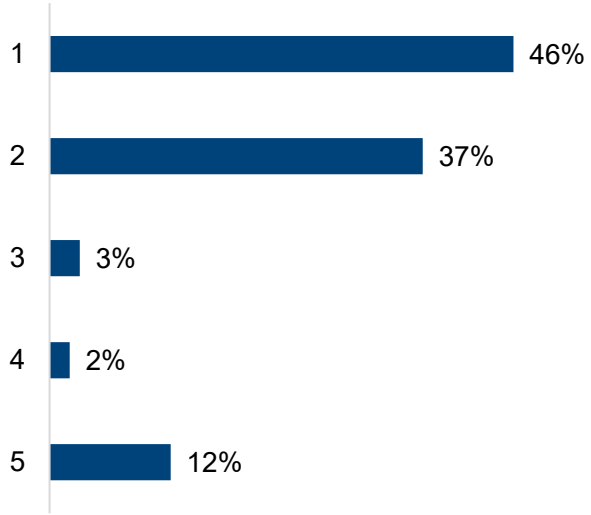
Figure 6.7: Price per person for Cognitive Behavioural Therapy



E8. What price do you charge per head for providing Cognitive Behavioural Therapy (CBT)? Base: All that charge for CBT (59). Please treat specific percentages with caution due to low base size.

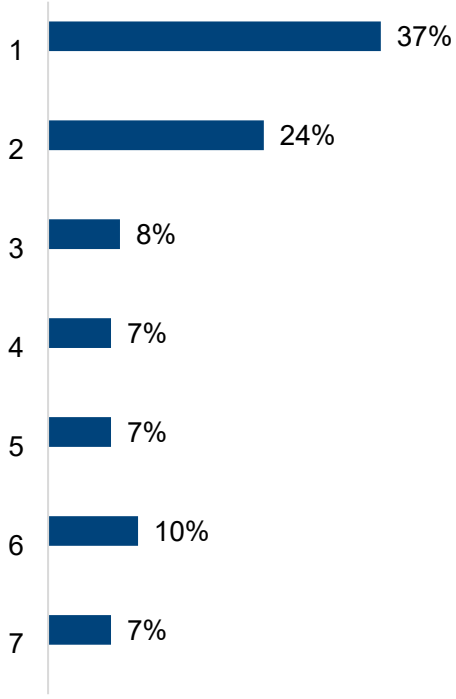
There was a relatively even split among providers of whether this price was based on face-to-face (46%) or virtual (37%) delivery (Figure 6.8.1). Pricing was most often based on delivery by counsellors (37%) but, as Figure 6.8.2 shows, pricing also assumed a range of other professionals delivering this service, including mental health professionals (24%), different staff types (8%), and nurses or OH therapists (both 7%). The base sizes are too small to break these findings down in further detail.

Figure 6.8.1: What type of delivery the price of Cognitive Behavioural Therapy was based on



E6a/b. And was this price based on? Base: All that charge for CBT (59). Please treat specific percentages with caution due to low base size.

Figure 6.8.2: What type of delivery the price of Cognitive Behavioural Therapy was based on



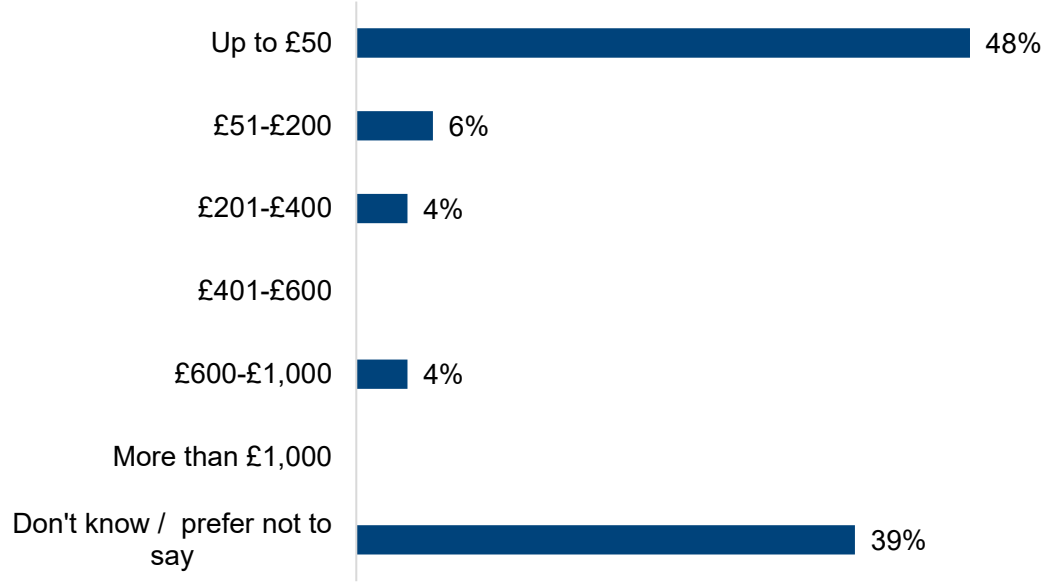
E6a/b. And was this price based on? Base: All that charge for CBT (59). Please treat specific percentages with caution due to low base size.

Employee Assistance Programmes (EAPs)

Employee Assistance Programmes (EAPs) could be considered a separate category to OH services. Although larger private OH providers are more likely to offer EAPs, some EAPs are offered by separate, specialist EAP providers, therefore the findings in this section are not completely reflective of how EAPs are typically offered overall.

Figure 6.9 shows that, amongst OH providers that offer EAPs, these are most commonly charged at up to £50 per person (48%).

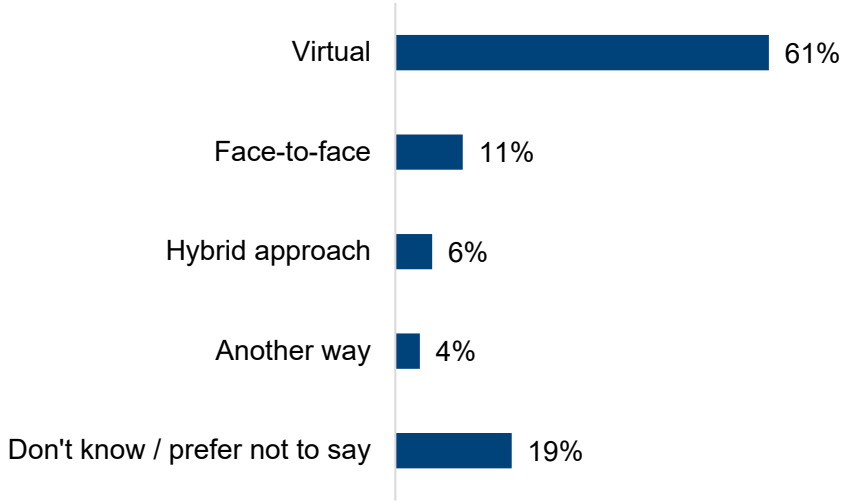
Figure 6.9: Price per person for Employee Assistance Programmes



E9. What price do you charge per head for Employee Assistance Programmes? Base: All that charge for EAPs (54). Please treat specific percentages with caution due to low base size.

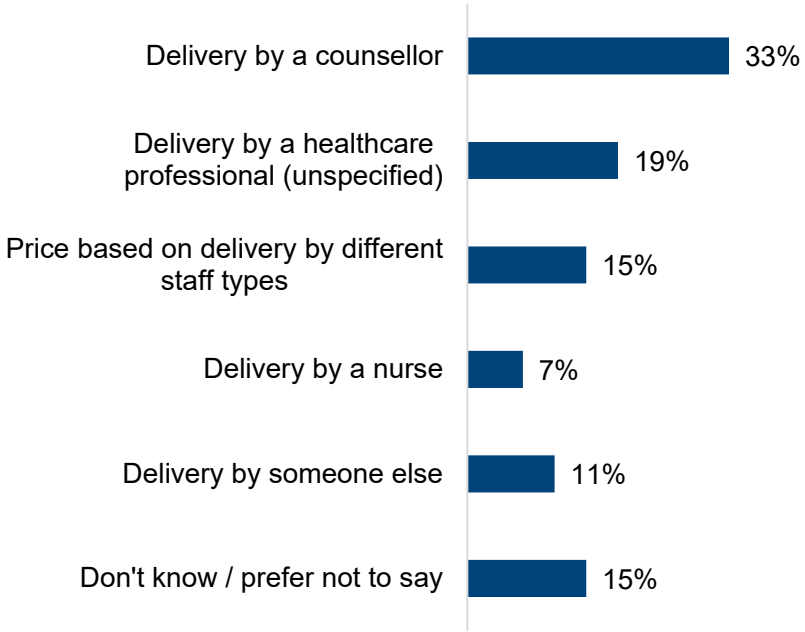
Figure 6.10.1 and Figure 6.10.2 show that pricing for EAPs was most often based on virtual delivery (61%) by various professionals including: counsellors (33%) and other healthcare professionals (19%). Note the relatively small base size for OH providers that offer EAPs, meaning that specific percentages should be treated with caution.

Figure 6.10.1: What type of delivery the price of Employee Assistance Programmes was based on



E9a/b. And was this price based on Base: All that charge for EAPs (54). Please treat specific percentages with caution due to low base size.

Figure 6.10.2: What type of delivery the price of Employee Assistance Programmes was based on



E9a/b. And was this price based on Base: All that charge for EAPs (54). Please treat specific percentages with caution due to low base size.

The base sizes are too small to break these findings down in further detail.

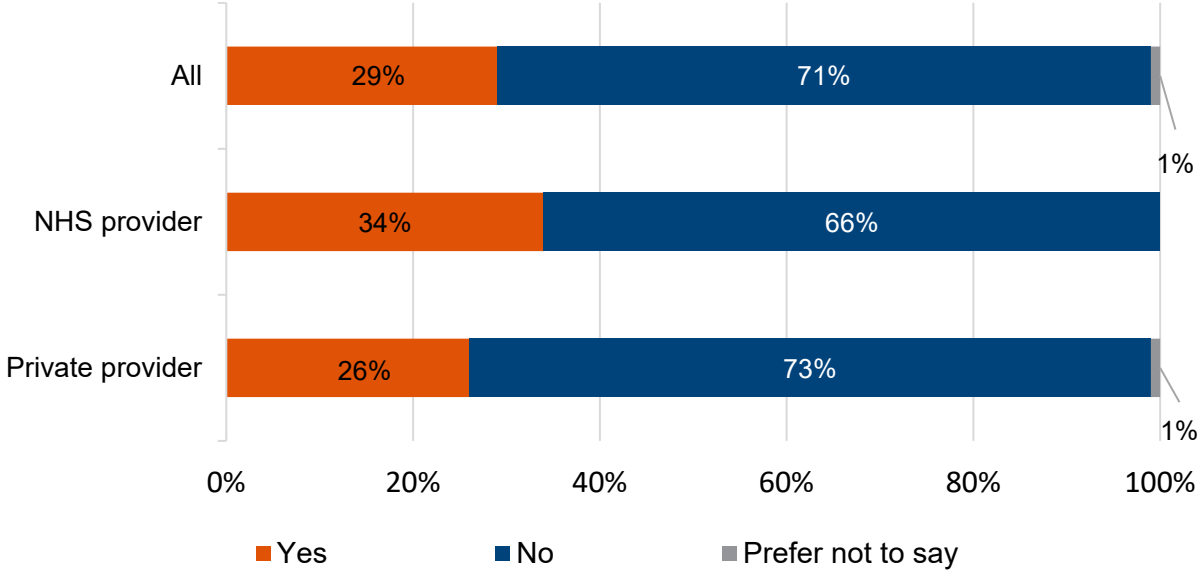
How services are charged

This section covers how providers charged for their services and whether they had any customers that paid them retainers or had annual contracts with them.

Retainers

Providers were asked whether any of their customers paid them a retainer for their services. Three out of ten (29%) providers that charged for their services had customers that paid them a retainer (Figure 6.11).[35]

Figure 6.11: Whether OH providers had customers that paid them retainers



E14. Do any of your customers pay you a retainer for your services? Base: All that charge for their services (156); NHS providers (38); Private providers (102). Note the relatively small base size for NHS providers, meaning specific percentages should be treated with caution.

While there were no significant differences by size in the survey, partly due to small base sizes, the qualitative in-depth interviews found that many smaller providers didn't offer retainers or long-term contracts because the majority of their work is ad hoc.

> *"We're usually an ad hoc service that they might, like I say, have on top of a basic service."*
>
> (Private provider, 1-9 employees, East of England)

The survey found that, amongst providers that had customers paying them a retainer, this retainer would often, but not always, reduce the charges per person for their OH services. Four in ten (42%) said the retainer would reduce the charges per head all or most of the time, a further one in five (18%) said that retainers sometimes reduced the charge per head. However, more than a third (36%) of providers with customers that paid retainers said that this would not reduce the charge per head. Where reduced charges applied, the mean average discount given was 28% and the median was 18%. Note the relatively small base size for OH providers that are paid a retainer (45 providers), meaning that specific percentages should be treated with caution.

[35] A fee paid in advance to someone, to secure their services for use when required.

Only a small number of providers that offered retainers and reduced the price per head were able to say what specific services the reduced prices would apply to. Most commonly they said they would reduce the cost of ongoing health assessments for any employees; management referrals or assessments of fitness for work for ill or sick employees; and the cost of support with health surveillance.

Qualitatively, only two of the OH providers interviewed had customers that paid a retainer, and these providers had differing pricing approaches for their customers paying retainers. One provider said the retainer completely covered the cost of employees accessing certain services and enabled a fee reduction for additional services.

> *"The client pays the cost per employee; for a business of 10 employees those employees would have one visit from the OH advisor onsite to cover all their health screening and surveillance, free services, and any additional service like case management, would get a reduced cost of about 40%."*
>
> (Private provider, Sole Trader, East of England)

The second provider said that the retainer was a management fee worked out on a 'cost per head' basis, but this did not reduce the cost of any of their OH services.

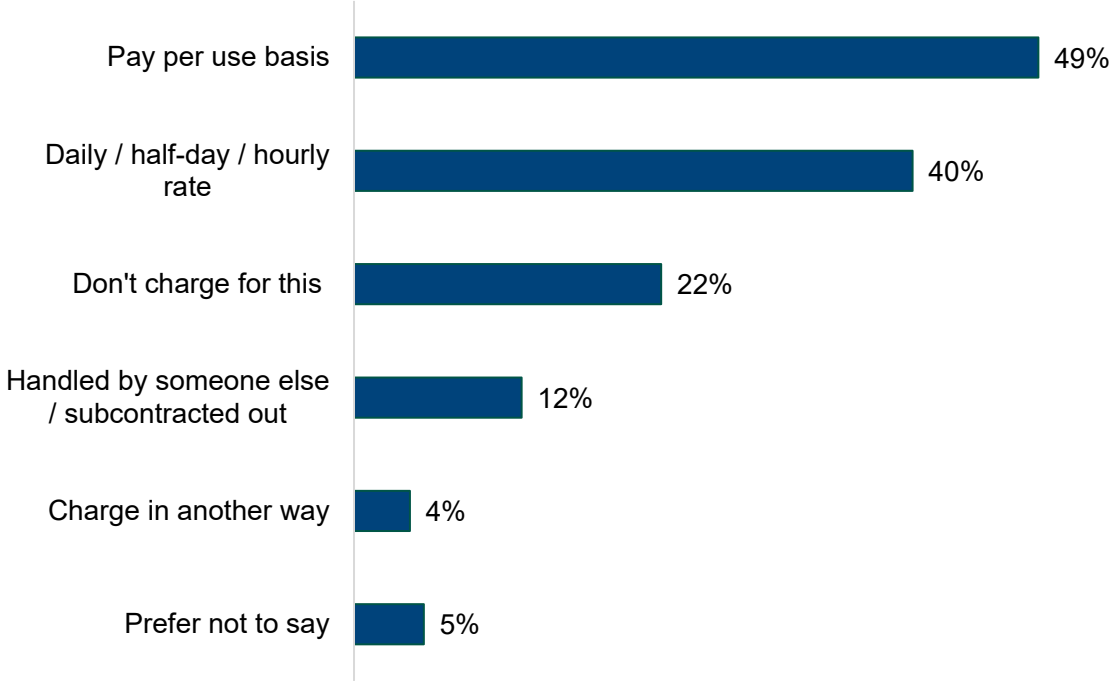
> *"We do have some contracts that require an annual management fee, and that can be worked out on either a per head basis (number of employees and that will reflect a monthly charge or annual charge) or a percentage of projected annual spend."*
>
> (Private provider, Medium sized, North West)

Other ways of charging for Occupational Health services

Pay per use basis

Providers that offered OH physiotherapy services were asked how they made their services available to customers (Figure 6.12). Most commonly this was charged on a pay per use basis (49%), followed by on a day, half-day or hourly rate basis (40%).

Figure 6.12: How providers that offer OH physiotherapy charged their services



E22. Do you make your OH Physiotherapy services available to customers…? Base: All that offer OH physiotherapy (92).

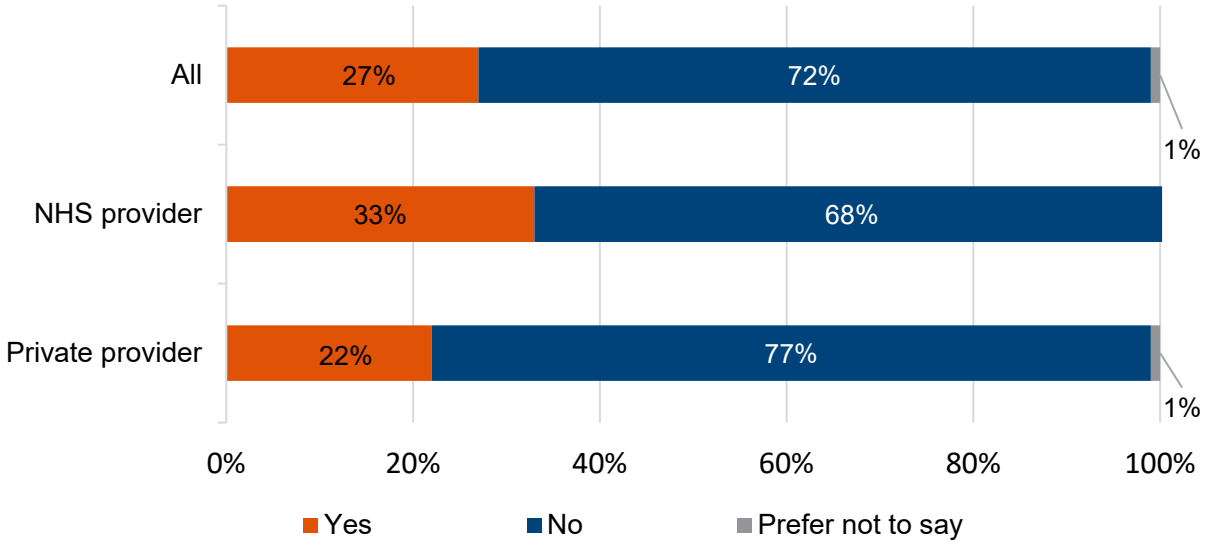
The following results should be treated with caution due to the low base size. Two-thirds (62%) of providers that made their OH physiotherapy services available on a pay-per-use basis charged between £51 and £200 for this, while 11% charged £201-£400.

More than half (55%) of providers that charged for OH physiotherapy at an hourly, half day or day rate, would charge the equivalent of £401-£800 per day for this, while one fifth (19%) would charge between £201 and £400 (based on an 8-hour day).

Annual contracts

Just over a quarter (27%) of providers offer their OH services via annual contracts, without any additional fees being charged when individual clients take up these services, while 72% did charge additional fees. One-third (33%) of NHS providers that charged for their services offered annual contracts without additional fees and 22% of private providers did so (Figure 6.13).

Figure 6.13: Whether OH providers offer services as part of an annual contract

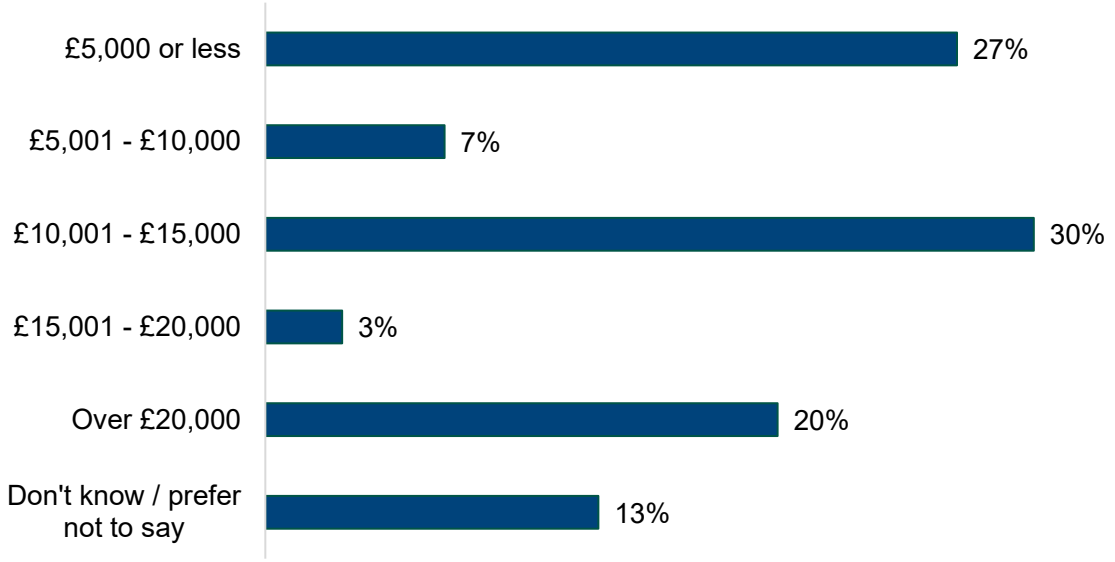


E28. Do you offer any of your OH department's / organisation's services via annual contracts, without any additional fees being charged when individual clients take up these services? Base: All that charge for services (159); NHS providers (40); Private providers (103) Note the relatively small base size for NHS providers, meaning specific percentages should be treated with caution.

OH providers that offered annual contracts were asked how much they would charge employers of different sizes for their services annually. The results can be seen in Figures 6.15 to 6.18. The base size for providers offering annual contracts is relatively small so, in the findings that follow, specific percentages should be treated with caution.

Firstly, for employers with fewer than 250 employees, three in ten (30%) providers would charge between £10,001 and £15,000 per year and 27% would charge £5,000 or less per year (Figure 6.14).

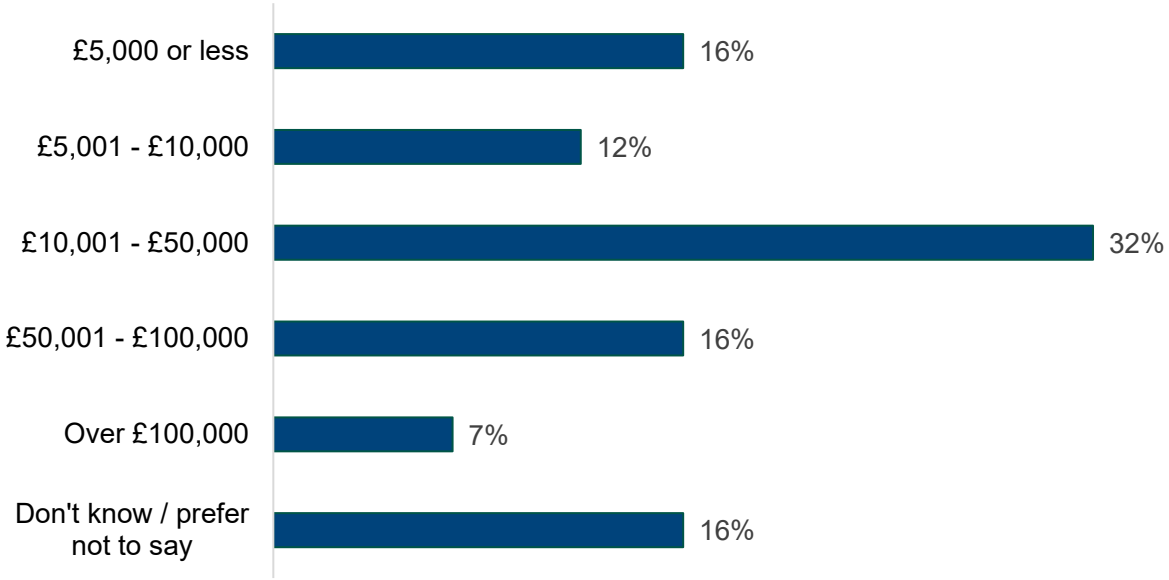
Figure 6.14: How much OH providers would charge an employer with fewer than 250 employees



E29. What sort of price range would you typically charge for an annual contract, for an employer with under 250 employees and an average level of utilisation of your services? Base: All that offer services on annual contracts (43). Please treat specific percentages with caution due to low base size.

Secondly, for employers with between 250 and 1,000 employees, a third (32%) of providers would charge between £10,001 and £50,000 per year and approaching one quarter (23%) would charge £50,001 or more (Figure 6.15).

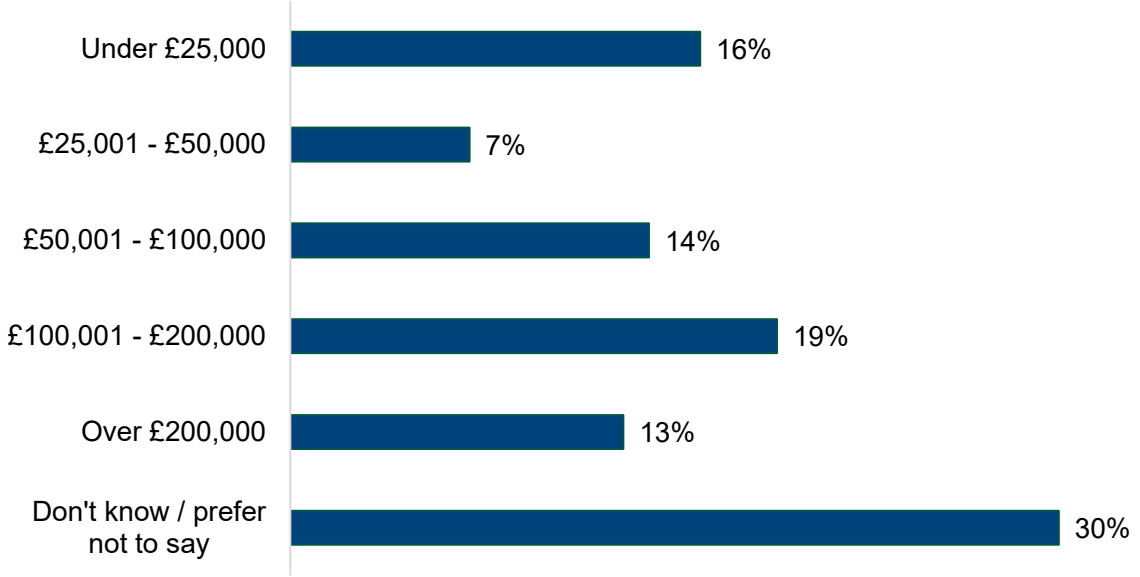
Figure 6.15: How much OH providers would charge an employer with between 250 and 1,000 employees



E30. What sort of price range would you typically charge for an annual contract, for an employer with between 250 and 1,000 employees and an average level of utilisation of your services? Base: All that offer services on annual contracts (43). Please treat specific percentages with caution due to low base size.

Thirdly, for employers with between 1,001 and 5,000 employees, one in five (19%) providers would charge between £100,001 and £200,000 per year, however three in ten (30%) were unable to say how much they would charge employers of this size, suggesting that many providers were unused to dealing with larger employers or that the larger the employer got, the more complex the pricing became (Figure 6.16).

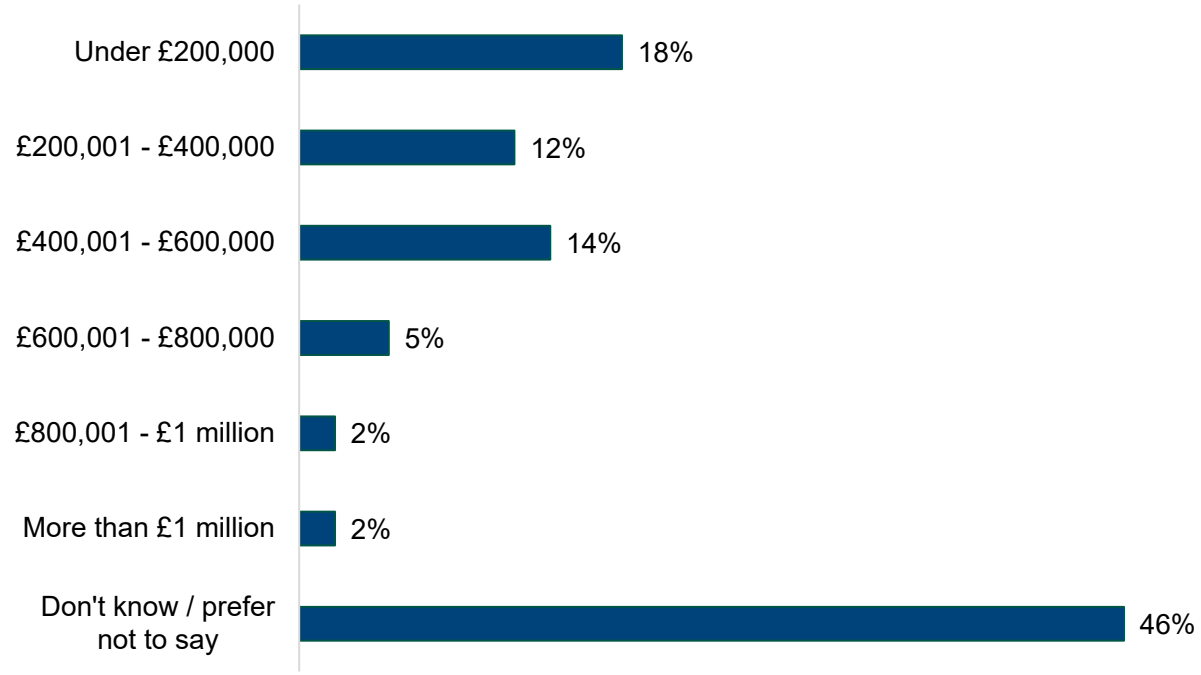
Figure 6.16: How much OH providers would charge an employer with between 1,001 and 5,000 employees



E31. What sort of price range would you typically charge for an annual contract, for an employer with between 1,001 and 5,000 employees and an average level of utilisation of your services? Base: All that offer services on annual contracts (43). Please treat specific percentages with caution due to low base size.

Finally, for employers with more than 5,000 employees, approaching a half (46%) could not say how much they would charge and approaching one in five (18%) said that they would charge less than £200,000 (Figure 6.17).

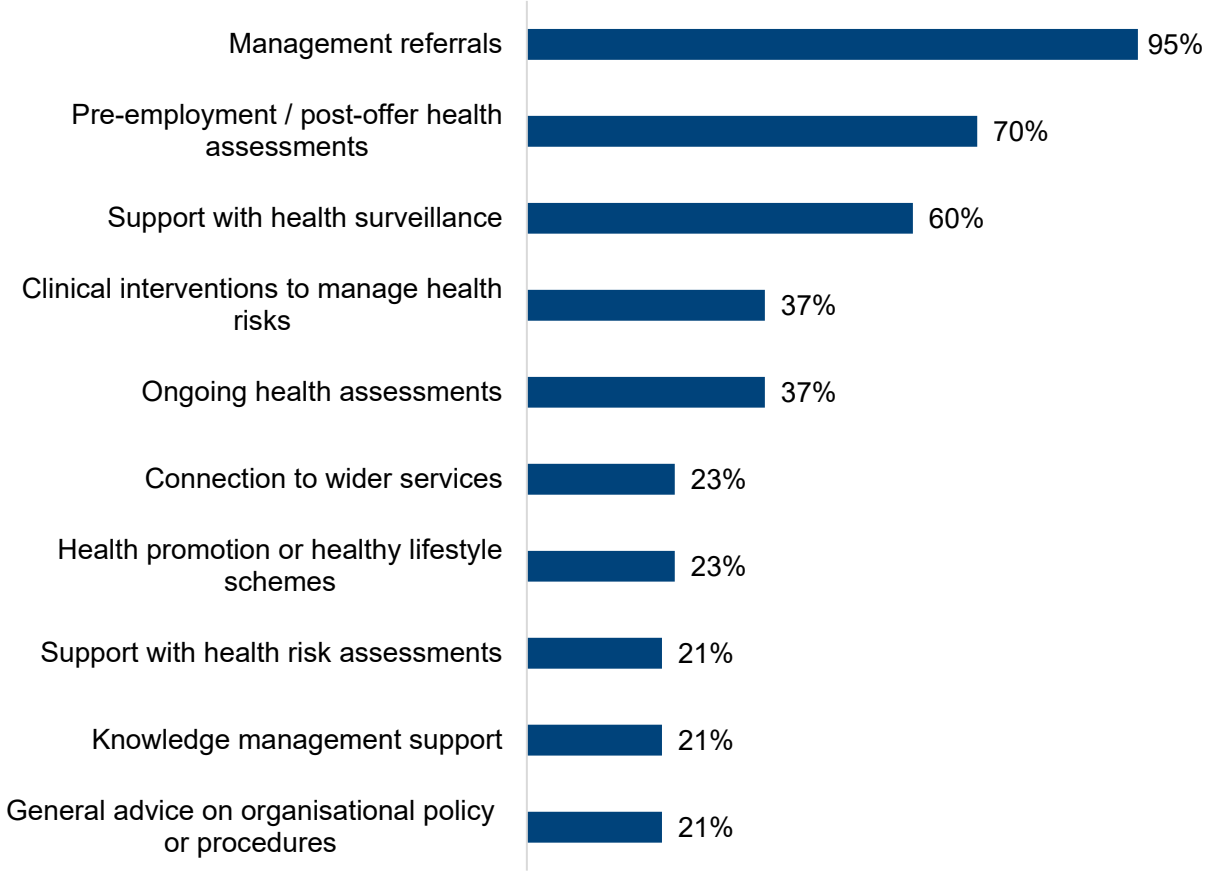
Figure 6.17: How much OH providers would charge an employer with more than 5,000 employees



E32. What sort of price range would you typically charge for an annual contract, for an employer with over 5,000 employees and an average level of utilisation of your services? Base: All that offer services on annual contracts (43). Please treat specific percentages with caution due to low base size.

OH providers that offered annual contracts were asked which of their OH services were most commonly included as part of these long-term contracts, without additional fees being chargeable. Providers almost always included, without additional fees, management referrals (95% included this). Seven in ten (70%) included pre-employment health assessments and six in ten (60%) included support with health surveillance (Figure 6.18).

Figure 6.18: Services included as part of contracts without additional fees being chargeable



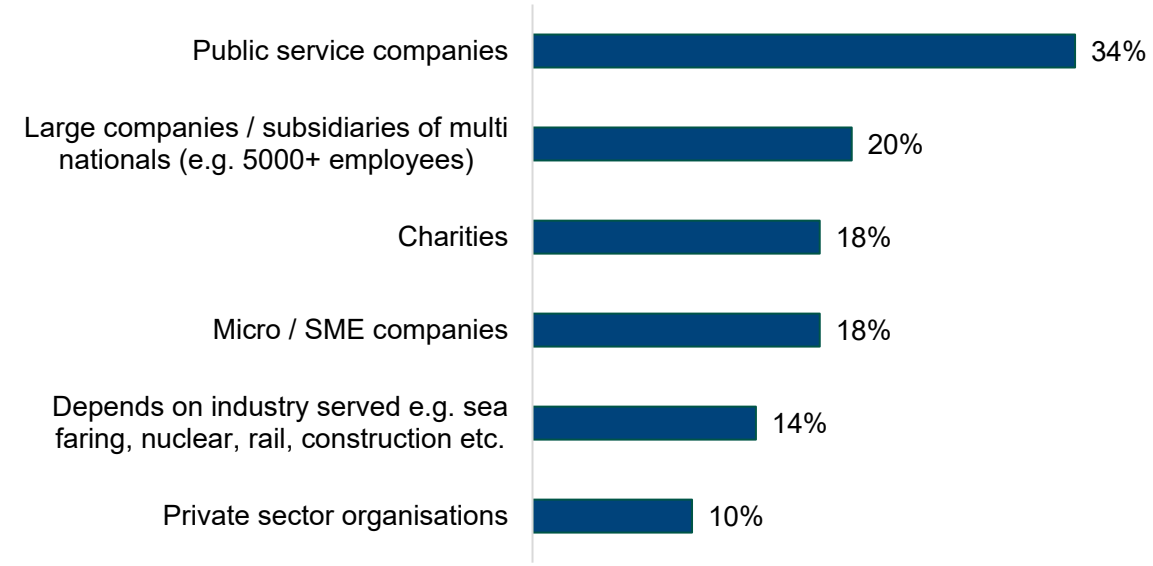
E33. Which of your services are most commonly included as part of these long-term contracts, without additional fees being chargeable? Base: All that offer services on annual contracts (43). Please treat specific percentages with caution due to low base size. Figure 6.18 includes only those responses mentioned by 20% or more.

Price tailoring

OH providers who charged for their services were asked whether they tailor their prices to specific groups or types of customers (for example, by industry or size of the company). Two-thirds (67%) did not tailor their prices to specific groups or types of customers; and nearly a third (31%) did. A quarter (25%) of NHS providers that charged for their services tailored their pricing and 35% of private providers did so.

A third (34%) of providers that did tailor their prices said that they tailored their prices to public services, including educational bodies (Figure 6.19). Size of customer was also a recurring theme, with one in five (20%) varying their prices for large companies or subsidiaries of multinationals and a similar proportion (18%) varying their prices for micro or SME employers. One in five also factored a customer's charitable status into their pricing (18%).

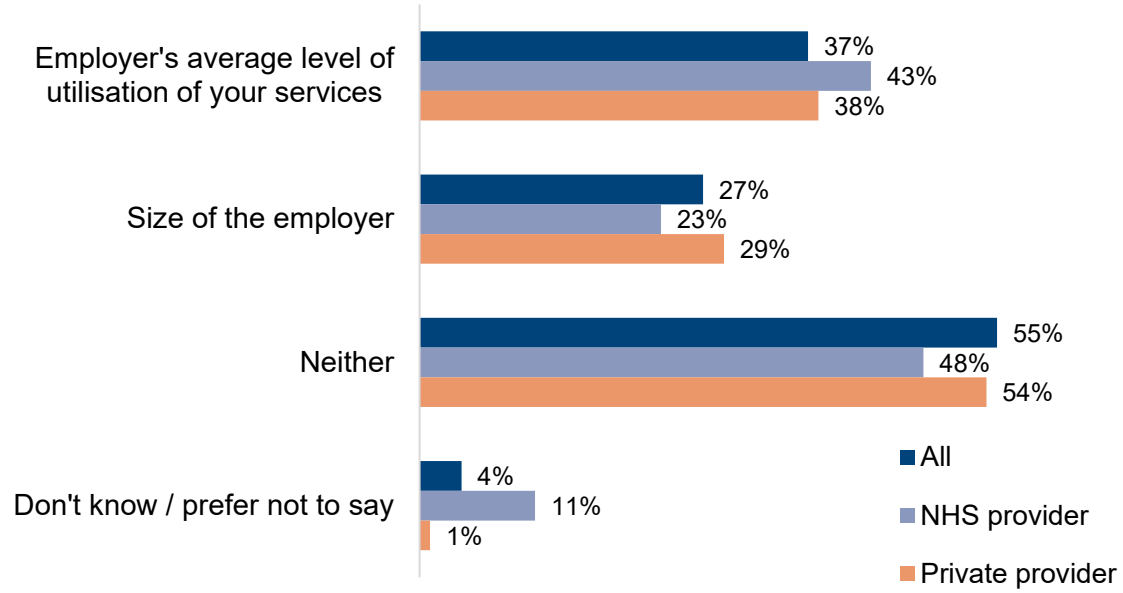
Figure 6.19: Groups or types of customers that prices for OH services are tailored to



E35. Which groups or types of customers did you tailor prices to? Base: All that tailor their prices (50). Please treat specific percentages with caution due to low base size.

All providers that charge for their services were also asked whether the price they charge varies according to either the size of the employer or the employer's average level of utilisation of their services. As Figure 6.20 shows, 37% said that they considered the employer's average level of utilisation of their services and 27% said that they considered the size of the employer.

Figure 6.20: Whether prices for OH services vary based on level of utilisation or employer size



E37 Just to check, does the price you charge for your services, vary according to...? Base: All that charge for their services (159); NHS providers (40); Private providers (103). Note the relatively small base size for NHS providers, meaning specific percentages should be treated with caution.

The qualitative findings echoed the quantitative survey, suggesting that OH providers generally did not tailor their prices to customers and that a set rate was generally applied.

> *"We don't change the structure of their pricing. It's been kind of set for many years, and we tend to put them up every twelve months…between three and five percent every year."*
>
> (Private provider, 10-49 employees, Yorkshire and the Humber)
>
> *"Generally speaking, we have whatever the cost price is of a service, and we will then apply a markup of around 40% to 45%."*
>
> (Private provider, 10-49 employees, North West England)

There was, however, a suggestion by smaller providers that they had more flexibility than larger providers to tailor prices on a case-by-case basis.

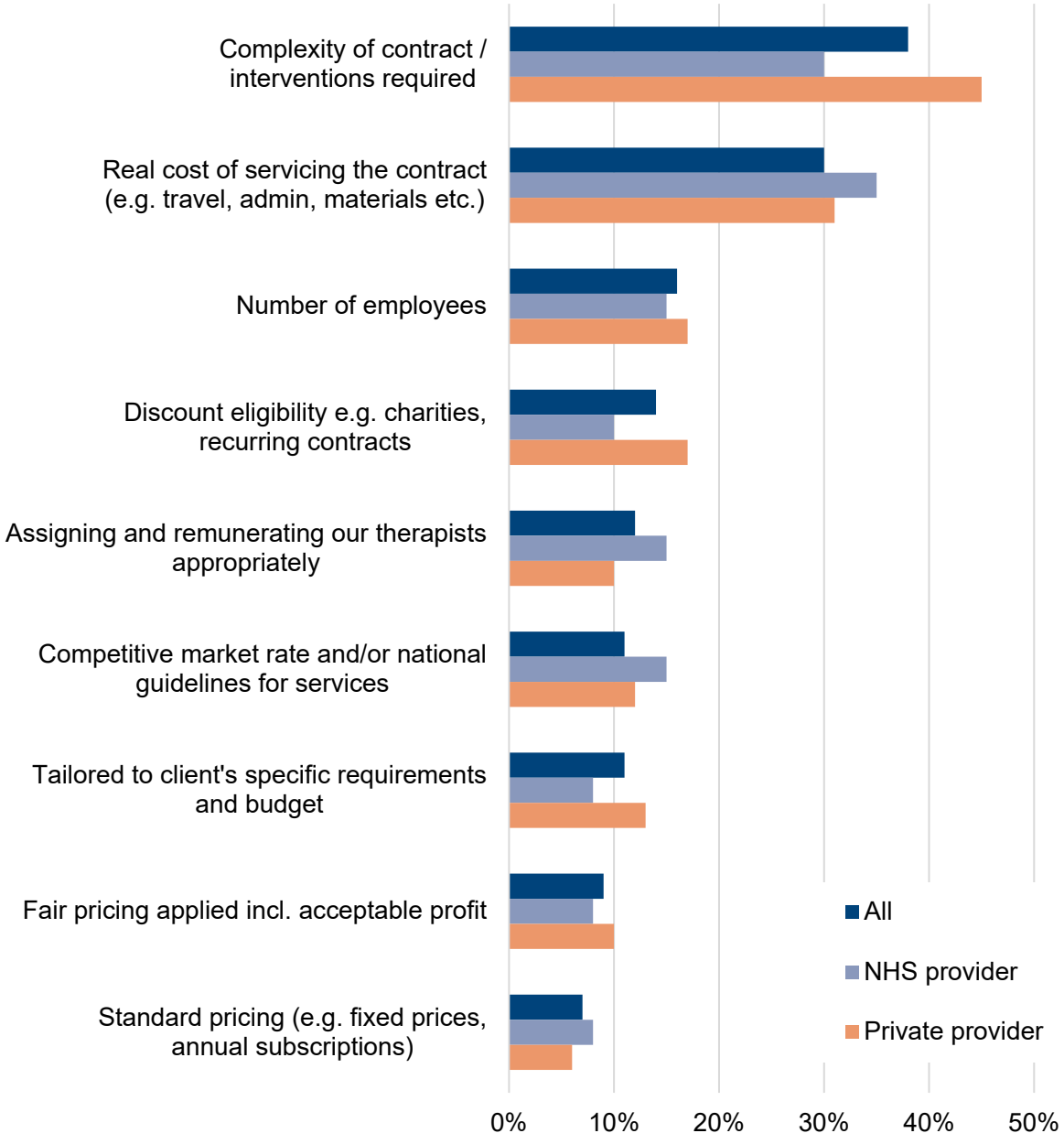
> *"I think it's market research really… so it's seeing what other companies would offer and then seeing how much we can adapt to bring that cost down slightly, and because we're so much smaller it does mean that we have more flexibility there."*
>
> (Private provider, 1-9 employees, East of England)

Price setting strategies

OH providers were also asked what other factors they considered when deciding their prices for specific customers. Responses were not prompted by a list.

Approaching four in ten (38%) considered the complexity of the contract or the interventions required and three in ten (30%) considered the real cost of servicing the contract. Sixteen per cent said that they considered the number of employees the customer employed (Figure 6.21 and Table A.9 in Annex).

Figure 6.21: Factors considered when considering pricing for specific customers



E36. When deciding the exact prices charged for services, for specific customers, what other factors do you consider? Base: All that charge for their services (159); NHS providers (40); Private providers (103). Note the relatively small base size for NHS providers, meaning specific percentages should be treated with caution. Figure 6.21 includes only those responses mentioned by 5% or more.

Private providers were more likely than average to consider the complexity of the contract or the interventions required when considering pricing (45% compared to 38% of all providers).

In the qualitative in-depth interviews, providers were asked what factors they considered when pricing their services. Providers emphasised getting the balance

right between providing attractive prices without devaluing their OH services. Many commented it was important not to be the cheapest, as they felt cost was closely linked to perceived quality.

> *“We believe that you shouldn't be the cheapest because then you're not valued, but we also have to be able to justify the fee.”*
>
> (Private provider, 1-9 employees, East of England)

The remaining considerations have been grouped into external factors, relating to the market for OH services, and internal considerations regarding delivery of the services by the provider.

External factors

The external factor that most commonly shaped the pricing of OH services was competitor prices. Most providers that took part in the in-depth interviews said that they factored this into their pricing.

> *“We do keep a bit of an eye on our competitors.”*
>
> (Private provider, 10-49 employees, Yorkshire and the Humber)
>
> *“We did a price comparison around 10 years ago, and we sat in middle of the market, where we are happy to stay. We haven’t increased our prices significantly since I started.”*
>
> (Private provider, 1-9 employees, East of England)

Some providers mentioned that prices were reviewed and increased annually, factoring in factors such as profit margins and inflation.

> *“We review prices yearly and adjust based on profit margins, client feedback and competitor analysis.”*
>
> (Private provider, 1-9 employees, South East)

Some providers factored the type of customer organisation into their pricing. For example, a few mentioned that they gave discounts to charities and not-for-profit organisations, while others said that smaller businesses would receive lower rates.

> *“Small businesses and charities get a discount because of the volatile nature of their business, whereas profitable medium and large businesses get charged more.”*
>
> (Private provider, 1-9 employees, Scotland)

Alternatively, a few OH providers said that some larger companies received lower rates due to economies of scale and a reduction in travel costs.

> *“There's a slight differentiation…[for] our large customers [we can offer a 10-15% discount], …compared to those with very small [numbers of employees], because we can offer some economies of scale.”*
>
> (Private provider, 1-9 employees, East of England)

“For individuals coming into the clinic there is a set price, but for companies it’s a lot cheaper if a nurse goes out and does a full day at the hiring company, …it cuts out the travelling time for the employee.”

(Private provider, 1-9 employees, North East England)

The likely complexity of a contract was also considered when determining prices. Providers would consider the length and frequency of delivery of each service as well the number of appointments needed or requested for each intervention.

“We'd ask the client what health surveillance services they require and how many employees would require it, and then we would calculate how many employees we'd be able to carry out the health surveillance on in a given standard day. Which is then multiplied by the day rate.”

(Private provider, 1-9 employees, North West)

A few OH providers factored in the customer’s prior engagement with and awareness of OH when considering pricing. Providers said that this had an impact on their administrative costs.

"If the client is a small startup that properly understands their internal OH needs, then…they've already done the preplacement and baseline questionnaires themselves and I don't need to charge them for that."

(Private provider, Sole-trader, Wales)

Internal factors

The level and expense of staff likely to be needed to deliver the services, as well as costs of participating in procurement exercises to secure the work, were the internal factors most commonly mentioned by providers in the qualitative interviews. Providers would consider who would be delivering the services and how much each professional would cost on an hourly or daily rate and would factor this into their pricing.

“Prices will be affected by the procedure sought, whether it’s a nurse or doctor delivering the support, the equipment required, and how complicated the procedure is.”

(Private provider, 50+ employees, London)

“Particular services, like a physiotherapist, are priced…by time, so it’ll take that physio an hour to do an assessment, …it’s all down to each profession’s time, that the price is set.”

(Private provider, 1-9 employees, North East England)

Strategic business decisions were considered by a few providers, for example, some mentioned the importance of generating enough profit to enable to them to grow as an organisation.

“It's important to us that we have enough to re-invest in the business, to continue to keep growing.”

(Private provider, 1-9 employees, East of England)

A few providers considered the social value of taking on certain customers. For example, considering the type of company they would be working with, offering reduced rates to SMEs or self-employed individuals because they were perceived to be less able to afford OH services.

> *“I am very, very aware of the dire situation that small companies can be in, in terms of getting proper OH and expert OH services in, so I would tend to charge less, particularly organisations where there are substantial hazards, so people working with asbestos, working with lead…because those businesses are on the verge of bankruptcy.”*
>
> (Private provider, 1-9 employees, Scotland)
>
> *"I'll really knock the price down if someone phones as [an] individual who is paying for themselves…I'll do it at cost or at a loss and that's a personal decision I make as a director.”*
>
> (Private provider, 1-9 employees, South East)

Some providers had clients on a membership scheme or paying them a retainer, which would be considered when setting pricing. Another provider offered regular customers and new customers discounts to help with customer retention.

> *“The organisation offers membership rates and yearly subscription rates. Those on contract will receive free services or will be offered a reduced rate on some services.”*
>
> (Private provider, Sole-trader, East of England)
>
> *“We offer a ‘loss lead’ where we offer a discount once, and then the price increases incrementally.”*
>
> (Private provider, 1-9 employees, North East England)

Summary

Most specific OH services asked about tended to be charged at £51-£200 per person, per use. Pricing is most often shaped by the complexity of the services required and the costs of delivery; though three in ten tailor their prices to specific groups or types of customers. Providers also sought to balance attractive prices against not devaluing their services.

7 SMEs and self-employed as customers

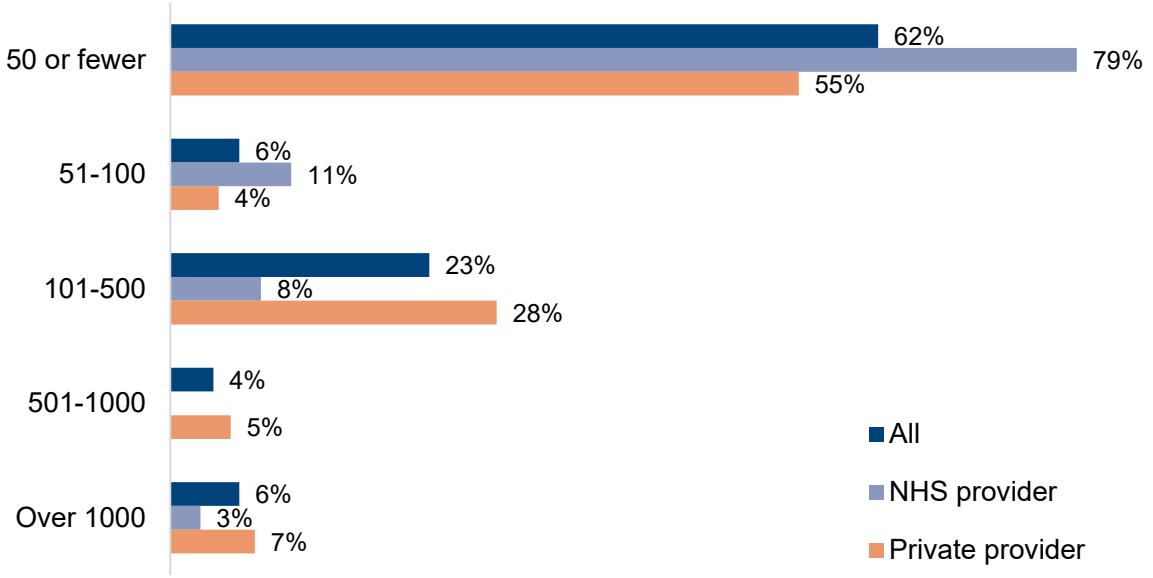
This chapter discusses the engagement of NHS and private OH providers with Small and Medium Enterprises (SMEs) and the self-employed as customers; and their attitudes towards working with these groups as customers. Findings are drawn from both the survey of OH providers and the in-depth qualitative interviews.

Engagement with SMEs as customers

To explore OH providers' engagement with SMEs, providers were first asked how many customers they had been commissioned by in the past 12 months; and then asked what percentage of these customers were SMEs.

Two thirds of NHS and private providers (62%) were commissioned by 50 or fewer customers over the past 12 months with the median number of customers being 30 (Figure 7.1). On average, private providers were commissioned by more customers in the past 12 months than NHS providers: a median of 45 customers compared with 13 customers for NHS providers (this is likely to be because NHS providers will primarily be servicing one large NHS Trust).

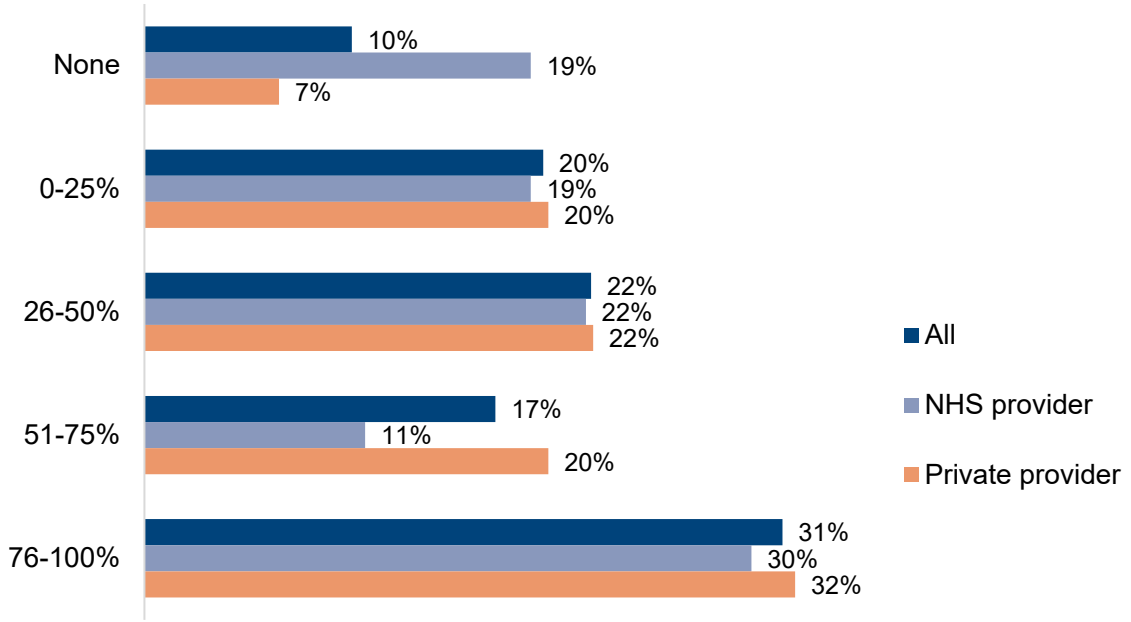
Figure 7.1: Number of customers OH providers have been commissioned to provide OH services to in the past 12 months



D1. In the past 12 months, what number of customers have you been commissioned to provide Occupational Health services or interventions to (whether they were taken up or not)? Base: All respondents except in-house providers (133): NHS providers (38), Private providers (95). Note the relatively small base size for NHS providers, meaning specific percentages should be treated with caution.

On average, half the customer base for NHS and private providers was made up of SMEs (an average of 50% overall, 50% for NHS providers and 60% for private providers)[36] (Figure 7.2). Given that 99.8% of UK businesses are SMEs[37], SMEs continue to be significantly under-represented in the OH provider customer base.

Figure 7.2: Percentage of OH providers' customer base made up of SMEs in the past 12 months



D2. Roughly what percentage of these customers were Small and Medium Enterprises (SMEs)? Base: All respondents except in-house providers (128): NHS providers (37), Private providers (91). Note the relatively small base size for NHS providers, meaning specific percentages should be treated with caution.

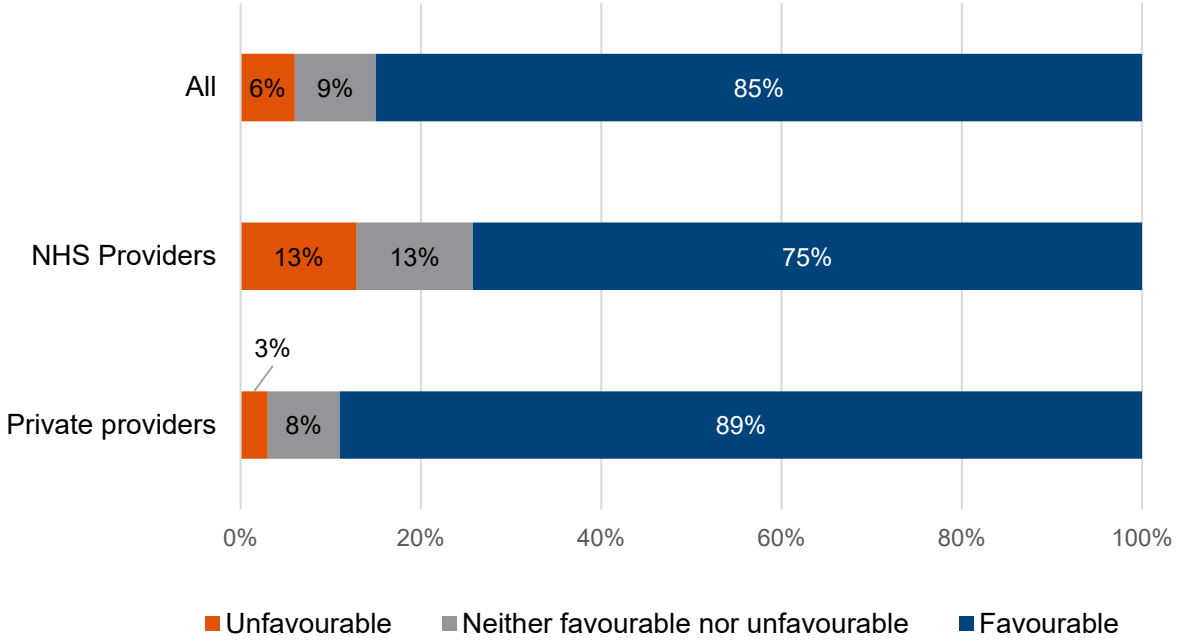
NHS providers were more likely to have had no SME customers in the past 12 months: 19% compared with 7% of private providers. There were no significant differences by provider size or by the country in Great Britain in which the OH provider is based or headquartered.

Attitudes towards SMEs as customers

Most NHS and private providers reported positive attitudes towards working with SMEs as customers. When asked how favourable or unfavourable their OH department or organisation was to working with SMEs, nearly nine in ten (85%) reported being favourable (Figure 7.3). Private providers were more likely to say they were 'extremely favourable' (62% compared with 30% of NHS providers).

[36] This is a median average, to avoid the average figures being distorted by a small number of outlying very high values.
[37] Business population estimates for the UK and regions 2024

Figure 7.3: Favourability among OH providers towards working with SMEs as customers



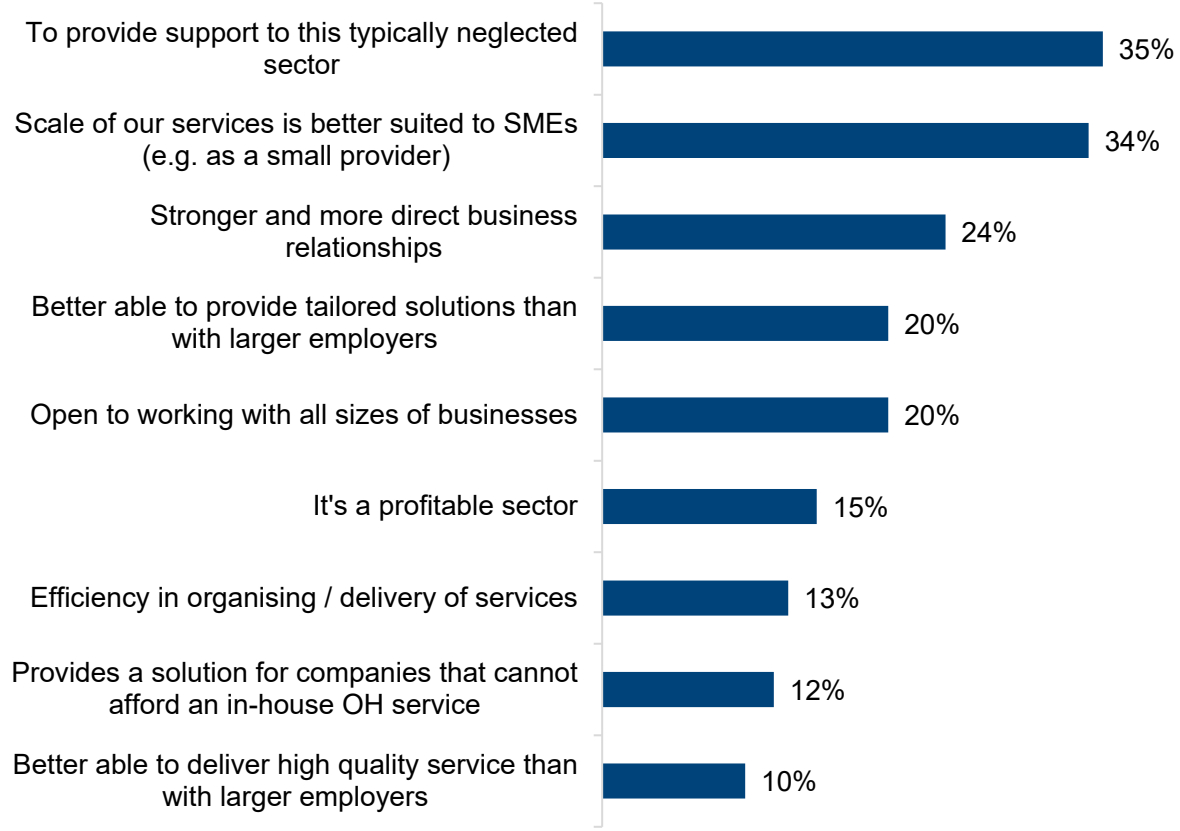
D4. On balance, what is your OH department's / organisation's attitude to working with Small and Medium Enterprises (SMEs) as customers? All respondents except in-house providers (143): NHS providers (40), Private providers (103). Note the relatively small base size for NHS providers, meaning specific percentages should be treated with caution.

Benefits and drivers of working with SMEs

In the survey, NHS and private providers who were favourable towards working with SMEs were asked why this was the case (Figure 7.4). The main reasons given for being favourable towards working with SMEs as customers were:

- To provide support to a typically neglected sector (35%). NHS providers were most likely to give this as a reason: 53% compared with 29% of private providers.
- The scale of OH providers' services was better suited to SMEs (34%). This reason was more commonly given by private providers: 43% compared with 7% of NHS providers.
- There were stronger and more direct business relationships with SMEs (24%). Again, this was more likely to be cited by private providers: 30% compared with 3% of NHS providers.
- OH providers could better provide tailored solutions to SMEs than larger organisations (20%). Private providers more commonly gave this answer: 26% compared to 3% of NHS providers.
- Open to working with businesses of all sizes (20%).

Figure 7.4: Reasons for favourability among OH providers towards SMEs as customers



D5. Why is your OH department's / organisation's attitude towards working with SMEs as customers favourable? All NHS and private providers who were favourable towards working with SMEs (122). Figure 7.4 includes only those responses mentioned by 10% or more.

Similar benefits of working with SMEs as customers emerged in the in-depth interviews, particularly the ability to form stronger relationships; and being able to make an impact on the customer's organisation, as providers felt SMEs were more willing to learn than larger organisations:

> *"The people we tend to be dealing with [with SME customers] are much more invested in the company and it's sometimes easier to build up a rapport with a smaller company than a larger one."*
>
> (Private provider, 10-49 employees, North West)

> *"We can meet their needs; we prefer to work with small organisations, and we have a close relationship with lots of them."*
>
> (Private provider, 50+ employees, London)

> *"Smaller organisations tend to be more willing to be flexible, I can build rapport with them which means we end up working together so well…They're…open to learning much more, which leads to less referrals."*

(Private provider, 1-9 employees, South East England)

"They can't afford the big expense of Occupational Health things. But if you show them that actually some of the pain relates to the things they're doing… the management will want to do something about it and that will then get rid of the symptom and the root cause."

(Private provider, 1-9 employees, South East England)

Some OH providers felt that SMEs were more caring about their employees and therefore sought more individualised OH interventions, in comparison to large organisations who were often after assessment packages at scale.

One provider felt there was a social value in doing work with SMEs, by ensuring that the benefits of OH were spread more widely.

"It's evidence that we look after everybody – as many people as possible – and we're not just going after the money."

(Private provider, 50+ employees, Yorkshire and Humber)

The theme of strength of relationships with SMEs also emerged in a commercial sense; with OH providers noting that relationships with SME customers would often lead to repeat work without having to engage in the formal tender processes often required by larger customers. Providers also noted that maintaining relationships with individuals within the customer organisation could lead to new customer relationships, when the individual point of contact moved from one organisation to another.

In addition, some OH providers felt it was less risky to have a range of SMEs clients as opposed to relying on a smaller number of large contracts.

"We're not dependant on one client; we can lose a client and not particularly feel it."

(Private provider, 1-9 employees, East of England)

"Having smaller clients, means you can have more of them and you don't have all your eggs in one basket."

(Private provider, 1-9 employees, Yorkshire and the Humber)

One provider commented that historically the bigger OH providers had not targeted SMEs and therefore it was a less competitive market.

Barriers to working with SMEs

Whilst providers were favourable to working with SMEs, some challenges were raised in the in-depth interviews, with the main challenge being financial. It was felt SMEs had limited budgets and therefore providing services could be less profitable. Providers also commented that SMEs' payment processes are more complex than those of larger organisations, which caused delays with payments.

“It's difficult, sometimes, to get them [SMEs] to understand the need to spend money, especially new clients."

(Private provider, 1-9 employees, South East England)

"Trying to make sure you get paid is always a challenge."

(Private provider, 1-9 employees, East of England

Providers also commented that there was a lack of awareness amongst SMEs of the benefits of OH, which was barrier to SMEs engaging with OH provision. Two providers noted that this could be linked to previous negative experiences with other OH providers.

“They feel like they're referring to OH only because they have to. We need to change that perception and customer experience so that smaller businesses engage with Occupational Health properly."

(Private provider, 1-9 employees, South East England)

Attitudes towards the self-employed as customers

The in-depth interviews explored providers’ views on working with the self-employed as customers. OH providers were willing to work with the self-employed but there was a lack of demand and most providers did not work with self-employed customers.

Barriers to working with the self-employed

Some providers commented that they felt the lack of demand was due to a lack of legal requirement for the self-employed to use OH services.

"If someone needs help, we’d support them, there's just no demand. Legal responsibilities increase when you employ someone – there’s liability."

(Private provider, 1-9 employees, South East England)

Providers also commented on the financial limitations of the self-employed and thought the self-employed were less likely to be able to afford OH services.

“They can't afford it; they don't come before being ill, only when they're already unwell so at that point they're not earning or not earning as much as before...Having to pay for OH support is then yet another burden for them. There's no one else to pay for them."

(Private provider, 1-9 employees, South East England)

One provider commented that self-employed people were more likely to go and see a GP or get one-off treatment as opposed to engaging with OH providers.

For the few providers who did not *want* to work with the self-employed, the main reasons given were linked to finances. Two providers had worked with self-employed customers previously and had concerns about them not attending appointments and not paying for the service.

> *“The effort involved in setting up medicals for one person is far outweighed by the cost you get.”*
>
> (Private provider, 1-9 employees, Scotland)

> *“Sometimes individuals don’t turn up, so the business secures a 50% deposit from self-employed clients, but the business can still lose money if the doctor and nurse are waiting for an appointment and the client doesn’t turn up, so you are out of pocket.”*
>
> (Private provider, 10-49 employees, North East)

Benefits of working with the self-employed

As with SMEs, providers were positive about the relationship they could build with self-employed customers. Providers felt better able to facilitate an open and honest relationship because there was no third party, such as line manager or an employer, to oversee what was being shared by the patient. This meant that the provider could better assess the patient and cover areas of need that may not have otherwise been identified.

> *"You're not negotiating with employers, it's just about the person and asking them 'what do you want?' so that they can voice that to me directly."*
>
> (Private provider, 1-9 employees, South East England)

Summary

Despite positive provider attitudes, SMEs continue to be significantly under-represented in the customer base. Most providers are favourable towards working with SMEs because they want to serve a neglected sector and feel the scale of their services is better suited to SMEs. Providers also tend to be open to working with the self-employed as customers, liking the absence of a line manager or employer as an intermediary between the provider and patient – but in practice they report a lack of demand.

8 Data collection, knowledge sharing and innovation

This chapter discusses the extent to which Occupational Health (OH) providers collect data for central analysis; and the types of data collected, distinguishing between customer and patient data collection. It also explores providers' engagement with and attitudes towards knowledge development and innovation, including engagement with the Department for Work and Pensions (DWP) and Department for Health and Social Care (DHSC) innovation fund. Findings are drawn from the survey of OH providers only; these topics were not covered in the qualitative in-depth interviews.

Data collection for central analysis was defined as follows, in the survey:

> *Data collected from your own staff, your customers or individual clients you work with, that has potential to be aggregated centrally. We don't mean data collected from individual clients or customers that is only used when working with that client / customer.*

When discussing innovation, providers were responding to the following definition:

> *By innovating, we mean investment in new or improved services, delivery methods or technologies that benefit people's health, wellbeing and capacity to work. Some of this work might be termed 'Research and Development'.*

The DWP and DHSC innovation fund was described as follows:

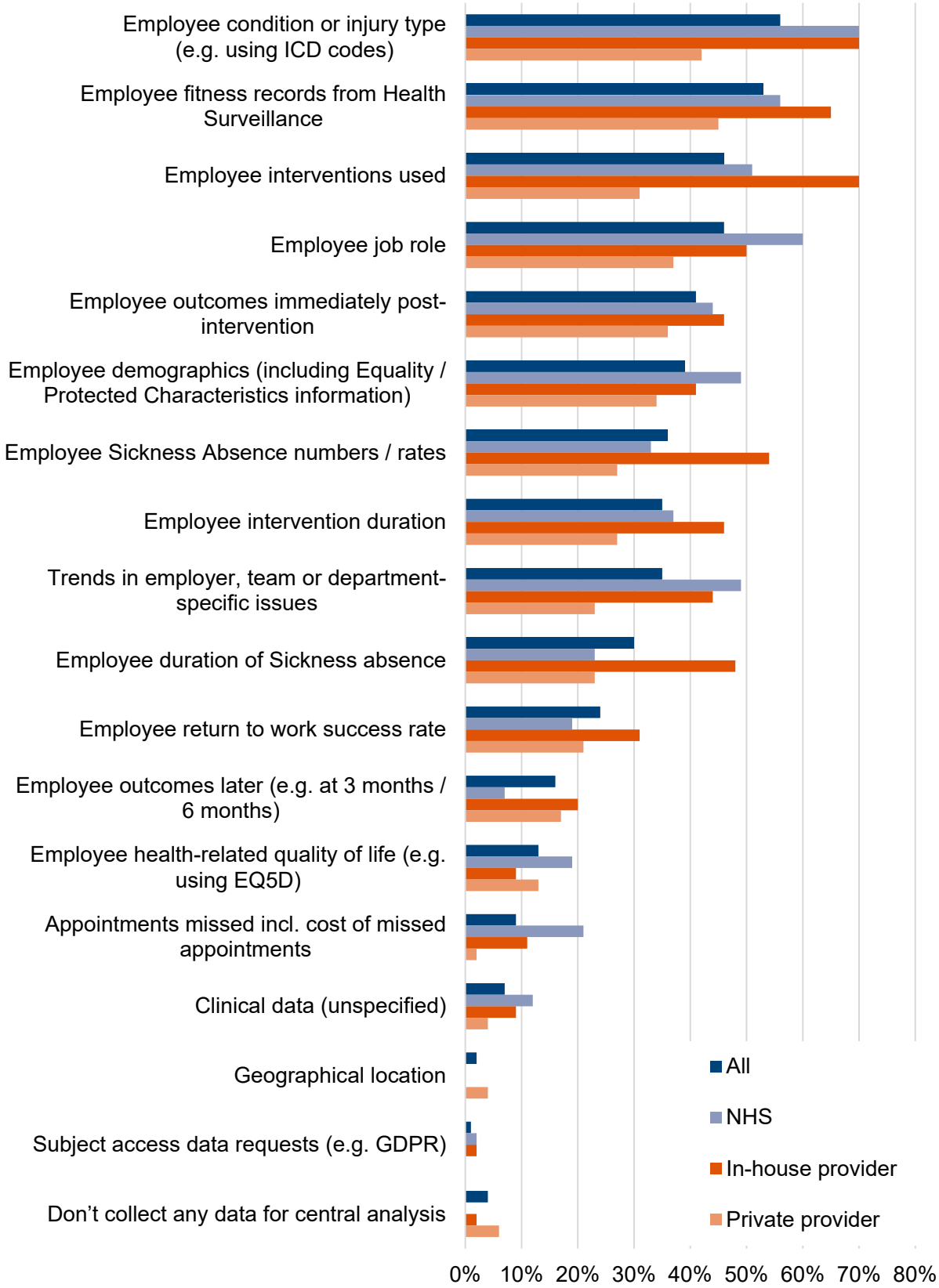
> *A £1 million fund for new ideas to boost health and welfare at work for Small and Medium Enterprises (SMEs) and the self-employed, launched by the Department for Work and Pensions (DWP) and the Department of Health and Social Care (DHSC).*

Types of data collected

Providers were asked, unprompted, what data they collected for their own central analysis. Almost all providers (96%) collected at least some data for central analysis. Data collection has been split by patient data (Figure 8.1 and Table A.10 in Annex) and internal data (Figure 8.2).

A wide range of patient data was collected by OH providers for central analysis (Figure 8.1). Most commonly providers collected data on employee conditions or injuries (56%), followed by employee fitness records from health surveillance (53%) and the interventions used on employees (46%).

Figure 8.1: Types of patient data collected by OH providers



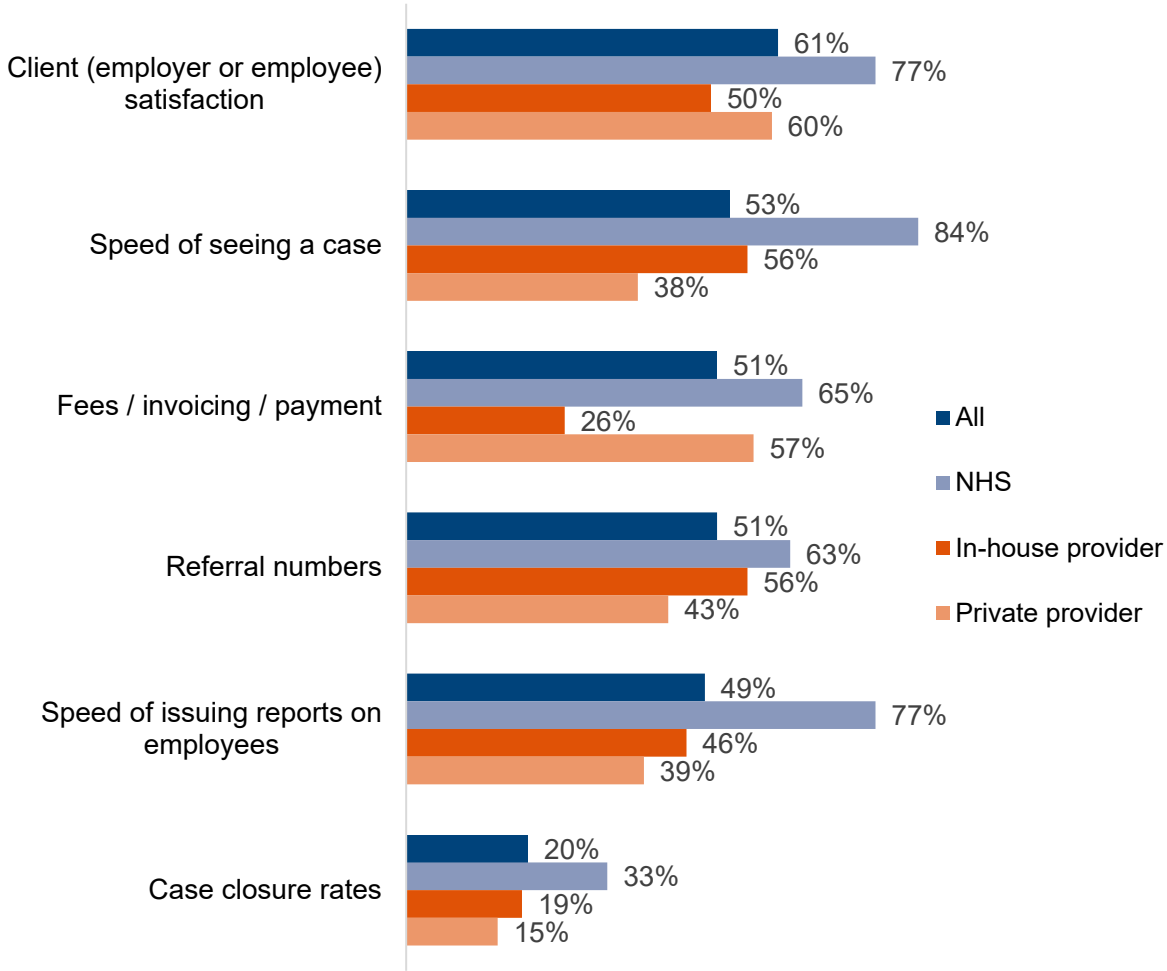
F1. What specific types of data does your OH department / organisation collect about its services, for analysis centrally? Base: All (200); NHS providers (43) In-house providers (54); Private providers (103). Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages should be treated with caution.

Private providers were less likely to collect most types of patient data for analysis centrally, for example:

- Seven in ten NHS providers (70%) and in-house providers (70%) collected data on employee condition or injury type, compared with 42% of private providers.
- Around six in ten NHS providers (56%) and in-house providers (65%) collected data on employee fitness records, compared with 45% of private providers.
- Half of NHS providers (51%) and seven in ten in-house providers (70%) collected data on employee interventions used, compared with 31% of private providers.

As well as patient data, providers also collected internal data for central analysis, the most common of these was client satisfaction (61%), followed by speed of seeing a case (53%), then fees, invoicing or payment information; and referral numbers, both collected by around a half of providers (51%) (Figure 8.2).

Figure 8.2: Types of internal data collected by OH providers



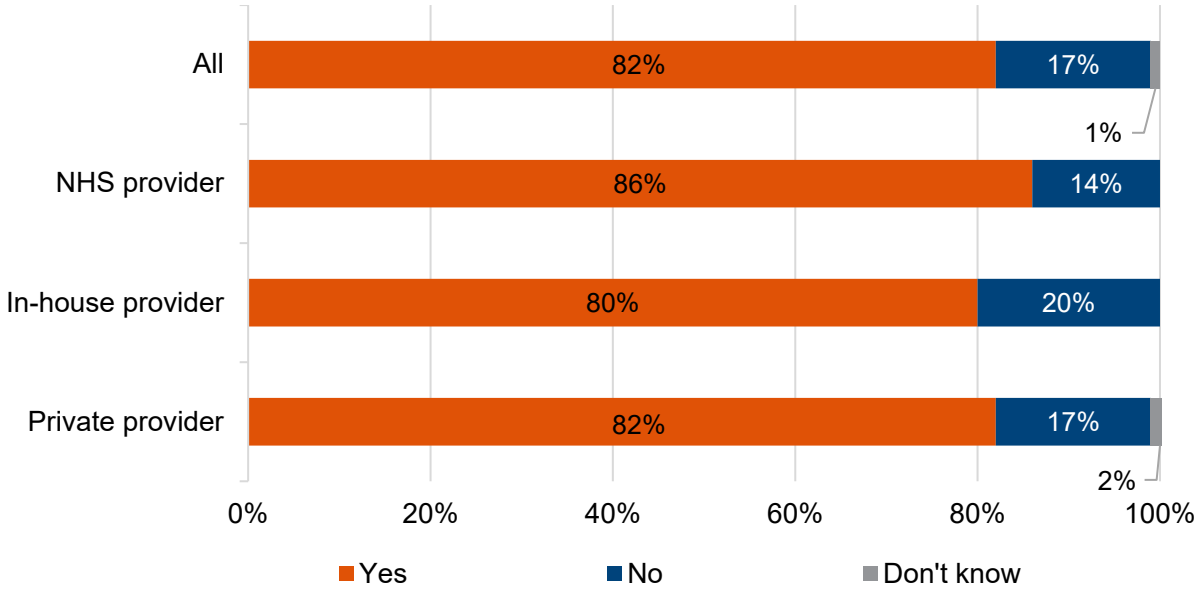
F1. What specific types of data does your OH department / organisation collect about its services, for analysis centrally? Base: All (200); NHS providers (43) In-house providers (54); Private providers (103). Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages should be treated with caution.

NHS providers were more likely than other provider types to collect several of these types of internal data. The majority of NHS providers collected data on the speed of seeing a case (84%), client satisfaction (77%), and the speed of issuing reports (77%).

Engagement with and attitudes towards knowledge development

OH providers were asked whether they invest resources or staff capacity in keeping up to date on new OH research. The majority (82%) reported investing resources or capacity into keeping up to date with new OH research (Figure 8.3). The proportion that did this was similar across all provider types (NHS: 86%; in-house: 80%; private: 82%).

Figure 8.3: Proportion of providers that invest resources into keeping up to date with new OH research



H3. Does your OH department / organisation invest resources or staff capacity in keeping up to date on new OH research? Base: All (200); NHS providers (43) In-house providers (54); Private providers (103). Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages should be treated with caution.

Providers that invested resource into keeping up to date with new research were asked what they did with that research (Figure 8.4). Responses from all provider types were broadly similar. The most common use for what they had learnt from new research was to identify ways of improving their practice (73%), followed by sharing their findings in team meetings (55%). Around three in ten used the research for staff continuing professional development, revalidation or peer coaching (29%).

Figure 8.4: How OH providers use what they learnt from new OH Research

H5 How does your OH department / organisation use what you learn from this new OH research?
Base: All that invest resource into keeping up to date with new Occupational Health research (164).
Figure 8.4 includes only those responses mentioned by 5% or more.

Barriers to knowledge development

Providers that did not invest resources into keeping up to date with the latest OH research were asked why they didn't do this. The most common reason given was that staff were too busy with their day-to-day work, followed by staff are expected to keep up to date with OH research in their own time, that they have no funding for this, or that keeping up to date is incorporated into continuing professional development time.

Engagement with and attitudes towards innovation

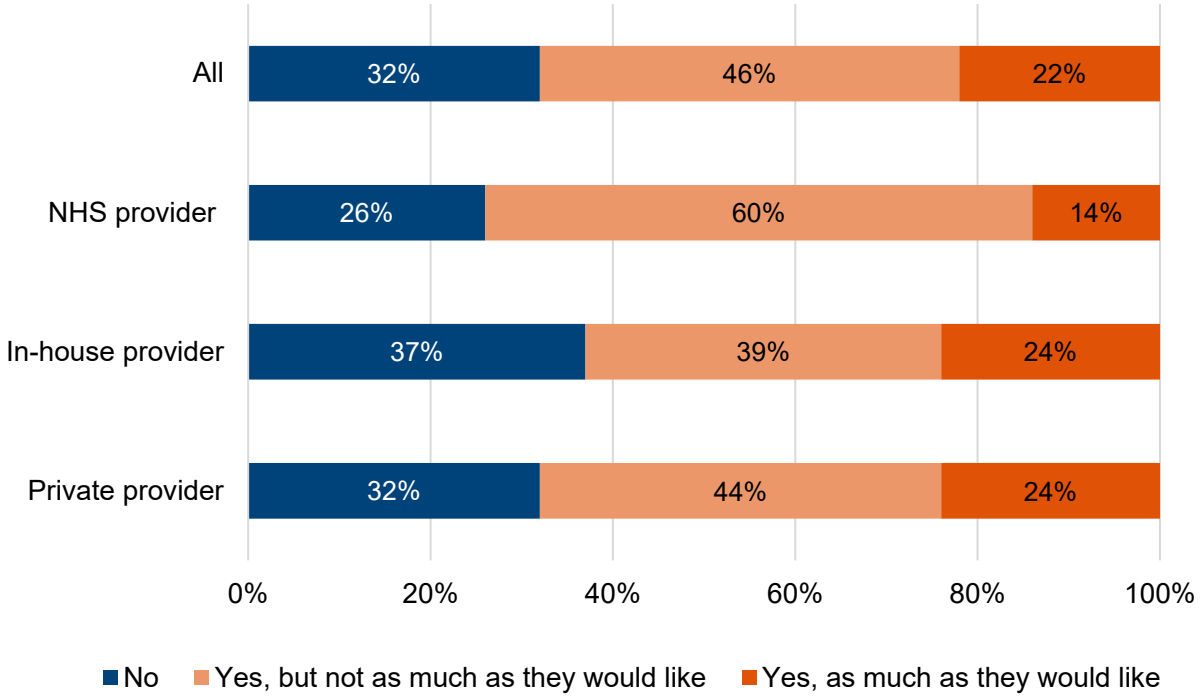
OH providers were asked whether their department or organisation innovates around its OH services. Again, 'innovation' was defined as investment in new or improved services, delivery methods or technologies that benefit people's health, wellbeing and capacity to work (some of which might be termed 'Research and Development').

Around two-thirds (68%) of all providers innovated when it came to their OH services; and this was at similar levels amongst NHS providers (74%), private providers (68%) and in-house providers (63%) (Figure 8.5).

Despite most providers innovating, approaching half (46%) said they did not innovate as much as they would like. NHS providers were most likely to say that they didn't innovate as much as they would like (60%, compared with 39% of in-house providers and 44% of private providers).

There were no significant differences by provider size, in the extent to which they innovated.

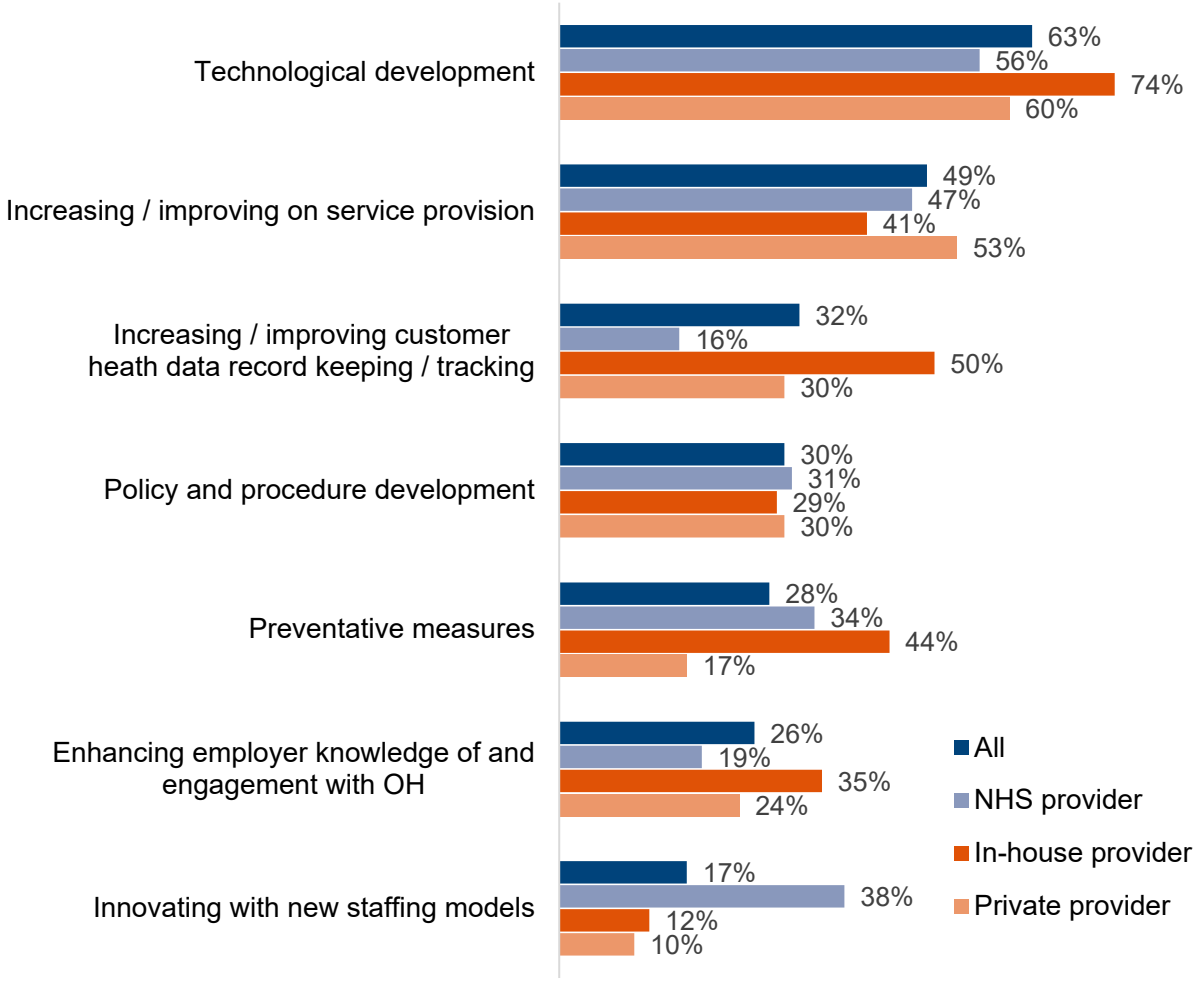
Figure 8.5: Whether providers innovate when it comes to OH services



G1 Does your OH department / organisation innovate when it comes to your OH services? Base: All (200); NHS providers (43) In-house providers (54); Private providers (103). Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages should be treated with caution.

Providers that did innovate were asked how they innovated (Figure 8.6). Approaching two thirds (63%) innovated through technical development, half innovated by increasing or improving on service provision (49%) and a third innovated through increasing or improving customer health data record keeping or tracking (32%).

Figure 8.6: How providers innovate their OH services



G2 How has your OH department / organisation been innovating around your OH services? Base: All (136); NHS providers (32) In-house providers (34); Private providers (70). Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages should be treated with caution.

In-house providers were more likely than average to innovate through increasing or improving customer heath data record keeping or tracking (50% compared with 30% of private providers and 16% of NHS providers); and through preventative measures such as workplace coaches, wellness training and steps to improve stress management and emotional resilience (44%, compared with 34% of NHS providers and 17% of private providers).

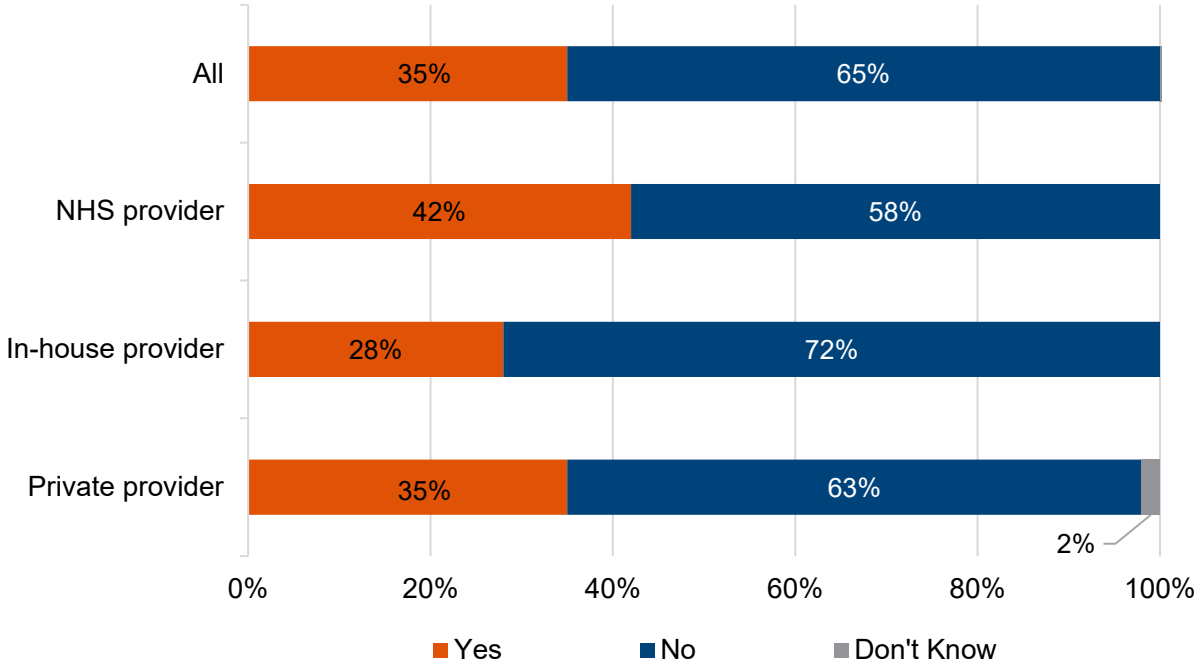
NHS providers were more likely than average to innovate with new staffing models (36% compared to 12% of in-house providers and 10% of private providers).

OH providers were asked what proportion of their organisation or department's total staff time, and total revenue or budget, is spent on innovation, research and development. Most providers reported spending a similar proportion of staff time and money on innovation and research and development.

The median average proportion of time spent on innovation, research and development among staff was 10% for all provider types. Similarly, the median average proportion of revenue or budget spent on innovation was between 6% and 10% for all provider types.

OH providers were also asked whether they were aware of the DWP and DHSC innovation fund, a £1 million fund for new ideas to boost health and welfare at work for Small and Medium Enterprises (SMEs) and the self-employed, launched by the DWP and the DHSC. Just over a third of providers (35%) had heard of the DWP and DHSC innovation fund (Figure 8.7). There were no significant differences in awareness levels by provider type, with 42% of NHS providers, 28% of in-house providers and 35% of private providers having heard of it.

Figure 8.7: OH provider awareness of the DWP and DHSC innovation fund



G8 Are you aware of the £1 million fund for new ideas to boost health and welfare at work for Small and Medium Enterprises (SMEs) and the self-employed, launched by the DWP and the Department of Health and Social Care (DHSC)? Base: All (200); NHS providers (43) In-house providers (54); Private providers (103). Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages should be treated with caution.

Amongst the providers that had heard of the fund, very few (4%, or three providers) had used the funding to do their own innovation or research and development work around OH services. Although it should be noted, at the point when fieldwork was conducted, the innovation fund was in its early stages, with funding open to a very small number of organisations including organisations who were not OH service providers.

All three providers that had used the funding, were private providers; and the types of innovation they had funded included streamlining data management; a gamification project for educational purposes; and digital partnerships to increase OH

engagement. One other OH provider had commissioned a service or product that had been developed from the innovation fund, this product was a form of database technology.

Barriers to innovation

OH providers that did not innovate, or did not innovate as much as they would like, were asked what barriers they faced to innovation. The most common barrier to innovation was cost (60%), followed by capacity (54%). Much smaller proportions of providers mentioned no requirement or appetite from the market; or no requirement or appetite for innovation internally (both 13%). Responses were similar by provider type.

In 2019, in a qualitative study to accompany the survey of OH provision,[38] NHS and private providers were asked what the barriers to innovating were; and similar themes were present, with cost and capacity being the most frequently mentioned.

Summary

Many providers report they tend to innovate, however, nearly half do not innovate as much as they would like to, and innovation costs and staff capacity are the main constraints. There are modest levels of awareness of the DWP and DHSC innovation fund.

[38] Innovation and knowledge development amongst providers of occupational health - GOV.UK

9 Accreditations

This chapter explores how Occupational Health (OH) providers view the SEQOHS (Safe Effective Quality Occupational Health Service) accreditation, in the context of other OH-relevant accreditations. It will include an overview of enablers and barriers to OH providers identified gaining SEQOHS accreditation. Findings are drawn from both the survey of OH providers and the in-depth qualitative interviews.

It is worth noting that the in-depth interviews identified that OH Providers sometimes conflate being accredited and being a member of OH associations or organisations, naming associations or organisations when asked about their awareness of non-SEQOHS accreditations.

It is also important to note that a new SEQOHS standard was introduced in November 2023 but, as the survey was conducted between August 2023 and January 2024, with the in-depth interviews running between October 2023 and January 2024, the findings in this chapter will likely reflect attitudes towards the old, pre-2023 SEQOHS accreditation. Some of the more negative views of SEQOHS discussed in this chapter may already have been addressed when the standard was updated.

Engagement with SEQOHS

The vast majority (94%) of OH providers surveyed were aware of the SEQOHS accreditation before taking part in the survey and all types of OH provider were equally likely to be aware of it.

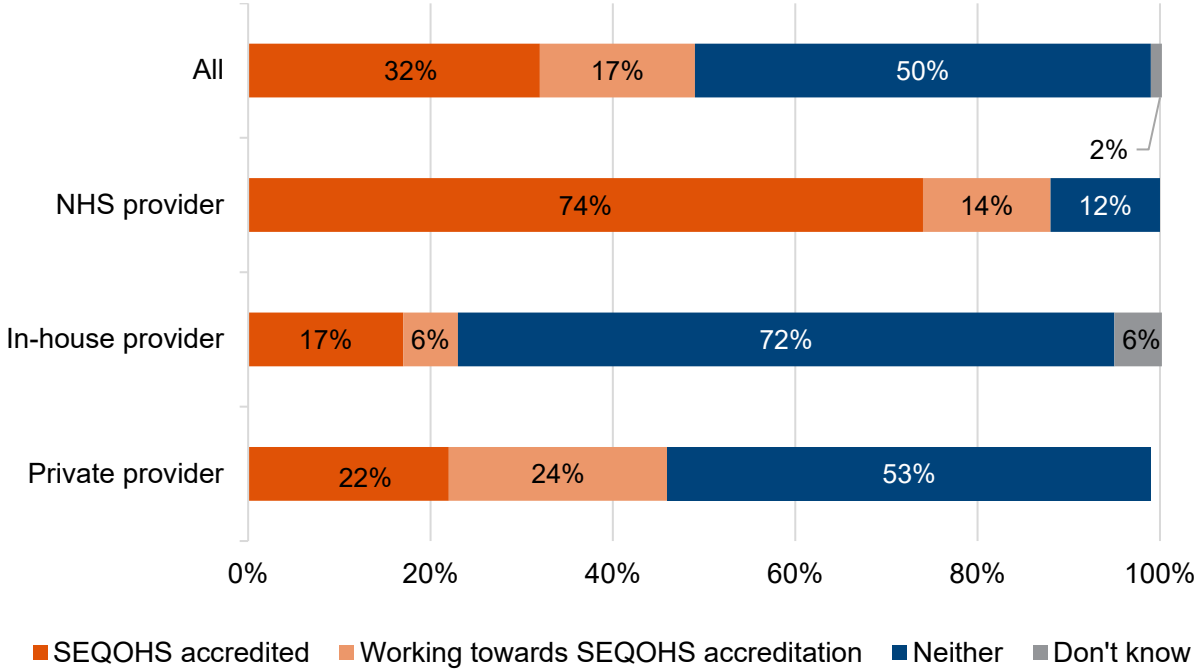
Around a third (32%) of providers who responded to this survey were already SEQOHS accredited, as shown in Figure 9.1 (though it is worth noting that this survey's sample sources – including lists of SEQOHS-accredited providers – may have over-represented OH providers who are SEQOHS-accredited).

NHS providers were the most engaged with SEQOHS, with almost three quarters (74%) stating that they were SEQOHS accredited compared with around one fifth of in-house providers (17%) and private providers (22%).

Private providers were the most likely to be working towards a SEQOHS accreditation, with almost a quarter (24%) reporting that they were doing so compared to one in seven (14%) NHS providers and less than one in ten (6%) in-house providers.

Overall, nearly all NHS providers (88%) were either accredited or working towards SEQOHS. Note that this study's steering group members noted that there are targets within the NHS for SEQOHS take-up, so this may have informed the high engagement with and favourability towards SEQOHS expressed by NHS providers in the survey.

Figure 9.1: Take-up of SEQOHS accreditation among OH providers



I3. Is your OH department / organisation currently SEQOHS-accredited or working towards the SEQOHS (Safe Effective Quality Occupational Health Service) accreditation? Base: All respondents (200); NHS providers (43); In-house providers (54); Private providers (103). Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages should be treated with caution.

However, half (50%) of all providers said that they were neither SEQOHS accredited nor working towards SEQOHS accreditation. In-house providers were particularly likely to say this (72%, compared with 12% of NHS providers and 53% of private providers).

Small organisations were more likely to be accredited (49%) or working towards accreditation (27%) whilst micro-sized organisations were less likely to have or be working towards to accreditation (73% said 'neither' compared to 23% of small organisations, Table 9.1).

Table 9.1: Take-up of SEQOHS accreditation by OH provider size

	All OH providers	Sole practitioner	Micro	Small	Medium
	%	%	%	%	%
SEQOHS accredited	32	0	13	49	88
Working towards SEQHS accreditation	17	8	11	27	12
Neither	50	92	73	23	0
Don’t know	2	0	3	0	0

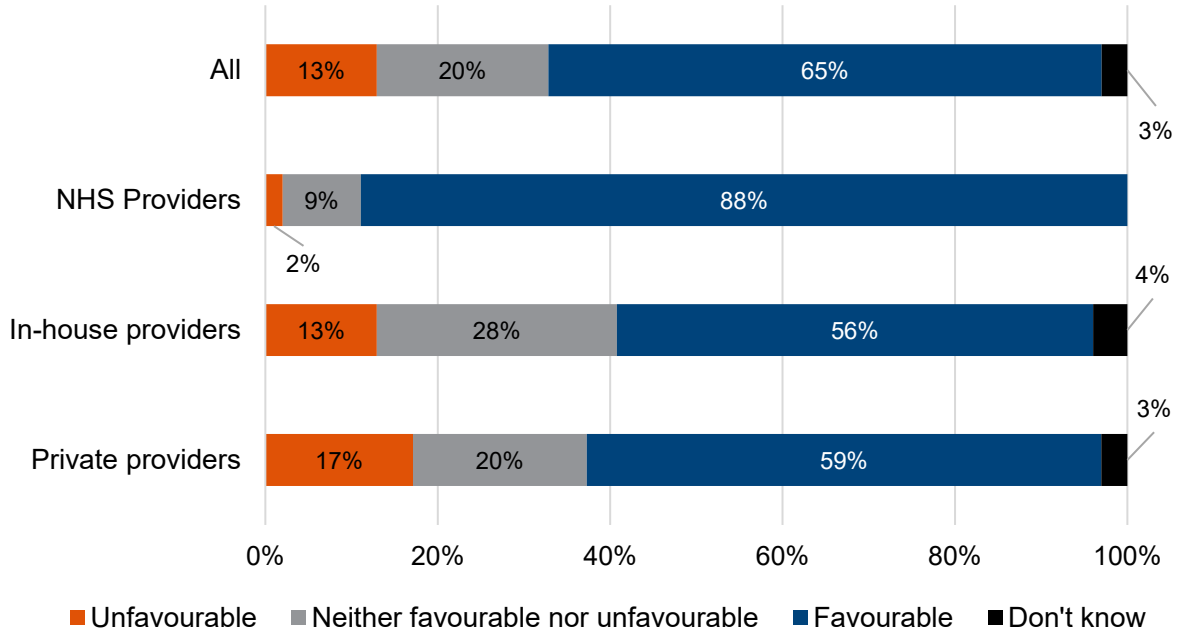
I3. Is your OH department / organisation currently SEQOHS-accredited or working towards the SEQOHS (Safe Effective Quality Occupational Health Service) accreditation? Base: All respondents (200), sole practitioner / sole trader (12), micro (96), small (73), medium (17). Note the relatively small base sizes for many of the provider size bands, meaning specific percentages should be treated with caution. Also, only two providers fell into the ‘large’ category, so this has been excluded from the table. In this table, total provider size is based on the OH team or department for NHS and in-house providers and the whole organisation for private providers. All sole practitioners/sole traders who responded were from private providers.

Providers not accredited or working towards SEQOHS accreditation were asked if they were likely to get it in the future. A quarter (25%) of these providers overall said they were likely to. There were no significant differences by provider type or size.

Attitudes towards using SEQOHS

When asked how favourable or unfavourable their OH department or organisation was towards using SEQOHS accreditation, almost two thirds of OH providers (65%) had a favourable attitude (Figure 9.2). NHS providers were particularly favourable; almost nine in ten (88%) of them expressed a favourable opinion compared with around six in ten in-house providers (56%) and private providers (59%). There were no significant differences by provider size.

Figure 9.2: Favourability among OH providers towards using SEQOHS accreditation



I6. On balance, what is your OH department's / organisation's attitude to using the Safe Effective Quality Occupational Health Service (SEQOHS) accreditation specifically? Base: All respondents (200); NHS providers (43); In-house providers (54); Private providers (103). Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages should be treated with caution.

Benefits and drivers of gaining/working towards SEQOHS

When those who expressed a favourable attitude towards SEQOHS accreditation were asked their reasons for this, the most common reasons given were that it ensures an industry standard quality of service (51%); that benchmarks provide quality assurance to customers and can help gain market share (40%); and that it is good for internal quality improvement (28%) (Figure 9.3).

Figure 9.3: Reasons OH providers were favourable towards SEQOHS accreditation

I7. Why do you say your OH department's / organisation's attitude to using SEQOHS is favourable?
Base: Those who gave a favourable response to using SEQOHS (129).

As this shows, the reasons for OH providers being favourable towards SEQOHS tend to be most commonly about establishing credentials and enhancing reputation amongst customers.

The qualitative in-depth interviews backed up the results from the survey, with providers who had favourable attitudes towards SEQOHS typically saying that it was required for them to sell their services to their intended clients and that it demonstrates they have been assessed as meeting high standards of service. Some providers chose to gain SEQOHS accreditation for the credibility it added to their OH service provision.

> *"We couldn't not do it because otherwise we wouldn't be able to sell our services to other NHS providers if we didn't. So there's no question about it, we'll be doing it every year."*
>
> (NHS provider, 50+ employees, North West England)

Barriers to gaining/working towards SEQOHS

For providers who had an unfavourable attitude towards SEQOHS, the most common reasons they gave for this in the survey were that SEQOHS provides minimal or no benefit to their business, including that it's just a paper exercise or does not benefit clinical outcomes; that the process for gaining the accreditation is complicated or time consuming; and that it is expensive.

This was largely confirmed by the in-depth interviews. Providers who were not SEQOHS accredited or working towards SEQOHS accreditation told us this was mainly because:

- They were already appraised as part of another accreditation scheme or were members of professional organisations that have high standards, so they felt a SEQOHS accreditation was an unnecessary extra and did not guarantee a good service or add value.
- They did not believe they fell under the SEQOHS umbrella.
- They perceived SEQOHS as costly – one provider noted that they use alternative, more cost-efficient accreditations that provide them with the equivalent knowledge and skills e.g. accreditations provided by the Royal College of Occupational Health.
- Gaining SEQOHS accreditation required too much complicated administrative work, which placed a heavy burden on smaller providers.
- They mainly worked with SMEs who have less awareness about SEQOHS and are less likely to require their OH providers to be accredited.

  "The NMC [Nursing & Midwifery Council] requirements and standards are already in place for nurses – I think the NMC should be setting the standards for the OH sector."

  (Private provider, 1-9 employees, South East of England)

  "It's quite elitist. The larger organisations can work towards the SEQOHS standards, and now individuals can, but it's a lot of work for the smaller companies to get accredited under SEQOHS [due to high workload]."

  (Private provider, Sole Trader, Wales)

In the in-depth interviews, SEQOHS-accredited providers said there had been no barriers to gaining SEQOHS as they were keen to become accredited. A couple of providers mentioned the time it took to raise standards and ensure they had processes in place across their organisation, but they did not view this as a barrier, just a part of the process. Another noted the time it took to become accredited, meaning they had less time to do fee-earning work, but again they did not view this as a barrier.

When survey participants who were not SEQOHS accredited or working towards it, were asked what would encourage them to become SEQOHS accredited, the most common responses were:[39]

- If it was relevant / beneficial to our business (27%).
- Funding / reduction in the cost (26%); and in the in-depth interviews, a couple of OH providers suggested funding to cover staff time for gaining the accreditation.
- Make it less complicated / provide more support (25%).

[39] Percentages are based on 102 responses (those neither SEQOHS accredited nor working towards it).

- Having the time (22%).
- If it was mandatory (14%).

Nearly a fifth (18%) said nothing would encourage them to become SEQOHS accredited.

Attitudes towards other OH accreditations

Findings from the in-depth interviews indicate a limited engagement with accreditations other than SEQOHS. There seemed to be a conflation of accreditation and membership of professional bodies or societies; and providers who had engaged with other 'accreditations' mentioned:

- The Nursing & Midwifery Council
- The Society of Occupational Medicine (SOM)
- Commercial Occupational Health Providers Association (COPHA)
- The Vocational Rehabilitation Association (VRA).

Where providers mentioned these other accreditations or organisations, they tended to argue that these offered better value for money.

> *"It's informative. We're getting something from it, we're not just doing all the giving… With SOM, I get an updated letter, a newsletter, I get a team of experts I can chat with."*
>
> (Private provider, 1-9 employees, Yorkshire and the Humber)

Summary

Awareness of and favourability towards SEQOHS accreditation is high, and it is perceived as a way of establishing credentials and enhancing reputation. Nearly all providers are aware of SEQOHS accreditation and most are favourable towards it, most commonly because it can reassure customers around quality.

10 Conclusions

On average, Occupational Health (OH) providers are relatively small and still face significant challenges in recruiting skilled staff – approaching four in ten have unfilled vacancies, and this is more common for NHS providers.

The most acute staffing challenges in the sector are around nurses with Specialist Community Public Health Nursing (SCPHN) OH qualifications and nurses with or training towards other OH postgraduate qualifications. As in 2019, nurses with an SCPHN OH qualification or with or training towards other OH postgraduate qualifications are seen as hardest to recruit; and nurses with an SCPHN OH qualification are also amongst the most common vacant roles. Workforce composition data suggests that nurses with an SCPHN OH qualification are also – along with admin staff – the 'backbone' of the OH workforce.

The sector is receptive to using newly-qualified OH professionals to meet their staffing needs. Overall, providers tend to be relatively favourable to hiring newly-qualified OH staff without experience to deliver their OH services. Those with unfilled vacancies are more likely to be favourable, suggesting that provider need may be driving open-mindedness.

The sector is positive about using multidisciplinary teams, and better patient care is the motivation driving this. OH providers are mostly favourable to using multidisciplinary teams and they are fairly commonly used, by two-fifths of providers. Rather than being used as a solution to capacity and recruitment challenges, providers use multidisciplinary teams to draw on multiple disciplines to better meet patient needs. However, the use of multidisciplinary teams is currently constrained by the availability of appropriately skilled OH staff; provider access to finance; and the extent to which customers accept their use.

OH providers commonly engage with training but want to do more. Provider funding for staff training and/or qualifications is commonplace but nearly a third would like to fund more of this than they are currently able to. Lack of funding, difficulty making time for staff to attend, and external provision costs and locations are the main barriers. Staffing challenges suggest that training that would help meet the shortfall in nurses with an SCPHN OH qualification, would benefit the sector most.

It may be more common for demands to exceed provider capacity than it was in 2019. In the past 12 months, for all types of providers the majority have been working either near maximum capacity, at maximum capacity or above maximum capacity. Whilst NHS providers have the highest capacity, they are also most likely to have been working beyond their maximum capacity.

Providers are mostly open to seizing the opportunity to expand, but some are constrained by recruitment challenges. Seven in ten providers are in favour of expanding; for those who are not, lack of interest and challenges recruiting skilled staff are the barriers.

Most specific OH services asked about tended to be charged at £51-£200 per person, per use. Pricing is most often shaped by the complexity of the services required and the costs of delivery; though three in ten tailor their prices to specific groups or types of customers and qualitatively, providers sought to balance attractive prices against not devaluing their services.

Despite positive provider attitudes, small and medium-sized enterprises (SMEs) continue to be significantly under-represented in the customer base. Most providers are favourable towards working with SMEs because they want to serve a neglected sector and feel the scale of their services is better suited to SMEs. Providers also tend to be open to working with the self-employed as customers, liking the absence of a line manager or employer as an intermediary between the provider and patient – but in practice they report a lack of demand.

OH providers tend to innovate but they do not have the funds or staff capacity to innovate as much as they would like to. There are modest levels of awareness of the innovation fund launched by the Department for Work and Pensions and the Department for Health and Social Care.

Awareness of and favourability towards SEQOHS (Safe Effective Quality Occupational Health Service) accreditation is high, and it is perceived as a way of establishing credentials and enhancing reputation. Nearly all providers are aware of SEQOHS accreditation and most are favourable towards it, most commonly because it can reassure customers around quality.

OH providers often seem to be influenced by altruistic motivations, including a commitment to high standards of patient care and a desire to spread the benefits of OH, over and above other factors. For instance, a commitment to high standards of patient care drives their use of multidisciplinary teams and motivates keeping up to date with new research, while a desire to spread the benefits of OH informs provider interest in expanding their capacity and appetite to work with SMEs.

Recruitment and capacity challenges, stemming from a shortage of appropriately qualified, skilled, and experienced OH staff, recurs as a constraint on OH providers. This surfaces as a constraint on their ability to expand; their ability to use multidisciplinary teams; and their ability to innovate.

11 Annex: Tables

Chapter 2 tables: Workforce composition and recruitment

For further details on the findings presented in Tables A.1 to A.5, see chapter 2.

Table A.1: Proportion of NHS providers that employed at least one member of staff in each role

	At least one of either	At least one full time employee	At least one part time employee
Admin staff	98%	93%	74%
Nurses with an OH SCPHN qualification	95%	81%	84%
Nurses without OH qualifications	81%	56%	72%
Doctors registered with GMC as an OM specialist	67%	42%	47%
Counsellors	51%	23%	47%
OH technicians or healthcare assistants	49%	33%	28%
Physiotherapists	47%	37%	30%
Nurses training towards OH SCPHN	44%	28%	23%
Registered nurses with or training towards other OH Postgraduate Qualification	42%	30%	28%
Registrars training towards registration with GMC as an OM specialist	30%	19%	26%
Doctors with the Diploma in Occupational Medicine (DOccMed)	26%	7%	23%
Clinical psychologists with specialty in OH	26%	14%	21%
Mental health nurses	26%	19%	14%
Occupational therapists	12%	9%	9%

Doctors not registered, or training, with GMC as an OM specialist and without DOccMed	9%	2%	7%
Other roles	19%	7%	12%

A1. How many of your OH department / organisation's staff are employed on a full-time basis, and how many are employed on a part-time basis? Base: NHS providers (43). Note the relatively small base size for NHS providers, meaning specific percentages should be treated with caution.

Table A.2: Proportion of NHS providers that employed at least one member of staff in each role in 2023-24 and 2019

	At least one full time 2023/24	At least one full time 2019	At least one part time 2023/24	At least one part time 2019
Nurses with an OH SCPHN qualification	81%	85%	84%	63%
Nurses without OH qualifications.	56%	38%	72%	42%
Doctors registered with GMC as an Occupational Medicine (OM) specialist	42%	29%	47%	63%
OH technicians or healthcare assistants	33%	33%	28%	12%
Physiotherapists	37%	23%	30%	27%
Nurses training towards an OH SCPHN	28%	23%	23%	17%
Registrars training towards registration with GMC as an OM specialist	19%	15%	26%	13%
Clinical psychologists with specialty in OH	14%	8%	21%	17%
Occupational therapists	9%	0%	9%	8%
Doctors not registered, or training, with GMC as an OM specialist and without DOccMed	2%	2%	7%	6%

A1. How many of your OH department / organisation's staff are employed on a full-time basis, and how many are employed on a part-time basis? Base: NHS providers 2023-24 (43); NHS providers 2019 (52). Note the relatively small base sizes for NHS providers, meaning specific percentages should be treated with caution.

Table A.3: Proportion of in-house providers that employed at least one member of staff in each role

	At least one of either	At least one full time employee	At least one part time employee
Nurses with an OH SCPHN qualification	83%	59%	57%
Admin staff	72%	54%	44%
OH technicians or healthcare assistants	54%	44%	15%
Nurses without OH qualifications	30%	20%	13%
Doctors registered with GMC as an Occupational Medicine (OM) specialist	22%	13%	13%
Registered nurses with or training towards other OH postgrad qualifications	22%	15%	13%
Counsellors	19%	11%	7%
Nurses training towards an OH SCHPN qualification	7%	7%	0%
Doctors with DOccMed	2%	2%	0%
Clinical psychologists with specialty in OH	2%	2%	0%
Physiotherapists	2%	2%	0%
Registrars training towards GMC registration with an OM specialist	0%	0%	0%
Occupational therapists	2%	0%	2%
Doctors not registered, or training, with GMC as an OM specialist and without DOccMed	2%	2%	0%
Mental health nurses	0%	0%	0%
Other roles	7%	7%	0%

A1. How many of your OH department / organisation's staff are employed on a full-time basis, and how many are employed on a part-time basis? Base: In-house providers (54). Note the relatively small base size for in-house providers, meaning specific percentages should be treated with caution.

Table A.4: Proportion of private providers that employed at least one member of staff in each role

	At least one employee	At least one full time employee	At least one part time employee
Admin staff	69%	48%	51%
Nurses with an OH SCPHN qualification	55%	42%	37%
OH technicians or healthcare assistants	42%	34%	23%
Doctors registered with GMC as an Occupational Medicine (OM) specialist	38%	18%	22%
Nurses without OH qualifications	21%	15%	16%
Physiotherapists	16%	9%	11%
Registered nurses with or training towards other OH postgrad qualifications	14%	13%	5%
Counsellors	13%	5%	10%
Doctors with DOccMed	10%	5%	8%
Occupational therapists	9%	8%	4%
Nurses training towards an OH SCHPN qualification	8%	5%	3%
Clinical psychologists with specialty in OH	8%	3%	6%
Mental Health nurses	8%	5%	5%
Registrars training towards GMC registration with an OM specialist	4%	1%	3%
Doctors not registered, or training, with GMC as an OM specialist and without DOccMed	4%	1%	3%
Other roles	22%	17%	9%

A1. How many of your OH department / organisation's staff are employed on a full-time basis, and how many are employed on a part-time basis? Base: Private providers (103).

Table A.5: Proportion of private providers that employed at least one member of staff in each role in 2023-24 and 2019

	At least one full time 2023/24	At least one full time 2019	At least one part time 2023/24	At least one part time 2019
Nurses with an SCPHN OH qualification	42%	50%	37%	33%
OH technicians or healthcare assistants	34%	29%	23%	22%
Doctors registered with GMC as an Occupational Medicine (OM) specialist.	18%	30%	22%	31%
Nurses without OH qualifications	15%	10%	16%	9%
Physiotherapists	9%	7%	11%	8%
Occupational therapists	8%	5%	4%	1%
Nurses training towards OH SCPHN.	5%	13%	3%	4%
Clinical psychologists with specialty in occupational health	3%	5%	6%	2%
Doctors not registered with GMC as an OM specialist and without DOccMed.	1%	2%	3%	2%
Registrars training towards GMC registration as OM specialists.	1%	10%	3%	3%

A1. How many of your OH department / organisation's staff are employed on a full-time basis, and how many are employed on a part-time basis? Base: Private providers 2023/24 (103); Private providers2019 (104).

Chapter 5 tables: Demand for occupational health services, and provider capacity

For further details on the findings presented in Tables A.6 to A.8, see chapter 5.

Table A.6: OH Services most commonly offered and most commonly used

	Currently offered	Most commonly commissioned
Management referrals or assessment of fitness for work for ill or sick employees	98%	88%
Pre-employment/post-offer of employment health assessments	94%	57%
Ongoing health assessments available for any employees (even if not ill or sick)	91%	36%
Support with health surveillance (this refers to assessing workplaces and workers for health)	88%	60%
Support with health risk assessments	78%	17%
Health promotion or healthy lifestyle schemes	72%	17%
Clinical interventions to manage health risks, e.g., vaccinations	69%	35%
General advice on organisational policy or procedures	69%	14%
Connection to wider services or support to address psychosocial issues	59%	10%
Training, instruction, or capacity building e.g., for managers or leaders	53%	7%
Knowledge management support such as sickness absence record keeping, data analysis	53%	9%
Providing physiotherapy	46%	16%
Employee Assistance Programme	44%	11%
Providing Cognitive Behavioural Therapy (CBT)	43%	12%

Travel health (e.g., assessments, immunisation)	29%	6%
Counselling	12%	0%

E1. Which of the following types of Occupational Health support or interventions does your organisation offer? E3. Which of your services are most commonly used or commissioned? Please pick up to ten of the most common. Base: All respondents (200). The table includes only those responses mentioned by 10% or more.

Table A.7: OH provider responses to being above maximum capacity

	Total	NHS	In-house provider	Private provider
Longer waiting times	79%	95%	83%	63%
Expand output using existing staff (e.g., by restructuring teams / workloads or upskilling staff)	68%	86%	61%	59%
Turn down potential work / limit client numbers	61%	81%	26%	74%
Refer to / recommend other providers	56%	57%	26%	81%
Subcontract work to other companies / individuals	49%	24%	61%	59%
Use temps / agency staff	44%	52%	57%	26%
Expand staff numbers	39%	33%	35%	48%
Draw on another organisation's capacity without formally subcontracting	13%	5%	17%	15%
Triage cases to prioritise by clinical need	7%	14%	4%	4%

C3. How do you respond if demand for your services exceeds your capacity? Base: All respondents who were at, or over, capacity (71); NHS providers (21); In-house providers (23); Private providers (27). Note the relatively small base sizes for the individual provider types, meaning specific percentages should be treated with caution. Table A.7 includes only those responses mentioned by 5% or more.

Table A.8: Detail of OH providers' interaction with government services

	All	NHS provider	In-house provider	Private provider
Signpost the employer / patient to apply	50%	47%	47%	53%
Recommend employers use / refer to Access to Work	34%	42%	16%	41%
Provide / receive support to implement solutions	27%	28%	37%	20%
Refer to Access for Work incl. specialised services	23%	19%	35%	17%
Advise how to self-refer / apply for services	14%	11%	14%	16%
Provide support to access funding	11%	14%	14%	9%
Receive referrals from Access to Work	9%	14%	7%	7%
Act as second opinion on advice given by Access to Work	4%	3%	5%	4%

C10 Please can you say a bit more about how your services interact with Government services such as Access to Work? Base: Those whose services interact with government provision (149); NHS providers (36); In-house providers (43); Private providers (70). Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages should be treated with caution.

Chapter 6 tables: Pricing

For further details on the findings presented in Table A.9, see chapter 6.

Table A.9: Factors considered when considering pricing for specific customers

	All	NHS provider	Private provider
Complexity of contract / interventions required	38%	30%	45%
Real cost of servicing the contract (e.g., travel, admin, materials etc.)	30%	35%	31%
Number of employees	16%	15%	17%
Discount eligibility e.g., charities, recurring contracts	14%	10%	17%
Assigning and remunerating our therapists appropriately	12%	15%	10%

Competitive market rate and/or national guidelines for services	11%	15%	12%
Tailored to client's specific requirements and budget	11%	8%	13%
Fair pricing applied incl. acceptable profit	9%	8%	10%
Standard pricing (e.g., fixed prices, annual subscriptions)	7%	8%	6%

E36. When deciding the exact prices charged for services, for specific customers, what other factors do you consider? Base: All that charge for their services (159); NHS providers (40); Private providers (103). Note the relatively small base size for NHS providers, meaning specific percentages should be treated with caution. Table A.9 includes only those responses mentioned by 5% or more.

Chapter 8 tables: Data collection, knowledge sharing and innovation

For further details on the findings presented in Table A.10, see chapter 8.

Table A.10: Types of patient data collected by OH providers

	All	NHS	In-house provider	Private provider
Employee condition or injury type (e.g., using ICD codes)	56%	70%	70%	42%
Employee fitness records from Health Surveillance	53%	56%	65%	45%
Employee interventions used	46%	51%	70%	31%
Employee job role	46%	60%	50%	37%
Employee outcomes immediately post-intervention	41%	44%	46%	36%
Employee demographics (including Equality / Protected Characteristics information)	39%	49%	41%	34%
Employee Sickness Absence numbers / rates	36%	33%	54%	27%
Employee intervention duration	35%	37%	46%	27%
Trends in employer, team, or department-specific issues	35%	49%	44%	23%

Employee duration of Sickness absence	30%	23%	48%	23%
Employee return to work success rate	24%	19%	31%	21%
Employee outcomes later (e.g., at 3 months / 6 months)	16%	7%	20%	17%
Employee health-related quality of life (e.g., using EQ5D)	13%	19%	9%	13%
Appointments missed incl. cost of missed appointments	9%	21%	11%	2%
Clinical data (unspecified)	7%	12%	9%	4%
Geographical location	2%	0%	0%	4%
Subject access data requests (e.g., GDPR)	1%	2%	2%	0%
Don’t collect any data for central analysis	4%	0%	2%	6%

F1. What specific types of data does your OH department / organisation collect about its services, for analysis centrally? Base: All (200); NHS providers (43) In-house providers (54); Private providers (103). Note the relatively small base sizes for NHS and in-house providers, meaning specific percentages should be treated with caution.