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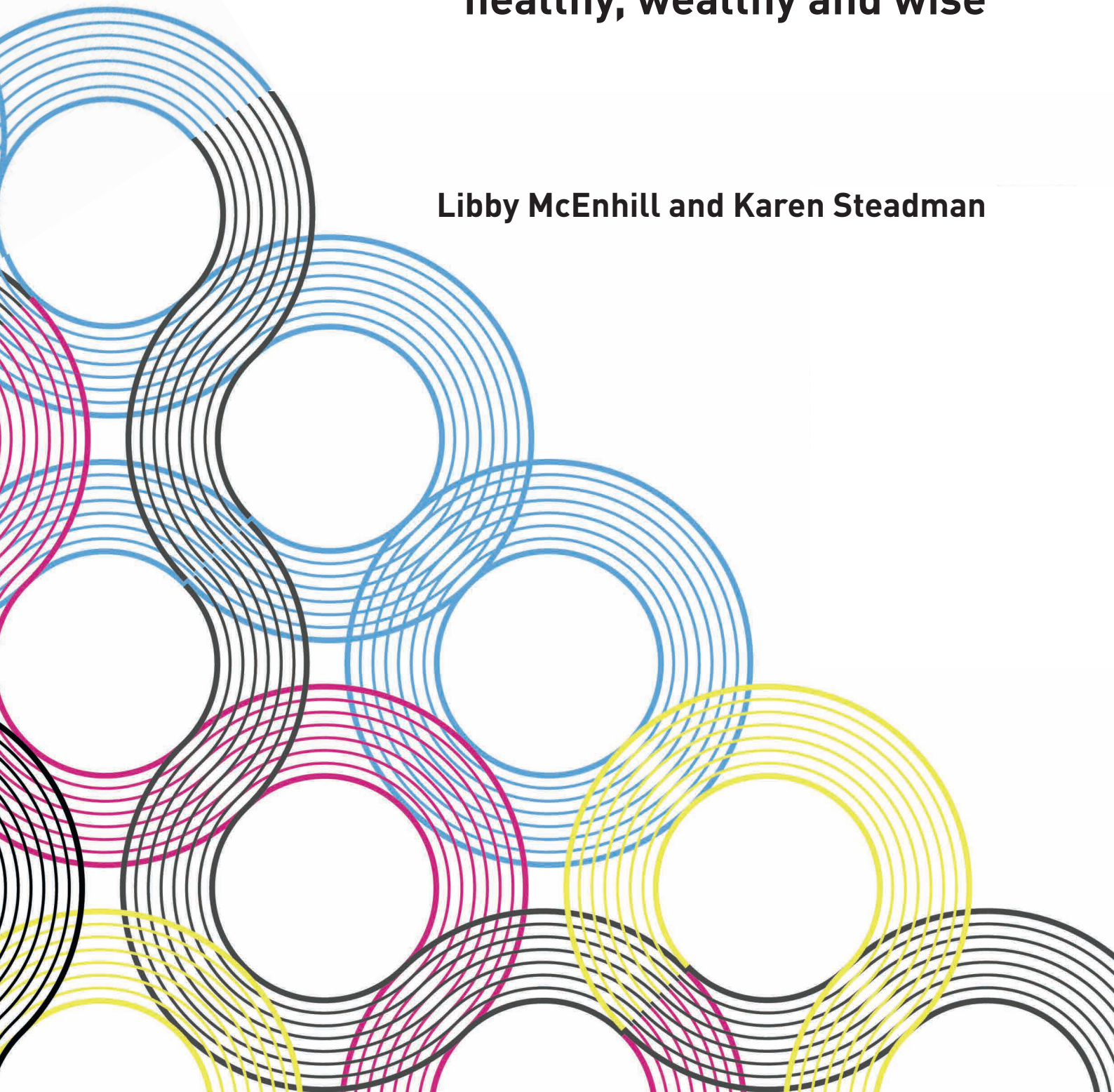
This Won't Hurt a Bit

Supporting small business to be healthy, wealthy and wise

Libby McEnhill and Karen Steadman



About us

Through its rigorous research programmes targeting organisations, cities, regions and economies, now and for future trends; The Work Foundation is a leading provider of analysis, evaluation, policy advice and know-how in the UK and beyond.

The Work Foundation addresses the fundamental question of what Good Work means: this is a complex and evolving concept. Good Work for all by necessity encapsulates the importance of productivity and skills needs, the consequences of technological innovation, and of good working practices. The impact of local economic development, of potential disrupters to work from wider-economic governmental and societal pressures, as well as the business-needs of different types of organisations can all influence our understanding of what makes work good. Central to the concept of Good Work is how these and other factors impact on the well-being of the individual whether in employment or seeking to enter the workforce.

For further details, please visit www.theworkfoundation.com.

About the Health at Work Policy Unit

The Health at Work Policy Unit (HWPU) provides evidence-based policy recommendations and commentary on contemporary issues around health, wellbeing and work. Based at The Work Foundation, it draws on The Work Foundation's substantial expertise in workforce health, its reputation in the health and wellbeing arena and its relationships with policy influencers. The HWPU aims to provide an independent, authoritative, evidence-based voice capable of articulating the views of all stakeholders.

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1 Introduction

The health of the UK workforce matters. In human and social terms we see links between health and employment that indicate not only that being in good health improves an individual's chances of finding, staying in and progressing in work (Black, 2008), but also that 'good work' is generally beneficial for an individual's health and wellbeing and provides social benefits related to reducing poverty and social exclusion (Parker and Bevan, 2011), while bad work can have a negative effect on health (Butterworth et al., 2014; Marmot, 2015).

There is also an economic imperative and a business argument for improving workforce health. The UK's productivity remains subdued following the recession, and the health of its workforce represents an 'increasingly serious barrier to growing productivity' (Bevan, 2010: 3). Over a quarter (28 per cent) of the UK population report that their activities are limited due to ill-health (ONS, 2013), while four out of every ten employees with a long-term health condition reports that it affects their work to some extent (Steadman, Wood and Silvester, 2015). Some 2.5 million people currently claim Employment and Support Allowance (ESA) and other incapacity benefits relating to their health (Dodd, 2015). Therefore, a number of government objectives including the overarching imperative of reducing spending on welfare and, ultimately, health, depend on improving workforce health.

Government-led public health initiatives play an important role in encouraging and supporting people to make healthy choices and to provide healthy environments for themselves and their families. However, with life expectancies increasing and working lives becoming longer (ONS, 2012), and

Box 1: SMEs - Definitions and UK profile

SMEs represent a very large proportion of UK workplaces: in 2015, over 99 per cent of all UK private sector businesses were SMEs. They employ 15.6 million people, accounting for 60 per cent of private sector employed (BIS, 2015) and almost half of the entire UK workforce (ONS, 2015).

SMEs are usually categorised by number of employees. In this paper we use the following categories, in line with the UK government:

- Sole traders: 0 employees
- Micro businesses: 1-9 employees
- Small businesses: 10-49 employees
- Medium businesses: 50-249 employees
- Large businesses: 250+ employees

The SME (0-249 employees) sector can be broken down as follows (Data correct as at start of 2015 – BIS 2015):

- 99.9% of all private sector businesses were SMEs.
- Small businesses accounted for 99.3% (5.3 million) of all private sector businesses
- 4 million UK business have no employees.
- Total employment in SMEs was 15.6 million; 60% of all private sector employment in the UK.
- The combined annual turnover of SMEs was £1.8 trillion, 47% of all private sector turnover in the UK.

plans to further raise the state pension age likely to further delay retirement, the workplace is now seen as a key setting for addressing working age health. Consequently, employers will also have to take on a role.

This goes beyond complying narrowly with health and safety legislation and following a 'do no harm' principle (Bevan, 2010). It also encompasses a wide spectrum of possible interventions, including helping employees to manage existing or new health conditions as they occur, and taking proactive measures to prevent employees from developing health conditions in the first place. Both aspects are essential for managing the longer-term costs associated with ill health.

To some extent this is already happening. Many large employers have been leading the way in promoting workplace health – recognising the economic and social arguments for doing so. However, many others are not doing so, either through lack of awareness, or lack of ability. Increasingly we see policymakers looking for new ways to not only support individuals but to support and encourage employers to take action.

In this regard, the UK's considerable network of Small and Medium-sized Enterprises (SMEs) is recognised as presenting a considerable challenge. Accounting for 47 per cent of private sector turnover (BIS, 2015), and 60 per cent of UK employment, SME health is crucial to UK productivity. Further, 95 per cent of people who move from unemployment into work in the private sector start their own business or work for a SME, highlighting their integral role in helping unemployed people back to work (Urwin and Buscha, 2012). However, as we will argue in this report, traditional workforce health interventions are having little impact on this group, and are placing SMEs and their employees at a disadvantage.

SMEs comprise a very wide range of businesses, both in terms of their size and the sorts of work that they do. Inevitably this complicates the process of developing and recommending workforce health interventions for SMEs. What works for office-based businesses may not be appropriate for construction contractors, and what works for a medium-sized business with 200 employees is unlikely to be directly transferrable to a micro business with four employees. Moreover, SMEs' ability to provide support – and even to see the business and human case for their providing it – will often be influenced by their size, and the time and resources available to them. Therefore a central challenge is not just that one size will not fit large organisations and SMEs, but that one size will not even fit all SMEs.

In this report, we argue that more needs to be done to address the workforce health needs of SMEs, before making some recommendations on what policymakers can do. In the next chapter we outline the picture of SMEs and SME workforce health, before presenting a business case for why workplace health support for SMEs needs to be improved, and engagement with SMEs on this agenda increased. Chapter 3 then looks at some of the interventions and support services that are available to SMEs at present, and how they are being used. Based on these, in chapter 4 we highlight gaps in current provision and barriers to engagement and use. We then discuss how these barriers could be ameliorated and engagement improved through looking at what SMEs want from health and wellbeing support services and what has worked previously. Finally, in chapter 5 we reflect on our findings, and make a series of policy recommendations.

Throughout the paper we also provide case studies based on the experiences of different workplaces and different approaches, as a means of illustrating the sorts of strategies that are available to SMEs, and the diversity of different responses that are required and can be taken.

2 SME health in the UK

To better understand what support would be valuable to improve SME workforce health, we first need to ask what we already know about the context, health and health needs of SME employees.

2.1 What do SMEs look like?

SMEs are diverse group of businesses, including sole-traders with zero employees, right up to those with 249 employees. They operate across a full range of UK industries, and across geographies, and range from family businesses which have operated for generations, to new start-ups. Figure 1 summarises key business statistics relating to UK SMEs.

Figure 1: Business statistics, UK private sector 2015

	Businesses	% of total	Employment (thousands)	% of total	Turnover (£ million)	% of total
All businesses	5,389,450	100.00	25,871	100.00	3,710,278	100.00
SMEs (0-249 employees)	5,382,485	99.87	15,611	60.34	1,753,870	47.27
Small businesses (0-49 employees)	5,349,930	99.26	12,482	48.24	1,215,873	32.77
With no employees	4,077,590	75.65	4,451	17.20	237,190	6.39
All employing businesses						
Of which:	1,311,860	100.00	21,420	100.00	3,473,088	100.00
1-9 employees	1,068,815	81.47	4,010	18.72	435,624	12.54
10-49 employees	203,525	15.51	3,967	18.52	543,058	15.63
50-249 employees	32,555	2.48	3,183	14.85	537,997	15.49
250 or more employees	6,965	0.53	10,260	47.89	1,956,408	56.33

Source: BIS, 2015

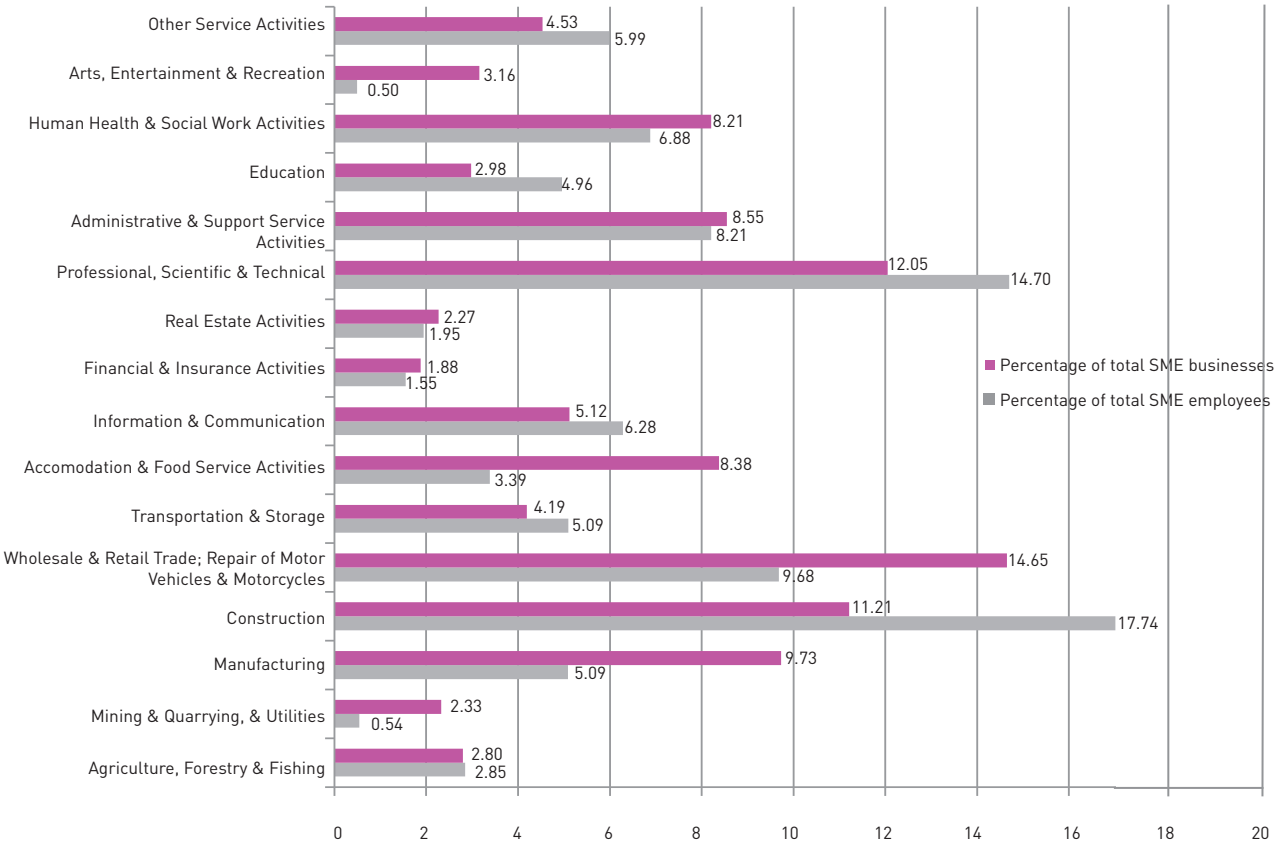
In this report we focus primarily on the 1.3 million UK SMEs which have employees. Though we recognise that self-employed sole-traders will have many challenges in common with SME employees, particularly those in the very smallest firms, there are many other challenges which are distinct to sole-traders which we feel warrant separate attention.

It is noted however that the distinction between employees and the self-employed is not always clear. In some sectors (such as construction), it is normal for large numbers of self-employed sole-traders to be contracted together on a specific project, creating a situation in which they are dependent on

a particular contractor (often regularly, and for a substantial period of time) for pay and conditions without being a direct employee of that contractor. This brings about similar challenges around health and wellbeing as would be experienced by a group of 'employees'. This is the norm in this industry and in many others, so we do try take these individuals into account. For the purposes of this report they are included as employees.

Almost 82 per cent of SMEs are micro businesses (i.e. with under 10 employees), while only 2.5 per cent are medium sized (50-249 employees). As micro-businesses comprise such a large proportion of the total number of SMEs and UK private business as a whole, there is a pressing case for focusing on them. In such businesses it is often the case that responsibility for the business and its employees falls exclusively on a single owner-manager, accentuating challenges of capacity and leadership around workplace health. As we discuss below, this is also likely to be the group of businesses where less provision is made for employees' health and well-being and where the business case for doing this is less likely to be perceived.

Figure 2: SMEs by industry: percentage of businesses and employees



Source: BIS, 2015

Taking an industry view, we see the highest proportion of SME employees work in Construction, while the greatest proportion of SME businesses are found in Wholesale and Retail Trade (see Figure 2). There is considerable regional variation in the number of SMEs, with business density much higher in London and the South East than elsewhere in the UK (BIS, 2015). Indeed, in 2015 there were over seven times as many SMEs in London as there were in the North East (974,400 and 135,300 respectively).

The variation in SME geography and industry brings with it a variation in health and safety challenges. For example, in manufacturing, construction and engineering the most pressing risks are often seen as resulting from the physical environment, and health conditions which affect mobility or dexterity may be seen as more relevant here. In office-based, non-manual environments, conditions such as work-related stress are more often the reason for absence (CIPD, 2015). Moreover, the wide geographical spread of SMEs, across urban and rural areas and more or less densely populated business communities influences ability to access both health and social support. Reaching employees in all of these situations will require flexibility and innovation.

2.2 The picture of SME employee health

Recent data on the health of the UK workforce has suggested that almost one in every three employees have at least one mental or physical health condition (Steadman, Wood and Silvester, 2015). This is across all sectors and sizes of organisations, indicating that employee health is an issue that all employers potentially need to be concerned about. Though we recognise that on an individual basis an SME is less likely than a large employer to have an employee with a long-term health condition, given the size of the SME workforce we argue that the health of SME employees as a community is not an issue that policymakers can afford to ignore. In this section we will look at the picture of SME workforce health and its implications for employers and society.

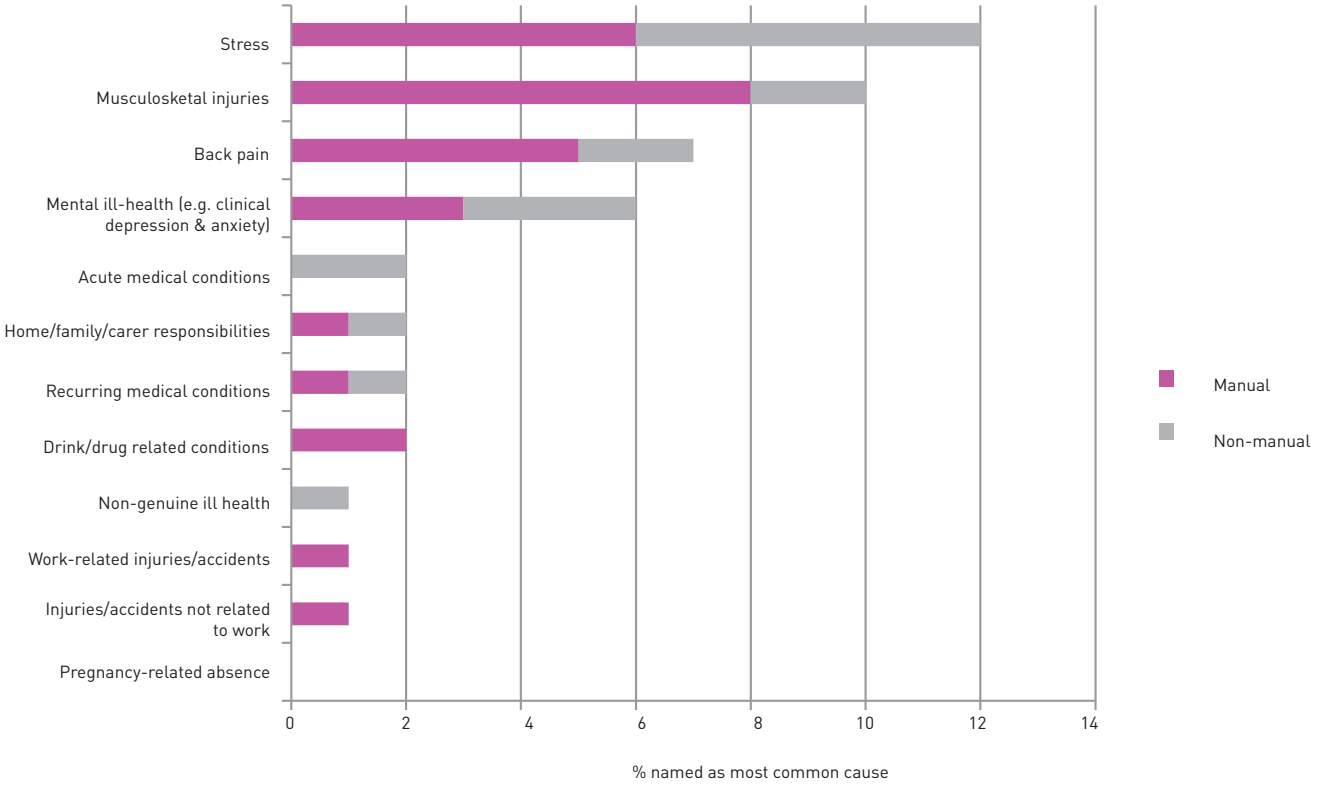
Levels of sickness absence are often seen as a proxy for workforce health and how it is managed. SMEs employers and employees alike tend to report lower levels of employee absence than large employers as well as shorter duration of absence (CIPD, 2015; Steadman, Wood and Silvester, 2015; Young and Bhaumik, 2011). It is therefore important that we explore what might differ between large and small employers to drive this effect. We suggest that this lower sickness absence is due to interrelated issues of employee health and organisational culture.

According to employers responding to the CIPD absence management survey, minor illnesses such as coughs and cold are the number one cause of short-term sickness absence (CIPD, 2015). In terms of long-term conditions, the greatest numbers of days lost to sickness absence are attributed to musculoskeletal disorders (MSDs), and stress, depression and anxiety (ONS, 2014). These conditions are regarded as major causes of both short and long-term sickness absences across industries, including manual and non-manual professions (CIPD, 2014; 2015 – see Figures 3 and 4, below).

There are some limitations as to how well such data reflects SMEs - most SMEs do not collect information on sickness absence and further, they are rarely engaged in formal networks, including professional bodies like the CIPD, through which this data might be collated and reported. There is however no reason to expect these patterns to be particularly different for SME employees. The limited available sector-specific data supports this assumption. For example, a survey on SMEs in the Engineering sector identified back problems and MSDs as the top reason for long-term absence, followed by 'awaiting surgery, medical interventions or tests', followed by stress and mental health problems (EEF/Jelf, 2015).

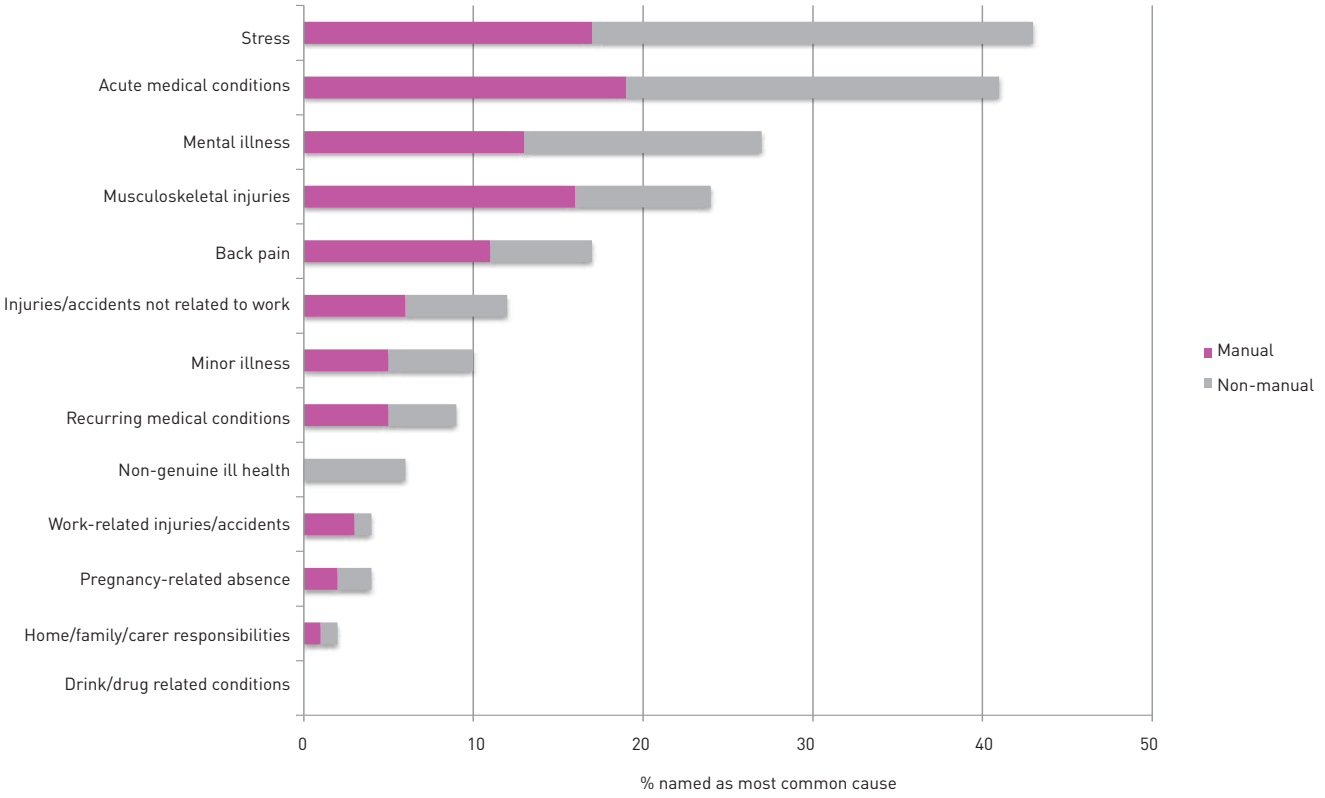
Rather than assume that the health of SME employees is fundamentally different to employees of larger businesses, it is important to consider other factors which might influence absence. Stress features prominently amongst reasons for work absence, and is seen as cause of poor health. There is no data to suggest that SME employees experience greater stress than those working for larger employers (CIPD, 2015); to the contrary, employee surveys indicate the opposite, with those in larger business more likely to report work-related stress (Steadman, Wood and Silvester, 2015). There is however some indication that SME employees experience stress differently from employees in larger organisations. Lai et al. (2015) identified that work overload, job insecurity and poor career progression, quality of work and poor communication had a stronger influence on employee stress levels in SMEs than in larger firms.

Figure 3: Most common reasons for short-term absence



Base: Manual 342; Non-manual 423
Source: CIPD, 2015
Note: Excluding minor illnesses such as coughs and colds

Figure 4: Most common reasons for long-term absence



Base: Manual 310; Non-manual 394
Source: CIPD, 2015

Stress is also seen as a predictor of presenteeism – attending work while sick– which is seen as a driver of poor health (Ashby and Mahdon, 2010). Presenteeism has been shown to increase the likelihood of long-term sick leave at a later date (Hansen and Anderson, 2009), and can also lead to illness spreading amongst the workforce (Widera, Chang and Chen, 2010). Though research on presenteeism in SMEs is limited, there is some indication that the context of SMEs would drive presenteeism (Knani, Fournier and Biron, 2015). Along with stress, decisions on whether to come into work while sick or to take time off are greatly influenced by the individual characteristics of employees and the features of their workplace (Hansen and Andersen, 2008). This is particularly true where there are concerns around the businesses' ability to cover absent employees work, or about placing an extra burden on colleagues (Ashby and Mahdon, 2010; Targoutzidis et al., 2014) – something likely to be even more relevant to small firms. Indeed, research on 91 SMEs in Greater Manchester suggested that SME employees often experienced these pressures, reported as an 'inability to "carry people" who are off sick' due to the impact that this would have on business operations (Holt and Powell, 2015: 52).

Holt and Powell's research also suggests that presenteeism is a particular issue in family-run organisations, where high levels of job demands alongside long hours have been widely observed (Chua, Chrisman and Chang, 2004). Employees may also avoid absence as they simply feel it is more notable in an SME than in a larger organisation (CIPD, 2015). Further it has been suggested that less generous access to sick pay in SMEs may also drive presenteeism (CIPD, 2015; HSE, 2005). However, evidence is limited on this topic, and other research found no patterns in the data between reports of presenteeism and how employees were paid when they took sick leave (Young and Bhaumik, 2011).

Reduced access to sick pay is, however, associated with even more troubling indications of poor employee health. Individuals who move directly from employment onto ESA without first having a period of sickness absence were significantly more likely to be have been working for a smaller organisation (and particularly micro organisations) than for a larger one (Adams et al., 2015). This has been suggested to be due, at least to some extent, to SMEs inability to pay for periods of prolonged sickness absence. This may be further exacerbated by the fact the SMEs are less likely than large employers to provide employees with access to formal workplace health interventions which are seen as being beneficial for both preventing and managing ill health at work. These interventions and their use in SMEs are discussed further in chapter 3.

Another influence on levels of sickness absence, as well as on health and wellbeing more broadly, is workplace culture, and particularly the notion of 'good work' (see Figure 5, below) (Bevan, 2012). There is a significant body of evidence outlining the relationship between good quality work and good health (Marmot, 2015; Butterworth et al., 2014).

There is some degree of consensus that smaller firms are more likely to generate a more positive working environment than larger firms (Sarantinos, 2007). SME employees, along with being less likely to report feeling workplace stress, are more likely than their colleagues in larger businesses to report finding their work rewarding and that they have control over their working conditions (Steadman, Wood and Silvester, 2015). They are also more likely than those in larger firms to report higher job quality (Storey et al., 2010), to say that they trust their managers and feel fairly treated by them, and reported incidents of bullying tend to be lower (FSB, 2008).

Figure 5: What do we mean by good work?

The greater likelihood of closer working relationships between employees and senior managers in SMEs than in larger firms is seen as contributing to 'good work'. For example, employees might feel that this facilitates their having greater control over their work, more influence over organisational decisions, and more direct communication. Similarly closer working relationships may also increase the likelihood that an individual's health becomes an employer's direct concern (Sarantinos, 2007).

Perceptions of improved job quality among SME employees have been associated with the lower likelihood of having formal HR policies and procedures due to SMEs size and need for greater flexibility (Storey et al., 2010). Such findings cast doubt on the idea that smaller businesses should necessarily seek to emulate the policies and approaches of larger organisations.

Recognising the differences between large and small employers in this context is vitally important. SMEs operate within business contexts that are specific to and shaped by organisational size, and employees of small and large firms appear to react to and manage stress and health factors at work in somewhat different ways. In turn, this creates different pressures, and means that SMEs use and access services in fundamentally different ways to large businesses. The different contexts and different needs mean the business and social case for SME investment in workforce health will also differ. This is explored in the next section.

2.3 SMEs and workplace health: making the business case

The day-to-day pressures of running an SME may leave SME owners, particularly those without any other managerial support, with little capacity to consider employee health in a strategic or even a reactive way. The relative rarity of an SME employee requiring health support, particularly in micro businesses, may further reduce the priority of workforce health. Therefore while on an individual basis an SME owner-manager may appreciate there is a human and moral case to support the health

of their employees, the business reasons could be less apparent. It is important therefore to clearly outline the business case for investing in workforce health, in a way that reflects the perspectives and the context of SMEs.

The 'business case' is usually made in terms of the financial implications of workforce health for business. Indeed, this is often significant - organisations with fewer than 50 employees lose an average of 4.2 days per employee per year to sickness absence, rising to 6.7 days for medium-sized organisations (CIPD, 2015). Costs associated with absence will of course vary between organisations. The Health and Safety Executive estimated the average direct financial costs to business (including productivity costs) of each case of employee absence due to ill-health for 7 days or more at £8,000 (HSE, 2013), but did not provide separate costs for SMEs and large businesses.

As the HSE figure makes clear, the costs of absence are not limited to direct salary or sick pay costs of absent employees, nor to the costs of bringing in temporary cover. There are also the costs of reduced productivity, and potential for reduced customer retention and lost business (Bajorek et al. 2014). This broader impact of sickness absence is exaggerated in smaller firms as there are fewer employees available to cover absent colleagues (Rikhardsson and Impgaard, 2004); as such, we would expect the cost of absence in SMEs to be higher than the average cost suggested above. Such expenses will be hard for many SMEs to absorb. Healthy workforces have lower absence levels; it seems clear that in many cases 'employers can achieve significant cost savings if they can reduce their absence by improving employee health and wellbeing at work' (Bevan, 2010: 9).

This is not just about reducing sickness absence, however; the case needs to be made for making real improvements in overall health and wellbeing, and not simply discouraging absence. Indeed, from a financial perspective, discouraging absence may be counterproductive, with research indicating that the costs to a business of presenteeism are even greater than the costs of absence. For example, presenteeism related to mental health conditions alone is estimated to be 1.5 times the cost of absence (Sainsbury Centre for Mental Health, 2007).

Improved employee 'wellbeing' has also been associated with improved productivity and job performance (Bryson, Forth and Stokes, 2014; Oswald, Proto and Sgroi, 2015). Subjective wellbeing as defined in this paper is 'all of the various evaluations, positive and negative, that people make of their lives, and the affective reactions of people to their experiences', and as such is different from 'health'. Many of the factors identified as influencing wellbeing reflect those which make 'good work' - for example, levels of control, appropriate demands on employees, HR practices and the workplace environment (Bryson, Forth and Stokes, 2014). Therefore we might surmise that there are potential productivity gains to promoting 'good work' and employee wellbeing.

Investing in workplace health programmes has also been associated with financial gains for businesses. There is some evidence of a causal link between organisational health and wellbeing programmes and financial benefits in the intermediate term, as well as improvements in staff turnover, employee satisfaction and reported injuries at work (Bajorek et al., 2014). Evaluations of health promotion initiatives – those aimed at preventing employees from developing health conditions in the first instance – trialled specifically in SMEs also produce encouraging results: eleven out of thirteen initiatives evaluated in one study were profitable over a five year observation period and, over the longer term (7 to 10 years), the two 'non profitable' initiatives turned a profit (Targoutzidis et al., 2014). Case study A provides an example of how an SME has made real cost savings through their workplace health programme, as well as improving staff satisfaction levels.

Case Study A: TRAC Services

TRAC is an independent regulatory affairs consultancy, employing 21 people as of 2014. The business has held a Cornwall Healthy Workplace Award since 2012, and has drawn on the resources provided by the Cornwall 'Be Healthy at Work' initiative and network in developing its own health and wellbeing policies and initiatives. These cover a range of issues from safe working environments, to helping employees to maximise their own mental and physical health and wellbeing.

TRAC's policies include:

- Health and wellbeing code
- Stress management
- Flexible working policy
- Back pain and prevention policy
- Smoke free policy
- Policies for new and expectant mothers

Alongside these TRAC also puts on a range of initiatives intended to promote health and wellbeing throughout the year. In 2014 these included:

- Presenting information on mindfulness to staff, and giving staff the opportunity to take an online mindfulness course
- Arranging a free health check up for all staff
- Delivering alcohol awareness, cancer awareness and diabetes awareness information
- Providing healthy food in the office and staff canteen
- Including information on health and wellbeing campaigns in staff communications such as the staff noticeboard and email newsletters.

TRAC's absence levels are well below that of both the public and private sector, averaging just 1.6 days per employee in 2014. This equates to a cost of total of £326 per employee, per year, compared to a national average of £520 within the private sector. TRAC's staff also reported very high levels of satisfaction with their employer, indicated in their staff survey. All respondents agreed that their stress levels were manageable, that they felt respected at work, and that they felt their health and wellbeing was important to the business.

However, knowing the financial costs to 'business' of poor workforce health and the potential gains of investing in it, may still not be sufficient to drive SME engagement more widely. The costs to the individual employee of ill-health at work are even more significant than for the business; while HSE estimates the direct cost to business as an average £8,000 per case for absence of over seven days, as discussed above, the 'human costs', borne by individuals, are almost three times as much (HSE, 2013). The higher likelihood of direct interaction between employers and employees in small firms, and the possibly closer relationships, may increase employers' understanding of the costs to the individual over the costs to the business, and encourage their engagement (Wang et al., 2007).

Wang et al. (2007) therefore suggest that the financial business case is limited in its utility in engaging SME owner-managers. They suggest that when seeking to engage owner-managers in business improvement activity (in this case, business planning) there is often an inappropriate focus on the economic outlook to the exclusion of other factors that might matter more to SME owner-managers. These include the broader, and often less tangible goals of starting your own business, such as autonomy, personal satisfaction and lifestyle. It is argued that owner-manager aspirations (rather than business aspirations per se) are integral to whether or not SMEs strategically plan, and the same might therefore be true when talking about the growth and productivity tied to employee health.

Also of considerable importance will be the immediate impact on everyday business operations of losing an employee to ill-health – even for one day of absence. Sickness absence may represent a long-term cost for a SME, but on a day-to-day basis, for many small and micro-businesses it will mean a struggle to maintain normal business operations. This will potentially result in a loss of custom if orders and expectations are not fulfilled.

All of the above factors, and likely more besides, need to be considered in devising a business case to drive SME engagement. What is viewed as most important will vary from firm to firm, but it is clear that taking a broader approach to the business case that recognises the challenges of SMEs and the ambitions of owner managers is more likely to be effective.

In this chapter, we have summarised the main characteristics of SMEs in the UK, emphasising the wide variation between employers in terms of size and industry. We suggested that there is a lack of data on the health profiles and needs of SMEs, which is a consequence in part of their lack of involvement in business networks and the tendency to not record such information (often limited by resources). There is clear evidence however that absence is lower in smaller firms, despite there being no indication that the prevalence and nature of health conditions is markedly different among SME employees. We surmise that this variation is likely driven by a mix of higher pressure to attend work, and better job quality in SMEs, with variations in access to sick pay, the presence of formal workplace policies and health support interventions all likely having further influence. The lack of access to support increases the likelihood that upon becoming ill, an SME employee will fall quickly out of work and onto ESA. The relative disadvantage of SME employees in this respect means there is a strong case for concerted policy action to support SMEs to look after their employees' health and wellbeing. They constitute a considerable proportion of UK employees and are as vulnerable to poor health as their counterparts in larger organisations, yet their access to support to both prevent ill-health and to manage their health conditions at work is much more limited. Further to this, we outlined the business case for why we should support and encourage SMEs to invest more time and energy in employee health.

In the next chapter, we explore current provision of workforce health support – from both an employer and a policy perspective – and discuss specific barriers to SME access and use.

3 Workplace health: interventions and support for SMEs

As we have outlined above, the health of SME employees is a continuing challenge, and presents a strong social and economic case for policy intervention. In this chapter we explore existing workplace health interventions (both promotional/preventative and reactive), look at how they are currently being applied to SMEs, and the extent to which they are effective. This is done both from the perspective of employer interventions and with reference to the current workplace health policy landscape.

It is worth noting that evidence around what works in terms of workplace health interventions is somewhat mixed and limited. Dibben et al. (2012) state that there is a reasonably strong body of evidence on workplace-based interventions for MSDs and on psychological interventions for depression in helping people to stay in work or return to work following sickness absence, but a paucity of good evidence on interventions addressing other conditions, or evaluations that demonstrate work-related outcomes, as opposed to just health outcomes. Given this we do not explicitly review the evidence for condition-specific interventions here.

3.1 Employer interventions

Though the academic evidence base might be limited, there is a growing consensus that effectively promoting, supporting and managing employee health requires a number of approaches. To some extent this will be about providing systems and policies to encourage continuity in support and processes. However it is also about providing physical access to effective workplace health interventions which provide timely treatment and ongoing support to manage conditions; about recognising likely health problems and taking action to prevent them or to intervene early; and, about developing a workplace culture that supports these activities and ensures employer and employee engagement in them.

We therefore consider interventions and activities that aim to stop employees from developing health problems in the first place (health promotion measures), as well as those more concerned with helping employees to manage their health conditions and remain at work, and those focussed on early intervention and rehabilitation (reactive measures). Within these we consider a range of interventions, both formal and informal, and workplace-focused to individual employee-focused.

3.1.1 Sick pay

Sick pay, provided by employers to employees who are off sick from work, is probably the most widely available workplace health intervention with the provision of Statutory Sick Pay (currently £88.45 per week) a legal obligation for many. Employees are not entitled to SSP for the first 3 days of sickness absence (so-called "waiting days") and it is paid for up to 28 consecutive weeks of absence[1]. Employers may also offer Occupational Sick Pay (OSP) on top of SSP, usually at a higher rate and with different entitlement provisions.

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

Many smaller firms will have less generous sickness absence policies than their larger counterparts (CIPD, 2015; Young and Bhaumik, 2011; HSE, 2005). For those who only offer SSP, the three day unpaid waiting period and the low pay rate mean that employees who are off sick may undertake a considerable cut to their income for that period. Indeed, as discussed above, lower access to sick pay has been linked (though not causally) to increased presenteeism and to a greater likelihood of falling out of employment and on to ESA, likely due to an SMEs inability to absorb the costs of long-term or recurrent sickness absence.

Prior to 2014, the **SSP Percentage Threshold Scheme** offered employers who experienced high rates of sickness absence compensation from the Government. However in 2015 this was abolished as it was felt to give 'the employer no incentive to reduce absence' (Black and Frost, 2011: 10), with the resulting cost savings instead being put into Fit for Work (see 3.2.2). The impact this has had on SMEs is not currently known, though a 2014 survey of Federation of Small Businesses' (FSB) members identified that around half of SMEs felt this would have a negative impact (FSB, – unpublished).

Income Protection (IP) **insurance** can be purchased privately at an individual or at a group level to cover the costs of employee absence. IP insurance will provide employee salaries while they are absent through sickness; this is beneficial both to the employee, who may receive a higher rate of sick pay than they would otherwise be entitled to through Statutory Sick Pay, and the employer who can claim back the cost of paying the absent employee. Both Group IP and Individual IP often also cover the costs of rehabilitation and absence management, helping the employee to return to work more quickly (Cebr, 2015). IP also often compensates employers for taking on an extra staff member to cover the absent employee. Given the difficulty managing absence in small and micro businesses this is seen as particularly relevant to SMEs.

However, it is relatively rare for SMEs to have such insurance coverage – one survey suggested that 65 per cent of SMEs had no insurance cover for any employees (Murphy, 2014). Further, since insurance is often seen as a very costly option, where it is taken out it is usually limited to very senior 'key' employees, leaving the majority of the SME workforce unprotected.

3.1.2 Sickness absence management policies and other health policies

Many employers develop sickness absence management policies to help them manage and monitor employee absence. Monitoring and recording sickness absence can help employers to identify the main health issues in their workforce and to recognise where employees have patterns of absence which might imply they need support, and warrant interventions. They may also outline provisions for returning to work, including keeping in touch with employees when they are on sick leave and processes around return to work planning and making adjustments (see 3.1.4 below), all of which are seen as having an important influence on the likelihood of a return to work (HSE, 2010).

SMEs are less likely to have a written sickness absence policy than larger organisations (Steadman, Wood and Silvester, 2015; CIPD, 2015). There are however understandable reasons why small and micro-business owners often do not monitor and record staff sickness in the same way as larger organisations. Dominant of course is the demand on time of such activity – particularly given the likely absence of a dedicated Human Resources (HR) team or officer. Another reason may be that although the prevalence of illness is not necessarily lower across SMEs as a whole, the likelihood of an employee in an individual SME being ill at any one time will be much lower in small and micro businesses in particular than in larger businesses, thus reducing its relevance. The lack of written policies does not necessarily mean that sickness absence is not managed in SMEs; indeed it may be managed instead in a less formal way. However from the little data we do have it appears that there are a significant proportion of SMEs who do not manage staff sickness absence in any way (EEF/Jelf, 2015).

SMEs tend to rely on formal health and wellbeing policies to a lesser extent than larger businesses in general, for example, Adams et al. (2015) state that small businesses are only around half as likely as medium or large businesses to have formal policies on stress or mental health in the workplace. This could be because of the closer relationship between small and micro-business owners and their employees which renders such formal approaches unnecessary, as discussed in the previous chapter, or again due to relatively low incidence due to relatively small numbers of employees.

3.1.3 Provision of support services

Occupational Health (OH) services and **Employee Assistance Programmes** are viewed by large employers in particular as common workplace health interventions. Though relatively easy to implement, such formal support often has significant cost implications. SMEs are much less likely than large organisations to offer such support to employees (see Figure 6). Research by Bupa (2015) suggests that just 13 per cent of SMEs have employed the services of a HR professional with specific responsibility for employee health. Lack of time is the most cited barrier to provision (FSB, 2011), and financial limitations and lack of knowledge and expertise also circumscribe the extent to which SMEs are willing and able to provide their own support (FSB, 2008). These barriers are explored further in chapter 4. McLellen et al. (2015), who distinguish between 'occupational safety and health' (concerned with minimum legal responsibilities to protect workers) and 'worksite health promotion' (to positively enhance worker health), suggest that the provision of either is not associated with size of organisation as such but with leadership support and enthusiasm and organisational capacity. The emphasis on organisational capacity appears particularly important here; while owner-managers in small and micro-businesses in particular may be keen to take care of and retain their workers, they are unlikely to prioritise preventative issues (that by nature do not appear to be immediately pressing) over the numerous other demands on their time. Indeed, anecdotally it is often suggested that where SMEs do seek support with workplace health issues, it is in reaction to a problem that has already occurred – often in light of related legal or other implications.

Box 2: Common types of workplace health and wellbeing support

There are various health and wellbeing interventions that organisations (and more often larger organisations) may provide to protect, support and improve the health of their workforce. They may be used reactively (i.e. when a problem has occurred), or proactively (aimed at preventing health and wellbeing problems from arising). Some common interventions and approaches are:

Occupational Health services

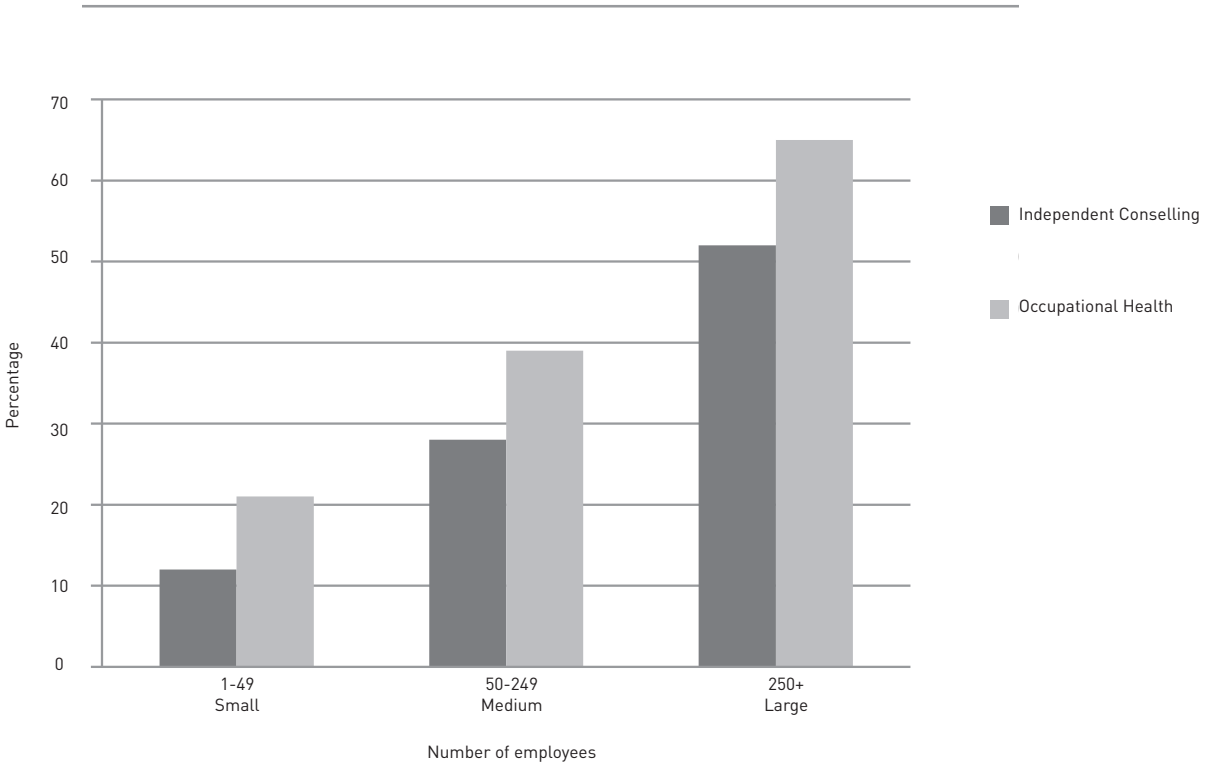
- Occupational health professional provides assessment of how an employee's work might affect their health and ensuring that they remain fit for the work that they are required to do.
- Can involve prevention (e.g. ensuring safe, comfortable working conditions) or reaction (helping employees to access services to help them return to work, or making necessary adjustments).

Employee Assistance Programmes

- Provision of confidential, independent support for employees to help them manage work and personal problems which may affect their health and wellbeing.
- Usually includes telephone based or face-to-face counselling support.

Paying for services on an on-going and preventative basis may represent an unreasonable cost to the owners of such businesses as it is likely that they will only make use of these infrequently. Additionally, as SMEs are unable to benefit from the economies of scale in service provision that larger businesses can take advantage of, services are actually more expensive for them to provide (Targoutzidis et al., 2014; Lancaster et al., 2003).

Figure 6: Employee reported provision of OHS and counselling in organisations of different sizes



Source: Steadman, Wood and Silvester, 2015.

The success of these interventions is also to some extent dependent on the broader culture of the organisation – particularly how far the employee believes that the organisation is supportive of their health and is willing to engage with available support and activities. This is discussed further in chapter 4.

3.1.4 Workplace adjustments

There is a legal requirement for employers to provide reasonable adjustments for employees with long-term health conditions and disability . These are made to enable an employee to return to work (for example after a period of absence), or remain in work. Adjustments may be to the work environment, working hours, the nature of tasks, or via the provision of specific support (such as support to travel to work or a job coach) or treatment. Making adjustments is positively associated with lowering the likelihood of long term sickness absence (Steadman, Wood and Silvester, 2015). Employees report that the most common adjustment made for them by employers was allowing 'time off at short notice', followed by 'shorter hours', and 'changes in job duties'. Some one in seven employees (14 per cent) who had received adjustments reported that there were other adjustments they thought would be useful which they had not received (despite in many cases requesting them). The most common 'unmet need' was a reduction in workload, followed by more breaks.

SME employees were more likely to report that adjustments made for them after a period of absence were helpful (Steadman, Wood and Silvester, 2015). However, the relationship between company size and whether adjustments were provided to employees in the event of illness was unclear, supporting McLellen et al.'s (2015) assumption that factors such as leadership attitudes have a greater impact on the likelihood of providing support than organisation size. In turn, this implies that there is a wide variation in the sort of support that SMEs provide, both proactively and reactively.

3.1.5 Early intervention and disclosure

It is important to note that workplace adjustments can only be made where an employee has disclosed their health condition(s) and needs to their employer. Early disclosure is likely to lead to a shorter period of absence (Steadman, Wood and Silvester, 2015). Fundamental to this is that earlier disclosure increases the likelihood of earlier intervention, and earlier access to rehabilitation. These have been demonstrated to result in significant decreases in length of employee absence and in costs to employers (Bevan, 2015).

Evidence suggests that line managers have a central role to play in recognising the early indicators of mental ill-health, and this is emphasised in the NICE (2015) guidelines on workplace stress. Overall, research shows that managers' attitudes towards mental ill-health are very important in determining whether an employee feels comfortable disclosing a problem to them, and whether they are able to keep working after a problem has arisen (Gilbreath, 2012, Martin, 2010). Perceptions of employer supportiveness are highly relevant to disclosure and may prevent adjustments being made, as stigma and concern about employee and colleague attitudes is a considerable barrier to disclosure of health conditions. Employees are less likely to feel comfortable disclosing a mental health condition than a physical health condition - one survey suggested that 70 per cent of employees with a physical health condition had disclosed this to their employer, compared to just 50 per cent with a mental health condition (Steadman, Wood and Silvester, 2015). They are also more likely to have reported disclosing a condition if they are working in an organisation with comprehensive health and wellbeing support structures, which are less prevalent in SMEs (Steadman, Wood and Silvester, 2015).

3.1.6 Training

Training to ensure that managers are implementing policy and interventions effectively can be an important intervention in itself. Other types of training may also be helpful – for example training in the recognition and management of stress or common health conditions. The two day Mental Health First Aid course, for example, helps people to recognise, understand and better manage mental ill-health in the workplace, providing them with the knowledge and confidence to intervene and provide support. A lack of confidence in providing support is identified as one of the main reasons why managers find it difficult to support employees with mental health problems (Munir et al., 2009). Directed towards employees, training can also help them to develop a better understanding of their own mental health and aid in managing conditions and factors that might affect this, such as stress (CBI, 2014).

Taking time out for such specific training is key barrier here for SMEs. This is compounded by factors also affecting other interventions, including economies of scale and the relative rarity of an employee requiring such support, particularly in the very smallest companies. This further reduces the appeal and possibly even the value of training initiatives.

Time is often of the essence for SMEs; the Responsibility Deal Working Group suggests that training should be kept to under a day, but our discussions with experts suggested that even shorter durations would be preferable. Some existing courses are already available in a shorter format which might better appeal to SMEs – for example, Mental Health First Aid offers a 3 hour 'lite' version. However, there has been no evaluation of the effectiveness of this – a short version is of no use if it does not achieve the desired outcomes. Indeed, there is little evaluation evidence available on the efficacy of such programmes from the SME context. As Martin et al. (2009) identify, where such evaluations of mental health interventions have been carried out, they have often uncovered high drop-out or low participation rates; however, they suggest that this could be countered by producing materials that are highly relevant to the needs of the target business community. This should be a central consideration in developing training resources.

There is a range of evidence around what works in terms of training interventions for SMEs, though the extent to which these are incorporated in to workforce health interventions is unclear. What we

know is that SMEs benefit from training that is delivered 'on the job', with a practical rather than a theoretical focus – 'learning by doing' – and that properly targeted e-learning can be particularly useful to SMEs as it is very flexible and can fit around day-to-day business (Jones et al., 2013; Farvaque et al., 2009). It is important that any training is specifically targeted at the real needs of the business and the challenges that it faces (Farvaque et al., 2009).

In the above section we have outlined a range of common, formal workplace health interventions and what we know about how they are used in SMEs. What we see is that such support is less available in SMEs, and this is for a number of reasons – chiefly the lack of time and resource for SMEs to engage with them, particularly on a preventive basis. Cost is a key issue – given the economies of scale involved, the costs of providing such support may be much higher for SMEs.

The lack of evidence on training in SMEs also means we cannot be sure which, if any, would actually be helpful to SMES should time and resources be less of a barrier. Further, it must be recognised that the effective implementation of such interventions is often highly dependent on the culture of the organisation, and the knowledge and commitment of managers and others to support employees. Indeed, what the available data does not tell us about is SME need, i.e.: the extent to which they are not using these interventions for practical reasons, such as cost or time, which means we may need to rethink current interventions and their delivery; and, the extent to which they do not feel these interventions are necessary, in which case we need to explore what is different in SMEs. These issues are further discussed in chapter 4.

It is clear regardless that SME employees are less likely to have access to workforce health interventions than their colleagues in larger employers, and consequently they are likely to be much more reliant on external support services and interventions. In the following section we discuss government policy and legislation which supports SME employee health.

3.2 Government intervention: policy, legislation and funding

As discussed, SMEs, and smaller and micro-businesses in particular, will be less likely (and are less able) to provide interventions which are commonly seen as supporting employee health to their employees. It is important to look at what support is provided externally through government policy and funding.

3.2.1 Legal and policy instruments

The main piece of legislation covering health and wellbeing at work is the Health and Safety at Work etc. Act (1974), and connected regulations. These are mainly focused on managing safety risks in the physical working environment. The Health and Safety Executive (HSE) is responsible for enforcing relevant legislation; however, in practice, the extent of enforcement (and capacity for enforcing any new legislation) is limited by the capacity of the HSE. The HSE also produces guidance for businesses on other issues related to health at work, for example on stress and MSDs.

The Flexible Working Regulations (2014) amend the Employment Rights Act (1996) to provide all employees who have worked at a company for over 26 weeks with the legal right to request flexible working, for any reason. This may present a challenge for SMEs, who prior to the change in legislation were much less likely to offer employee flexible working than their larger employer counterparts (Steadman, Wood and Silvester, 2015). SMEs, like other employers, will also have to comply with the Equality Act (2010) and Disability Discrimination (1995) legislation.

3.2.2 Fit for Work

Fit for Work[2] provides occupational health advice and assessment to employers and employees. It is run by the DWP. Though accessible for all employers and employees, it is particularly targeted at

[2] See http://fitforwork.org/

SMEs and businesses which do not have dedicated OH teams. It was rolled out during 2015 – with separate services for England and Wales, and for Scotland. The service is voluntary to use. Fit for Work comprises a telephone and online advice service for employers (replacing the Occupational Health Advice Line) and an assessment and support service for employees. Employers can refer their employees to Fit for Work after four weeks of absence, and GPs can refer before this point if they expect the patient to be off work for at least four weeks. Employees will then receive an occupational health assessment over the telephone and an occupational health specialist will put together a return to work plan for the employee, including recommendations on adjustments, which will (with permission) be sent to their employer. Businesses, including SMEs, are offered financial incentives to enable and encourage them to provide support as recommended in the return to work plan. Since 1 January 2015, employers implementing treatment plans recommended via Fit for Work can claim a £500 tax rebate per employee, per year on the cost of treatment (DWP, 2015).

An evaluation of Fit for Work is currently underway so we do not know at present how well this is working or how extensively it is being used by SMEs. An employee survey conducted prior to the launch of the Fit for Work identified that 78 per cent of SME employees thought the service would be useful - a lower proportion than employees of large organisations (87 per cent). Employees of businesses with less access to workplace health interventions in general were also markedly less likely to view it as useful. It is also noteworthy that employees of SMEs were more likely to say they would not use the service as they would not feel comfortable involving their employer (Steadman, Wood and Silvester, 2015) – perhaps suggesting that disclosure is more of an issue in SMEs than often suggested.

There are a number of concerns about how well Fit for Work will work for SMEs. These include the lack of employer input into return to work plans; once a referral has been made, it is developed exclusively through OH providers, GPs and the employee. Employer representatives that we spoke to were concerned that return to work plans would suggest measures that were not feasible or appropriate for their business. Discussions with experts also raised concerns that the four week minimum absence for referral to Fit for Work is much too long. Micro and smaller SMEs in particular find it very difficult to compensate for absent staff (Holt and Powell, 2015). For these businesses a four week absence would constitute (at the very least) a serious disruption to business, which would be less likely to be the case in a larger organisation. The lack of alternative means of ameliorating the impact on business, such as recourse to insurance schemes, further compounds this issue.

A further concern is that poor awareness of Fit for Work will be a significant barrier to use. Previous advice lines in a similar vein were under-used by small and micro-business due to a lack of awareness of their existence and a lack of confidence in the value of the advice provided (Sinclair, Martin and Tyers, 2012). There are concerns that there will be a similar lack of awareness around Fit for Work. Experts have suggested that communication around the launch of Fit for Work has been limited and had not reached sufficient numbers of SME employers or GPs. This was despite activity from DWP including, for example, outreach workshops and presentations at relevant conferences.

Comprehensive data on awareness and use of Fit for Work is not yet available. However, three months after the services was made available to employers, polling (from a survey of 689 employer conference delegates) suggested that around 75 per cent of all employers were unaware of Fit for Work's existence, and only 22 per cent of SME employers had heard of it (YouGov/Cigna, 2015). This is clearly a major barrier to employers making use of the service but, encouragingly, 49 per cent of employers who had heard of Fit for Work said that they were likely to use it. However, we do not know how many of those employers are from SMEs. As referrals to Fit for Work can also be made by GPs, their awareness and buy-in is vital to success. Again, however, we see low awareness; a survey of 1000 GPs found that 60 per cent had not heard of Fit for Work, and of those who had, only 21 per cent believed it would help to improve absence levels. Moreover around two thirds of GPs who were aware of the service did not intend to use it, believing that it was up to employers exclusively to address the problem of workplace absence (YouGov/Cigna, 2015).

Cigna's research also uncovered low awareness of the £500 tax credit that is available to support the costs of making interventions (YouGov/Cigna, 2015), adding a further perceived barrier.

3.2.3 Access to Work

Access to Work is a government service aimed at employees with a disability or long-term health condition who are either already in work or about to start a new job. Grants can be provided to employee to cover the cost of adaptations to the workplace that enable the employee to carry out their job. There is also a dedicated Mental Health Support Service within Access to Work, which is run by Remploy.

Employees must self-refer to access support, and therefore awareness is crucial– both on the part of employees, but also their employers in directing them towards it. Data available on Access to Work does not break down usage by size of organisation, therefore it is not possible to gauge the extent to which it is used within SMEs, nor its effectiveness. There are, however, concerns around awareness of the programme more broadly; a recent report by MPs described it as the 'best kept secret' in the DWP (Work and Pensions Select Committee, 2014).

3.2.4 Charters, frameworks and awards

Government policy interventions have driven the development of frameworks and guidance to support businesses to improve workplace health. These include: the Workplace Wellbeing Tool[3], which helps employers to work out the cost of ill-health to their business; the Public Health Responsibility Deal[4], that encourages employers to take part in the public health agenda; and, the Employer's Charter[5], which helps employers to understand their responsibilities towards staff and includes guidance on sickness absence and assessing fitness to return to work.

The Workplace Wellbeing Charter is the first set of national standards for workplace health. It was published by Public Health England in 2014. Organisations signing up to the Charter are supported to take action across each of the eight Charter Standards[6], and can be accredited at one of three levels: commitment, achievement and excellence. The Charter offers opportunities for assessments and self-assessment, and provides participating organisations with access to toolkits and advice to help them progress through the levels of accreditation. It also aims to function as a means of sharing good practice around health at work, and to provide employers of all sizes and sectors with a systematic, evidence-based approach to workplace health improvement. The model was developed and is owned by Liverpool based charity 'Health@Work'. Charter schemes are run and/or funded by local authorities. Case study B provides an example of a small business that has engaged successfully with the initiative.

[3] https://www.gov.uk/government/publications/workplace-wellbeing-tool
[4] https://responsibilitydeal.dh.gov.uk/
[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/32147/employerscharter.pdf
[6] Leadership, Absence Management, Health and Safety, Mental Health, Smoking and Tobacco, Physical Activity, Healthy Eating, Alcohol & Substance Misuse

Case study B: Rigo Spa and the Workplace Wellbeing Charter

Rigo Spa employs 22 people, designing and manufacturing swimming pools and spas. In 2015, it began using services provided by the Health@Work network in Liverpool to support and improve the health of its staff. Prior to this it offered no dedicated health and wellbeing support to staff, but within a year business has been accredited on all eight Workplace Wellbeing Charter standards.

The business operates from a rental property which lessened the owners' incentive to make large-scale changes to the physical environment. Alongside this, time and money available to invest in health and wellbeing support were limited. Despite this, the directors were still able to identify a good business case for investment.

The directors recognised that the business employs very specialised staff who they wanted to hold onto, and that providing this support could increase the extent to which staff felt valued by the management. As Rigo Spa deals mainly with clients in the health and wellness industry, business culture in this area also was thought to be important to maintaining a good company image. Additionally, its clients expect its health and safety procedures to match that of a large company which meant that it had to be able to demonstrate how it was looking after its staff.

The local aspect of the Health@Work/Workplace Wellbeing Charter network was very helpful to the business, and they were able to quickly begin to put into place appropriate written policies and access to resources on aspects of health and wellbeing including drugs and alcohol advice, smoking cessation advice, and a bike to work scheme. This has resulted in improvements in staff work ethics and greater staff interest in health and wellbeing, including some staff taking on extra responsibilities and extra training.

Over 1,000 organisations already hold the award, including many local authorities, NHS bodies and private sector businesses both large and small. There is no data currently on overall uptake of the Charter by organisation size (an evaluation on the Charter is currently underway). Looking at data from Health@Work in Liverpool however, we see that small and micro-businesses made up just over half of their members (Health@Work Centre/NHS Liverpool, 2013). Though this indicates that small and micro businesses may be well represented among Charter participants, this will only represent a tiny proportion of SMEs nationally. Though such schemes are usually well-regarded, anecdotally there are concerns that limited resources in local authorities seriously impact on their ability to assess and accredit greater numbers of businesses, while a lack of attachment to formal networks among SMEs and a lack of awareness of the workforce health business case are barriers to SMEs being aware that such support exists. This is discussed further in Chapter 4.

Further it is noted that not all local authorities are signed up to the Workplace Wellbeing Charter, with some retaining their own commissioned services. An example of this is the Healthy Workplace Programme in Leicester, which is aimed specifically at SMEs (Fit for Work Team, 2012) - see case study C

Case study C: The Healthy Workplace Programme – Fit for Work Team

The Healthy Workplace Programme is funded by the public health department within Leicestershire County Council. The Fit for Work Team deliver the programme through a team of Workplace Health and Wellbeing Specialists.

The programme is structured around five key steps:

1. Engagement with businesses
2. Interpretation of data to identify priorities and need
3. Targeted action planning
4. Supported signposting towards evidenced-based interventions
5. Review, measure impact and outcomes and embed practices.

The Fit for Work Team (FFWT) focus on engaging with SMEs, and specifically with Managing Directors and CEOs. To date they have worked with over 60 SMEs, with over 1500 employees. They are seeking to increase SME participation through steps such as removing the need for a face to face inception meeting.

At the start of the programme, SME participants complete a Health Questionnaire (HQ). Topics include physical activity, healthy eating, smoking, alcohol, mental health and wellbeing. It also explores managers understanding of what they should be doing to support employees' health and wellbeing.

The FFWT also carry out an audit that captures key information, for example: number of staff, occupational groups, mix of full-time/part time employees, available facilities, current practices, current challenges and key business metrics to benchmark against in the future. They also use the outcomes of the HQ to understand the employees' and organisational needs.

Findings from these processes are used to compile a bespoke company report, facilitating management discussion and the formulation of an action plan. The report consists of data, an interpretation of the key findings, guidance on each health and wellbeing topic and the business case for implementation. The report also contains a list of interventions that can be matched to the assessed needs of the employer. The plan includes a calendar of activity in order to embed behavioural change. Supporting this, the FFWT have developed a network of interventions and coordinate, recommend and broker in free or low cost activities.

Decision makers within the SME will then consider what they can realistically and feasibly implement or offer to their employees. It's important the 'offer' is pitched to the employees to gauge their interest, since engaging employees at this stage empowers them to make positive lifestyle choices.

The FFWT repeats the HQ after 12 months to measure the impact and outcomes so far. Regular contact is maintained to review current practices, offer support and advice and keep clients up to date with initiatives and current guidance.

Similarly, local authorities may also provide their own workplace health award schemes to engage local business in the healthy workplace agenda – for example the Cornwall & Isles of Scilly Healthy Workplace Award[7]. 'Healthy workplace' awards are also run by various private sector organisations, such as Simplyhealth[8] and more recently 'Britain's Healthiest Company'[9].

The extent to which SMEs, and particularly the smallest businesses, participate in such schemes is unclear, but likely to be limited to the few who already recognise the business case for workplace health, and the few that are actively engaged in relevant networks and therefore would know about these awards and see prestige in achieving them.

3.2.5 The NHS

Given the lack of alternative avenues, the NHS remains a key provider of occupational health support for SME employees. One sector survey reported that a third of its respondents relied exclusively on the NHS for treatment and rehabilitation programmes (EEF/Jelf, 2015). This brings with it a number of problems, notably around waiting times for treatment. For example, the most recent statistics on the NHS Improving Access to Psychological Therapies (IAPT) programme indicated that almost 20 per cent did not receive a treatment appointment within six weeks (HSCIC, 2015). As discussed above, absences from work are very costly for SMEs and the costs associated with presenteeism due to mental ill-health are even higher. Such long waits for treatment are likely to represent a significant business cost, and could seriously disrupt operations. Further, as SME employees are less likely to be offered flexible working, this may also have implications for their ability to access NHS services, which are often only available during normal working hours.

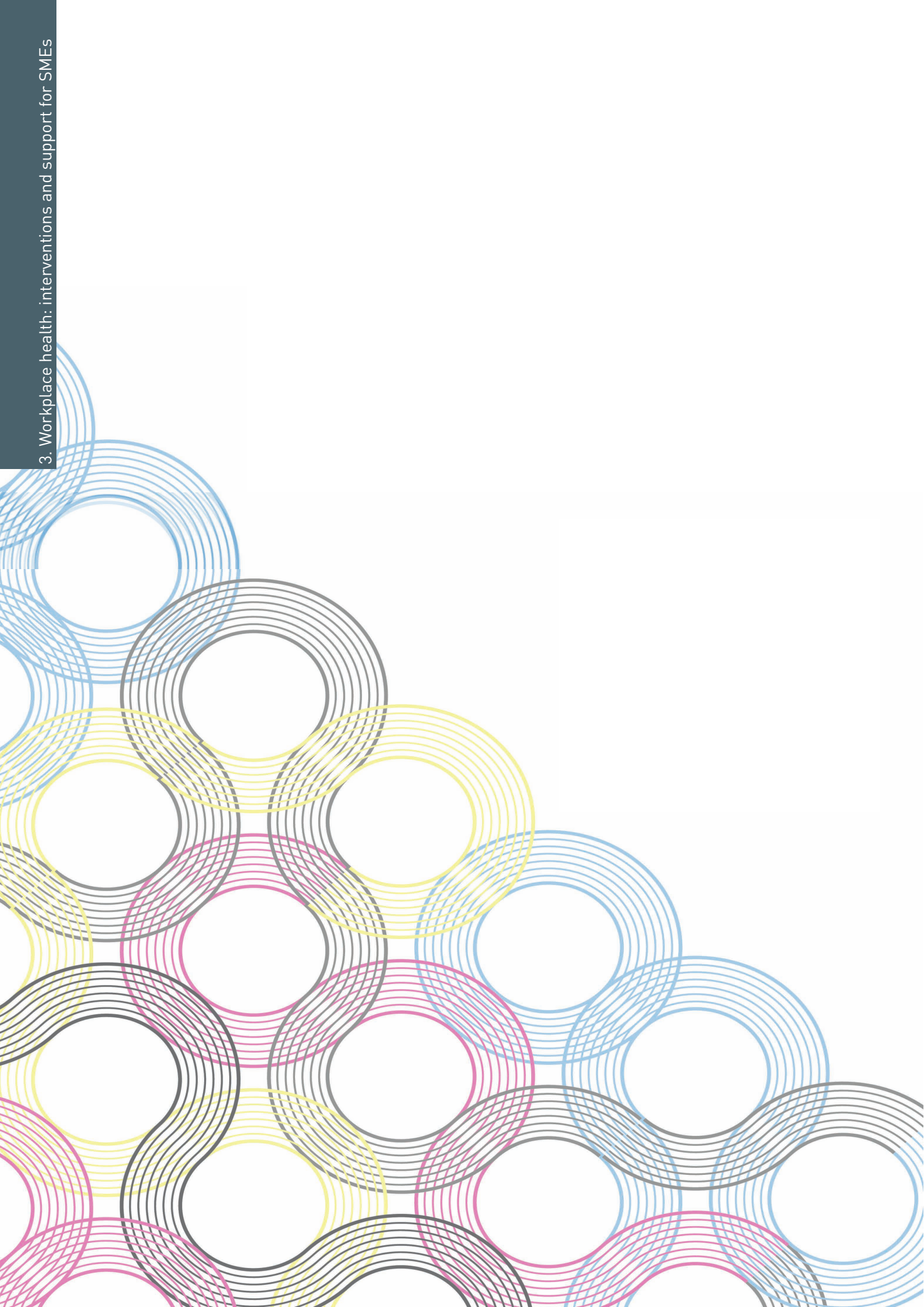
Further, it is often recognised that GPs simply do not have the time or the specific expertise to provide occupational health advice. This is reflected in evaluation of Statements of Fitness for Work (known as fit notes) (Shiels et al., 2013). Further to this it has been suggested anecdotally that even where fit notes are completed correctly, poor occupational health literacy among SME employers will further limit the impact this will have on workplace health.

GPs are also unable to refer patients to appropriate support, as occupational health is not available through the NHS. This is in contrast to some other European countries, such as Finland, which have a mandatory national occupational health system. GPs can now refer to the voluntary Fit for Work, but as discussed above we are yet to see how well this will work for SMEs.

Some NHS trusts provide occupational health support by offering their own occupational health services to local businesses. This is supported by the NHS Health at Work network[10], and can include services such as absence management, rehabilitation, risk assessments, general wellbeing advice and immunisations. There is unfortunately no data on the availability of this service across England, nor how or if it is being used by SMEs. Experts have suggested that it is difficult supporting SMEs through this service, given the high likelihood that SMEs will only seek out help when they have to reactively address a specific concern, rather than in order to undertake a strategic, longer-term approach to workforce health. Consequently the costs for NHS OH can be quite considerable for little return on investment or impact, often making it untenable.

In the above section we have outlined the main policy and legislative instruments to support SME workforce health. This is again marked by limited data to show us what is and isn't being used and working, making it difficult to assess whether they are appropriate or useful for SMEs. A significant barrier to using such support however is poor awareness of their existence. This is further discussed in the next chapter, where, drawing on the above analysis and other evidence, we identify and explore some strategic barriers to SME action on workplace health.

[7] http://www.behealthyatwork.org/healthy-workplace-award/how-it-works/
[8] https://www.simplyhealth.co.uk/sh/pages/businesses/healthy-workplace.jsp
[9] https://www.britainshealthiestcompany.co.uk/
[10] http://www.nhshealthatwork.co.uk/support-for-business.asp



4 Does current support work for SMEs?

The need to support SME employee health is not being met by current provision. Lack of resources – including time, money and staff within SMEs, particularly the smallest – presents considerable barriers for SMEs to provide common workplace health interventions, or to access government support. This is however only part of the picture. Having reviewed SME usage of specific interventions, in the following section we outline a number of barriers to SMEs accessing workforce health support which need to be considered and addressed order to improve access to new and current support.

4.1 Barriers to use of existing services

A central problem is one of **awareness**: many SME employers simply do not know what support is available to them. A case in point is Fit for Work (see 3.2.2), which SMEs do not have high awareness of, despite it having been developed primarily for their use. This reflects previous research which suggests that it is a lack of awareness of services rather than inherent difficulties with the services themselves which limit SME use (Husk et al., 2014). The difficultly in communicating interventions to SMEs is compounded by their **lack of networks**, with only a small proportion of SMEs engaged in either locally-based networks (e.g FSB or Chambers of Commerce) or industry-based networks (Husk et al., 2014).

Research has further indicated that low engagement might be driven by distrust among SMEs of the quality and relevance of public services. A 2007 study from Canada suggested that the owner-manager perceptions of the usefulness of the public sector agencies providing services, and their knowledge about the service itself was a considerable barrier to use – more so than the reality of the nature or quality of services (Audet and St-Jean, 2007). Their research reflected earlier suggestions that the failure of SMEs to use public services is due in part to **lack of confidence in support agencies**, due to perceived poor quality or irrelevance of services (Curran Shaw and Blackburn, 2000).

Adding to the difficulty of reaching and engaging SMEs is that much of the **communication from government** around health and wellbeing at work comes from the Department for Work and Pensions and Department of Health (often through Public Health England and NHS England). As such it is pitched predominantly at employee level, rather than at a business level. This may reinforce the perception that employee health and wellbeing is not an important aspect of business success, but a personal issue. Arguably, messages around workforce health as a business issue, related to economic growth and business prosperity, might sit better alongside other business messages, such as those provided by the Department for Business, Innovation and Skills (BIS) and particularly alongside economic growth initiatives such as those provided through Local Enterprise Partnerships (LEPs) and the Growth Fund. Indeed, there would likely be benefits from clear leadership on this agenda from within the business community.

The lack of awareness and poor uptake of services is further consolidated by a more general **lack of knowledge and understanding of workforce health and wellbeing** and the benefits that proactively looking after employee health can have for business (Floyde et al., 2013). If messages are framed in terms of improving individual employees' health, SME managers may find it difficult to see what

their responsibilities are, and to clearly identify the benefits of interventions for their business. We are failing not only to communicate the message, but also to get the message right. Indeed, many experts reflected that **government is not currently 'speaking the language' of SMEs**, nor ensuring that their message reflect SME challenges. This creates a barrier in terms of getting the messages across to and understood by SMEs.

Case study D: In Business for Good

Wilson Sherriff is a small business offering training and facilitation services. In addition to its core business, Wilson Sherriff is also the host and founder of the 'In Business for Good' network, which is unusual in having a specific focus on the health and wellbeing of SME employees. The network aims to provide practical advice and peer support to other small businesses on issues around social and business responsibility. The network is supported by both the Department of Health and the Federation of Small Businesses.

Health at work is one of the main issues that In Business for Good engages with, using a number of strategies. For example, the network will host a summit in December 2015, featuring contributions from a range of parliamentarians, SME business owners and policy experts and discussing how SME employers can help to improve and support the health and wellbeing of their employees. The network also hosts a website, which supports its aim of showcasing what SMEs are already doing in this area and encouraging and facilitating the sharing of good practice.

A key contention underpinning In Business for Good's work is that the best source of advice and support to small businesses comes from other small businesses, who are likely to understand the particular challenges and pressures that SMEs face and to be able to effectively relate to them.

Part of getting the message right, and getting that message out to SMEs, also relates to making sure the **messages are coming from the right places**. Wilson Sherriff, a small business that runs the 'In Business for Good' small business network (see case study D), suggests that professional small business networks are one of the best ways of spreading information and knowledge, and are preferable to accessing small business through the supply chains of larger businesses (Wilson Sherriff, 2013). Small businesses are likely to better understand, and be perceived to understand, the particular pressures that other SMEs face and this enhances their status as a **source of trusted business advice** (Wilson Sherriff, 2013). Unfortunately however, low engagement in such formal networks means that SMEs are often isolated and difficult to reach through these channels. Further there is little to suggest that health and wellbeing would be a topic of interest within many existing networks, with 'In Business for Good' providing a notable exception.

Another notable example is the SME Masterclass programme at Lancaster University, which provides ongoing networking and learning opportunities for SME owner-managers in the North West of England (see case study E). The masterclasses build on an established SME programme, and its success is largely attributed to word of mouth between SMEs who have had a positive experience with the programme. What is important in all these models is that messages and support are coming from business peers, who are perceived as having an understanding of the context, challenges and needs of business.

Case Study E: Lancaster University Management School SME Masterclasses

Lancaster University Management School (LUMS) have been running business masterclasses for over 10 years, drawing audiences from across the North West's SME networks. They were originally developed as part of the highly successful LEAD (Leading Enterprise and Development) programme - designed to help owner-managers focus on leadership development and responsible business growth. LEAD supported more than 3,000 small-and-medium sized enterprise (SME) owners, creating over 10,000 jobs. An evaluation of this programme found a return on investment of £10 for every £1 invested.

The masterclasses have since become a stand-alone activity, held monthly, and attended by up to 200 owner-managers. Attendees come from a range of industries, and operate business of different sizes – from sole traders to business with over 100 employees. Though many participants were recruited through LEAD and other programmes, the masterclasses are also promoted through word of mouth – with SME owner managers who have found the masterclasses useful spreading the word through their local networks.

Masterclasses feature 'inspiring speakers' who recount their own businesses experiences and advice. Recent topics have included productivity and performance, family businesses, or psychological wellbeing and resilience. The masterclasses are focussed on SME owner managers, though managers in larger organisations sometimes attend. The masterclasses provide access to free learning opportunities. Events are usually split between expert presentation, Q&A/discussion sessions and an opportunity for networking at the end. During this time owner managers are able to share their business issues and get feedback from peers and expert speakers.

The success of the masterclasses is attributed to many factors, these include – the high quality of speakers, the timing of events (held in the evening after usual working hours), and the provision of an opportunity to share issues with and learn from other smaller business owner managers.

Lancaster University won the Small Business Charter award in 2014 in recognition for its SME programme.

As suggested above, **the support that is currently available does not appropriately reflect the needs and the context of many SMEs** – limited as they are by time, capacity, resources, manpower, and economies of scale. As suggested above, a perceived or actual poor fit between services and need is a key barrier to SME uptake (Curran Shaw and Blackburn, 2000). For example, our discussions with experts highlighted that SMEs will likely find it difficult to access training initiatives, since these often require staff to take time out from everyday operations, even though they are identified as a potentially helpful type of intervention. Anything requiring more than a few hours away from the business is likely to be judged impractical for both owners and employees.

This problem reflects a wider view that SMEs do not feel that their **specific business needs are always appropriately considered in developing support**. There can be a tendency to develop advice and support with larger businesses in mind, even if not explicitly, and this does not always scale down effectively. SMEs are not simply smaller versions of large businesses, but have their own requirements and differences in context that mean that they provide and access support in different ways and hence require dedicated support services that reflect this. Research has shown that small business are often sceptical of the benefits for their business of receiving theoretical advice on good practice from larger businesses, which may be poorly suited to their needs. Further it is suggested

that publicly provided support also often draws on the experiences of larger businesses, and does not sufficiently understand and integrate SMEs needs or contexts (Curran Shaw and Blackburn, 2000).

There are also concerns about the **bureaucratic burdens** that are, or that might be, placed on SMEs as a means of ensuring their engagement with health and wellbeing agendas, which are linked to the lack of integration of SMEs business needs. A case in point is the idea that SMEs should implement formal policies on employee health and wellbeing. The Public Health Responsibility Deal's Health at Work pledges (2011), for example, make a number of references to the need for formal HR procedures which, for many SMEs, simply do not exist. Many SMEs do not have the capacity to do this, and as we suggested in the previous chapter, they employ so few staff that such policies may be both unnecessary and unhelpful. In smaller organisations employers are more likely to use informal mechanisms, as they work closely enough with their employees that this is possible. Research suggests that this management style can work well for them (Storey et al., 2010).

Similarly, the idea of bringing health and safety requirements into public procurement policy (so that public sector organisations only procure services from organisations that have demonstrated how they meet particular standards) is popular in some circles as a means of improving standards. However, the experts that we spoke to suggested this was likely to make it even more difficult for SMEs to access these contracts, at a time when they are already experiencing challenging circumstances (Pickernell et al., 2011). Avoiding increasing the burden and the barriers for small businesses requires a more nuanced approach.

There are of course likely to be things of value to some if not all SMEs within existing initiatives, programmes and advice around health at work. The wide array of information from government (and others), which varies in usefulness to SMEs, may in itself be a barrier to those SMEs who are actively seeking to find out more. **Currently, available advice for SMEs is highly fragmented and can be confusing**. As such, in addition to problems with the way that advice is framed, there is a problem with SME employers not knowing where to go for authoritative, reliable and relevant advice, or who should be listened to, leaving them having to attempt to synthesise advice from multiple sources that may not even be particularly relevant to them. As discussed above, there is a real need for strong leadership in this space from a place which is known to and respected by SMEs, who they trust to have their best interests at heart and to provide them with good quality, relevant advice.

Further, given the considerable variation from one SME to the next, they require practical hands on support which address their specific challenges. We heard concerns, for example, that even if employers wanted to carry out adjustments, they would have little practical idea of how to do so, and that in many cases, SME owner-managers do not have sufficient occupational health literacy. This further highlights the need for employers to have access to clear, direct advice, but also to ensure that they are able to access **additional support to help them to understand what they need to actually do to respond to advice** – including that given in fit notes and return to work plans.

Important to consider in all of this is not only the interventions themselves, but the context in which they are provided, with **organisational culture** a considerable influence on workforce health and on the effectiveness of interventions (NICE, 2015) . Developing a culture which is positive for employee health is fundamentally complex. On a practical level, this may include activities such as training for managers, revisions to policies, and to communication strategies. To have an effect on workplace health and wellbeing, such activities need to have a sustainable positive impact on range of factors, such as leadership, management styles, and managers' wider expectations of their employees. This may mean making fundamental changes to working practices across the organisation, focusing on meeting the aspiration of providing 'good work' (Parker and Bevan, 2011). Such changes go beyond basic legal requirements around safety and physical working environments, encompassing practices that allow employees greater control and autonomy over the nature of their work such as flexible working and involving employees at an appropriate level in decision-making.

Though SMEs are less able to provide employees with formal interventions, they are perhaps at an advantage when it comes to the opportunity to build better organisational cultures. Indeed, many appear ahead of their large organisation peers in these terms – with their small size potentially driving closer working relationships, removing barriers to communication, and offering employees more control and influence over their employer and the business. As such, many SMEs will already be doing things that support good health amongst their employees, without either they or the employees explicitly recognising it as such (Mind/FSB, 2011). It also underlines that supporting workers health and wellbeing need not necessarily entail providing expensive in-house services or packages of benefits; some of the most beneficial interventions around culture are effectively free to maintain as they are more focussed on attitudes and communication. This is a somewhat idealistic view however, and on the flipside of this will be many SMEs which do not have a positive work culture or provide good quality jobs – there may be some indication of this in the discussion in previous chapters on presenteeism, and in a reluctance to share return to work plans with employers. Indeed, **we must be careful not to simply assume that working for an SME comes with a more positive working culture**, as this will likely vary considerably, and may be somewhat harder to spot.

Overall this section has suggested reasons why current support mechanisms are not working effectively for SMEs. These include issues around the difficulty of communicating and raising awareness of interventions, consolidated by messages not coming from the right places, and therefore feeling less relevant to SME needs. There is a lack of government leadership on workforce health from the areas of government which SMEs are most likely to respond to, and the case for SME engagement in this agenda has still not been comprehensively and effectively made. What is currently available does not actually fit the needs of SMEs operating under specific contexts which are markedly different from those of larger firms. Solutions are not currently tailored for and targeted at the SME audience, and often do not have SME 'buy-in', further reducing the likelihood that SME will engage with them. Even where existing support might be valuable, it can be difficult to find, and time-poor SME owner-managers will simply not be able to invest much time in searching various sources for information. They need to know what they can trust, and have extra support available to ensure that they are interpreting unfamiliar information correctly. Underpinning all of this is the need for conversations about good quality work and organisational culture to be extended to SMEs. Many SMEs will be performing well in this but many others will not be, and this can have a considerable influence on employee health and retention.

Having established the context and the needs of SMEs, as well as what is and isn't working with current workforce health provision, in the next section we draw on all this evidence to provide an overview of the policy gaps which need to be addressed in developing a better approach to SME workforce health, and reflect on the related evidence of what works.

4.2 What types of support would be useful to SMEs?

Developing specific interventions and support which are relevant across the broad spectrum of UK SMEs is very difficult - what works within a small office-based organisation in the city will, inevitably, be very different from what works on a construction site, a local shop, or what is suitable for a family-run farm. Having reviewed what we know about SME needs, SME use of support, and the barriers to greater use, we have identified some key factors which we believe must be primary considerations when developing interventions, support and policy to address SME workforce health.

First, there must be a strategic approach to driving better engagement of SMEs in the workforce health conversation. Key to this will be making a clear, considered business case, which reflects the actual needs and challenges for SMEs, and is able to convince SMEs of the benefits of investing their limited resources in this area.

Management commitment is crucial to successfully engaging SMEs in providing health and wellbeing support (Floyde at al., 2013). Consequently the business case for supporting employee health and wellbeing must be framed in terms that are relevant to the people who will be responsible

for implementing this: SME owners and managers. Discussion with experts highlighted that in accomplishing this effectively it is important that the language used by government to talk about workforce health and wellbeing strikes the right tone. Along with the financial or individual health implications of investing in this area, the business case needs to consider broader motivators, such as impact on operations and service provision, the consequences for individuals, and the impact on owner-managers in terms of their personal aspirations.

Importantly, it needs to be seen to be relevant to the specific needs of SMEs, rather than reflecting the story for large organisations. Indeed, an 'SME lens' needs to be more extensively and effectively used for all policy in this area – in terms of the development of policy, and when evaluating policy and interventions. As suggested above, evaluations of current interventions such as 'fit note's and Fit for Work should explicitly consider their effectiveness in supporting SMEs, including what the barriers to SME use might be, and take proactive steps to address this. This may include for example, consideration of the potential benefits for SMEs of the Fit for Work becoming mandatory.

Crucial to the success of this strategic approach will be strong leadership from the business community, and considerable input from those with a specific understanding of SMEs, who will be adept at articulating a relevant and convincing business narrative. We need to think about where messages must come from to be truly effective for engaging SMEs.

Second, we need to develop services and support which reflect the specific needs and the context of SMEs. Interventions and support, including training to raise awareness and support management, need to be delivered in a way that is practical and manageable for SMEs. It is important that these initiatives are both developed and delivered specifically for small firms, considering the evidence on what works for them. Developing resources which are useful for and attractive to SMEs is a key challenge, and it is clear we need a more creative, evidence-informed and SME-led approach to developing SME focussed support.

Provision of support which is successful in larger firms is often not appropriate for smaller companies due to differences in the way that they operate, and the amount of time that they have available to dedicate to this (Floyde et al., 2013). SMEs will struggle to engage with anything that takes them away from their business for too long – a particular concern for training. Costs of the service will also be a major barrier, given the limited resources, and the lower numbers of employee service users. Indeed, the fact that SMEs will only need services such as occupational health infrequently is a considerable barrier to occupational health service providers. SMEs are often reluctant or unable to pay for support; experts have suggested that interventions that had been popular and successful when provided for free soon fell apart when SMEs were asked to pay, suggesting that having to pay for services is a significant factor in whether or not SMEs remain engaged.

Case study F: The Olympic Park and Athlete's Village

The construction of the Olympic Park and Athletes' Village for the 2012 London Olympics involved 30,000 workers over its lifetime, with up to 12,000 on site at any one time during the peak construction period. As is common in construction, much of the work was undertaken by sub-contractors, who were not formal employees of the contracting organisation.

To ensure that workforce health was being appropriately supported, the contractor provided a range of health and wellbeing interventions onsite, for the use of all workmen – employed and self-employed sub-contractors. The Park/Village site was equipped with a dedicated health and wellbeing team, including a traditional occupational health wing working alongside occupational hygienists to 'prevent and treat occupational ill-health and promote healthy behaviours'. Site culture was to encourage contractors to see 'health like safety' as part of their day-to-day activities, and as something that was easy to integrate with the safety management aspect that they were more familiar with. To support this, existing and familiar tools were used in relation to health, such as near-miss reporting.

The provision achieved several positive outcomes, both financial and otherwise. In particular:

- The net benefits accrued from on-site provision were estimated at between a net loss of £0.4 million and a net benefit of £4.3 million (the difference depended on whether wage or production costs were used).
- 67 per cent of workers used the health service and 25 per cent used the walk-in centre. 113,666 clinical interventions were delivered, with the greatest single problem being MSDs.
- Almost 90 per cent of workers felt that their understanding of OH had improved after working on the Olympic site, and they will take this knowledge with them to other sites.

Several lessons and principles that can be easily scaled down emerged:

- A proactive approach worked well. Teams that learned the most were those that actively engaged with OH.
- Talking about wellbeing – conceived as more workers' more immediate circumstances - provided a good way of talking to workers about longer-term issues, as they preferred to start by discussing issues that were of concern to them in the present moment.
- Technical language around health and wellbeing was avoided wherever possible in favour of approaches and terms that were more familiar to the workers. Park Village Health talked to workers about 'slow accidents' and 'long term health risks', highlighting the difference between these and more immediately pressing safety concerns.
- Success in improving outcomes was dependent on OH having contact with the whole of the supply chain. This allowed them to access the least developed SMEs, where the greatest gains were to be made.
- Having OH involved as early in the life of the project as possible was critical to embedding high standards and ensuring good engagement with the health and wellbeing teams.

The full evaluation of the project was carried out by Tyers and Hicks (2012) for the Health and Safety Executive.

Making services cost effective for both service providers and for SMEs is a key challenge. There are some discrete examples of how this has been addressed which might offer lessons for wider development. This includes large businesses sharing their provision with smaller businesses (for example, in the case of the **Olympic Park/Athlete's Village project** – case study F), and small businesses 'pooling resources' to increase their buying power (see FSB model – case study G).

Case study G: Federation of Small Businesses: Collective Insurance Scheme

Collective or Group Income Protection Insurance has been identified as a potentially effective way of offsetting the costs of employee illness, both for the business and for the individual employee. However, this form of insurance is often inaccessible for SMEs due to its cost, and take-up is higher amongst larger organisations.

To overcome this, the FSB proposed a collective insurance scheme for its members that would provide cover for firms who experience long or medium-term absence alongside good employee benefits such as maternity and paternity pay, in exchange for regular contributions. Grouping together in collective should enable small businesses to provide better benefits at a reduced cost. This drew on the experience of the Danish 'DA Barsel' scheme. The FSB suggested that this could be incentivised via tax measures applicable to scheme members.

The benefits to SMEs would not just be directly related to staff absence. As well as covering the direct costs of illness, offering staff benefits would also enhance SME competitiveness in the employment market, and could reduce staff turnover. Meanwhile, SME employees would enjoy enhanced security and protection against illness or other needs to take time off.

Although designing resources which meet the needs of and speak to SMEs is a challenge, there is some evidence available on how to achieve this which it will be important to reflect upon. Business pressures in SMEs are often acute, and services will need to be highly reactive – quick and straightforward to access. Flexibility is likely to be key, with SMEs more likely to engage with training and resources which are flexibly delivered (Farvaque et al., 2009; Abraham et al., 2013). A strong message from experts was that SMEs respond best to direct advice on specific problems over more general information and procedures. There is evidence available to support the case for provision of this more intensive, specific advice to smaller businesses - albeit not directly related to the provision of health and wellbeing interventions. Evaluations of the UK Business Link service found that Business Link Organisations that focussed on 'more intensive assistance on appropriate beneficiaries', providing 'deeper' advice achieved better returns on investment than those providing broader advice (Mole et al., 2009).

As discussed above in relation to training, interventions which are more effective for SMEs tend to be short, flexibly delivered, and overtly focussed on solving a recognised real-life business problem. This was reiterated by an evaluation of a SME support website, which further identified that SMEs valued task-focussed, practical, specific advice with opportunities for peer-learning and ongoing access to expert advice as and when needed. They also valued having a variety of different ways to access information, including both online and face to face, and emphasised the importance of any resources made available being from a trusted source, and being up-to-date (Abraham et al., 2013).

Practically, delivering support flexibly and on an SME's own terms might be as simple as arranging training and other programmes outside of normal office hours, as seen with the SME Masterclasses (see case study E). Services that visit the workplace are also preferred since these minimise disruption to business operations. This is already recognised in some service provision. In Scotland, for example, the Healthy Working Lives initiative provides workplace visits, along with direct advice on how employee health and wellbeing can be improved. 'Workboost Wales' offers a similar service in Wales. However, these services are more suitable for some types of business than others. For

example, SMEs that are based in one location permanently (such as an office or a shop) may find these kinds of services more useful than those whose work is more mobile.

Personalised support may not always be possible; we also need to enhance the ability for SMEs to access information which will be relevant to their specific needs. Directing SME owner-managers towards case studies can be helpful, giving practical examples of the sorts of actions that SMEs could take, as well as supporting the business case by demonstrating the sorts of investments and returns that can be expected from taking action (Responsibility Deal Working Group, 2011). Though many case studies on workplace health are available online, they are currently spread across a range of different locations including the Public Health Responsibility Deal website, the Fit for Work portal, and the websites of various initiatives such as the Workplace Health Charter. There is no centralised source, and the case studies vary in their relevance to SMEs across different industries; indeed some, such as those on the Fit for Work portal, are not clearly aimed at businesses at all but at employees. Given the very wide variety of SMEs operating across different industries, it would be useful if employers were able to access readily available case studies that represented all of these, that they could then use to inform their own decisions about what services are right for their business and their needs (both practical and financial).

Finally, we need to improve SME access to advice and support, simplifying and optimising the channels we use for communicating with SMEs on workforce health issues, alongside other issues relating to business support and growth. SMEs need to be given a clear steer on where to go to access information and support which is relevant to their needs. This suggests that a website or portal that directs SMEs towards reliable and up-to-date sources of advice could be of use (Abraham, Fleming and Godfrey, 2013), but it is important that this fits within or is clearly connected to a source that SMEs recognise and trust. Government initiatives have provided examples of how SMEs can be connected with useful services, albeit not yet within the context of health and wellbeing.

For those SMEs who do not actively seek out information of workforce health support, we need to think more creatively about how we can get information on existing services and support to them. As we have discussed, the awareness and usage of services (such as Fit for Work) appears quite low, suggesting that current communications strategies are not optimally effective. Reaching SMEs – especially those that are not part of any networks – is challenging, and publicity strategies need to be proactive and use a variety of channels. In 2012 more than a third of SMEs used Facebook regularly and around one in six used Twitter (Taylor, 2012), but experts told us that social media was not being used to its full potential in reaching SMEs. It is not enough for initiatives and programmes to have a presence on Twitter; they need to be active in networks that SMEs use. These could include local area networks and business networks. Additionally, 11 per cent of SMEs have no internet access (Cabinet Office/Government Digital Service, 2014). This highlights that any communication strategy needs to make extensive use of a range of channels, including more traditional methods such as mailings.

Business supply chains and partnerships provide a potential avenue for communicating information and providing advice on health and wellbeing. Partnerships between large organisations and SMEs have been trialled in England as part of the Public Health Responsibility Deal, with the large companies acting as mentors on health and wellbeing to small companies in their area (Department of Health, 2011). The evaluation of these projects highlighted that they could serve as an example of good practice, but also noted that there were significant challenges in maintaining SME engagement, especially amongst very small businesses. As a result they were very resource intensive (Public Health Responsibility Deal Health at Work Network, 2012).

Though there is a role for government and large businesses in communicating workforce health messages, discussions with experts and with SME owners who had successfully implemented health and wellbeing interventions in their businesses suggested that this communication could not be entirely 'top down'. Messages from peers were thought much more likely to contribute to developing a widespread and substantial constituency around health and wellbeing from the bottom up. This

would, in turn, increase the likelihood of SME buy-in to existing or future services. This suggests a general preference for peer advice over other means of accessing SMEs, such as through the supply chains of larger organisations (Wilson Sherriff, 2013). It further reinforces the point that the language and source of interventions is crucial; other SMEs are more likely to understand the business context and concerns of small business owners, and to be able to usefully advise and support each other, given this.

Making use of existing, effective channels of communication with SMEs might be another way of enhancing our capacity to 'speak to' and engage with SMEs. Regionally co-ordinated initiatives have been seen to work in other contexts - for example, the Business Link service offered a face-to-face advisory service via regional hubs, funded by the Regional Development Agencies up until 2011, offering SMEs a single point of access or 'one stop shop' to consultants to help them to grow and improve their businesses. Growth Hubs, funded by Local Enterprise Partnerships (LEPs) which have responsibility for driving business growth at a regional level, fulfil a similar purpose, providing a regional focal point for SMEs looking to access national business services (Cabinet Office, 2015). Evaluations of Business Link suggest that it reached 32.6 per cent of businesses (Mole et al., 2008); the evaluation of Wave 2 Growth Hubs also suggests that this is a good way of targeting smaller SMEs, since over 78 per cent of businesses using the service were small or micro-sized. Experts suggested that this 'one stop shop' approach established a clear means of providing accessible, reliable services combined with practical advice, and as such could be a potential model for delivering information on services, support and initiatives on workforce health, alongside other business topics.

In this chapter, we have identified a number of barriers to SME engagement with health and wellbeing support, and then identified and discussed some of the gaps between current provision and what will support SMEs. To this end, we identified clear areas for attention. **First**, there is a need for a **more strategic approach to SME workforce health** – setting out a clear business case, and ensuring policy development and evaluation is undertaken looking through an 'SME lens'. There also needs to be clear leadership from a body who can effectively speak to SMEs. **Second**, we explored and made suggestions about **what makes an effective intervention for an SME**, and how support can be developed that better fits their needs than we see in current models. **Third**, we looked at how we might **enhance the way we communicate with SMEs**, particularly in terms of making sure they are aware of support and interventions, and making them more accessible and user-friendly.

In our final chapter, we address this directly, and provide a suite of recommendations for how to improve workforce health support for SMEs.

5 Recommendations

In this paper we have outlined the picture of SME workplace health. We have reviewed evidence on the health of the SME employees, exploring how this affects SME productivity, the current support available to them and the extent to which this meets their needs. Through this we have identified some gaps in current provision that we feel there is scope to address by changes to policy.

The three key challenges we identified are around:

- Taking a strategic approach to SME employee health and wellbeing
- Developing and delivering SME appropriate training, resources and support
- Improving SME access to advice and support.

In response, we have developed a series of policy recommendations aimed at addressing these gaps grouped under three core themes. These are outlined below:

5.1 Taking a strategic approach to SME employee health and wellbeing

Given the particular circumstances of SMEs it is important that the business case for investment is adequately tailored towards the SME context. We need to better understand SME needs and owner-manager goals (which may not be only financial), and ensure that these are reflected when outlining the business case and engaging with SMEs, as well as when developing advice and support. The importance of developing all aspects of support including interventions, advice, communication and dissemination plans with SMEs and SME stakeholders cannot be underemphasised. We need to ensure we understand the context in which they are operating, and that we communicate via pathways that SMEs trust, use and can relate to.

Recommendation 1: Develop a coordinated cross-government department narrative highlighting the business, economic and human case for SME engagement in supporting staff health and wellbeing.

Many of the current support services for SMEs focus on health and work outcomes for the individual employee, with Public Health England and the Department for Work and Pensions most engaged with this. There is less emphasis on how engaging in health and wellbeing support services can be good for businesses, and even less on the value for smaller businesses, which will not have the same returns on their investment as larger businesses and may have different reasons for investing.

Where the messages come from may be just as important as the message itself. We recommend that in order to demonstrate that employee health is a business issue – affecting business sustainment and growth – messages of this nature would benefit from stronger leadership from the Department for Business, Innovation and Skills who, working with colleagues in Public Health England, NHS England, the DWP and other organisations, can provide SMEs with a business-focussed narrative for making the case for investment. Within this is a call to increase engagement of LEPs, and links with

Growth Hubs. As discussed in 'Healthy, Working Economies', a previous paper from the Health at Work Policy Unit (Shreeve, Steadman and Bevan, 2015), we believe that LEPs should be encouraged to take a stronger role in the workforce health agenda.

Recommendation 2: Use an 'SME lens' when developing and communicating policy and interventions through the introduction of a SME expert stakeholder group.

SMEs – especially the very smallest of businesses – are not simply smaller versions of large businesses. Advice coming from government on the provision of health and wellbeing support in SMEs needs to reflect their specific differences in terms of needs, pressures and ways of using services.

We recommend the convening of an SME stakeholder group, to work with government to coproduce SME related policy and interventions. This group will provide an SME lens through which new workplace health policy can be viewed, and ensure that what is being developed is relevant and accessible to SMEs. This stakeholder group would need to be at the heart of any policy relating to SMEs, working alongside the key government bodies as outlined in Recommendation 1. Membership should be rotating, to try to limit the impact on SMEs of participation, and to ensure that the full range of industries that SMEs are active in are represented.

Recommendation 3: Identify what works in terms of existing support, by making 'the impact on SME workforce health' a specific goal in policy and program evaluation.

Ultimately, provision around health and wellbeing support for SMEs is only valuable if it is perceived as useful and relevant by the end users, and is well-used. There is, therefore, an on-going need for evaluation of whether SMEs are using support services that are provided, how they are using them, and – if usage is lower than expected – what the reasons for this are and how they can be improved. It is only through this process that SMEs can be offered support that fits with their needs.

We recommend that SME usage, focusing on micro-businesses, should be a standard component of all government-provided health and wellbeing at work programme evaluations. In particular we note that SMEs should be a primary focus of the evaluation of Fit for Work (including the £500 tax rebate), and the Workplace Wellbeing Charter. The evaluation criteria should be co-produced with the SME stakeholder group, who will be able to highlight what it is that makes a successful intervention in the eyes of SMEs.

5.2 Developing and delivering SME appropriate training, resources and support

Given that most SMEs lack the resources to provide employees with privately funded health and wellbeing support, support provided outside of businesses is often even more important for SME employees than their colleagues in larger organisations. Once we have made the business case clear to SMEs and communicated this to them, it is of critical importance that SME owner-managers and employees are able to access appropriate services to put commitments into action. Just as the business case and the narrative around employee health needs to be developed with the perspective of SMEs specifically in mind and communicated through channels that are relevant to them, so too does training, advice and support need to be developed and delivered in ways that are appropriate to their business context.

Recommendation 4: Invest in developing training initiatives that meet SME owner-manager needs.

Many organisations, primarily large ones, invest in training for their managers improve awareness and management of employee health. This approach may have value also for SMEs, but SMEs require different training formats from large businesses and as such need initiatives that are specifically targeted to the SME context.

We recommend that the government invests in the development of training services and resources which reflect the needs of SMEs, drawing on the evidence around resources and training that works for SMEs in other fields, including leadership. As in Recommendation 2, coproduced initiatives between SMEs, SME representative bodies and employee health experts offer a very valuable means of creating useful advice and training resources; indeed, it will be extremely difficult to produce such resources without the input of SME stakeholders.

Recommendation 5: Deliver occupational health support to SMEs on their terms.

Bringing occupational health services and support to SMEs, at a time that is convenient to them, is highly preferable to providing services that require owner-managers and employees to take time away from work. We also know that SMEs value direct advice, which is specific to their particular situation, over more general advice which may be more useful to larger organisations looking to implement broader health and wellbeing policies. Often, SMEs need an answer then and there to the challenge that is in front of them. Currently, services are in place offering this in Scotland (Healthy Working Lives) and Wales (Workboost Wales), but not in England where advice through Fit for Work is only given remotely or communicated to employers via the employee. We recommend that the Scottish and Welsh models of provision should be evaluated to ascertain the value (and cost) of this for use in the English context.

Recommendation 6: Incentivise the development of local healthy working partnerships to enhance the availability of appropriate support to SMEs.

There could be value in developing models of support which encourage health and wellbeing resources to be pooled. Several case studies in this report provide examples of where this has worked. These include:

- Project-based pooled occupation health services (such as the Olympic Park/Athlete's Village); or,
- Hub and spoke models whereby a larger business (private or public sector) provides services to several local SMEs; or,
- Locally based 'chipping in' pooled services or,
- A collective health insurance scheme (as recommended by FSB).

We recommend that the Health at Work Joint Unit review these models to ascertain which (or which combination) of them will work best for the greatest number and range of SMEs. Consideration should be given to the benefits of each model both as a means of providing access to treatment, as well as providing access to health promotion.

To enable the wider application of the selected model(s), the correct incentives would need to be in place to encourage participation. We therefore suggest that there may be a room to implement a system of temporary tax breaks to encourage business uptake and mitigate against the financial outlay that such models might require from both large and small businesses.

We must reiterate the importance of SMEs taking a lead role in the development and implementation of any such interventions. Without their buy in, and without local leadership, success will be severely limited.

Recommendation 7: Incentivise and enable SMEs to make greater use of income protection insurance programmes.

Currently, very few SMEs take out Group Income Protection insurance for their employees as this is a costly product and is often beyond the reach of SME owners. Drawing on recommendations made in our previous papers (Steadman, Shreeve and Bevan, 2015), we recommend that more could be done to develop appropriate models of group income protection insurance and enable SMEs to take up

this option. Again, this could be linked to tax incentives, with a temporary tax break offered to SMEs who cover all of their staff.

5.3 Improving SME access to advice and support

Developing appropriate services and support is one challenge. The next, which is perhaps even greater, is ensuring that the right information reaches SMEs.

There is a large volume of information and advice available on employee health and wellbeing, from a wide range of different sources, offering advice of varying quality and of varying practical use. A challenge for SME owner-managers searching for information is where to go to quickly find the 'right' information, i.e. advice which is relevant to smaller businesses and addresses the specific challenges that they are facing. Lack of awareness of services is also a major barrier to SME usage of them, and this needs to be improved. In many cases SMEs are isolated, rarely belonging to any networks, and having limited opportunity to interact with their peers. Therefore opportunities for learning about and sharing useful and effective support are severely limited.

The following recommendations seek to address the fragmentation in advice and support services, and to improve awareness among SME owner managers of where there is effective advice which is tailored to their needs.

Recommendation 8:Develop a dedicated portal or 'one stop shop' for SME health and wellbeing information.

The sheer quantity of information available on health and wellbeing and the fact that much of it is more suitable for larger businesses makes it difficult for SME employers to know where to go for good quality, relevant advice.

We recommend that the government create a dedicated, up-to-date and well maintained portal or 'one stop shop', collating information on existing services, detailing the advice and support available, and signposting SME owner managers to them. The local dimension is important, and there would likely be substantial added value in developing specific regional or local advice. This could be publicised via services that SMEs are likely to use and come across already in the day-to-day course of business, as suggested in Recommendation 10. As suggested above, co-production and SME buy-in will be important to the portal's success.

Serious thought would need to be given to where such a service is hosted; in line with Recommendation 1, we suggest that BIS could take a lead on this as part of its business support function. Ideally this service would be incorporated into more general SME business support services, which would aid in both maintaining relevance to business and in improving SME usage and awareness, since owner managers would not have to go out of their way to access the portal.

Recommendation 9: Develop a centralised knowledge bank of case studies and examples to support SMEs to identify their own solutions.

Case studies can be of use to SME owner-managers in different situations, seeking advice on how best to support their employees' health and wellbeing within the context of different business sizes, industries and challenges; however, currently these are dispersed across many websites, and come from many different sources. We suggest that the development of a single library of workplace health case studies, searchable by characteristics such as industry and/or business size would be an important component of the SME portal (see recommendation 8). This would provide a source of clear, practical examples on what other SMEs in the same area have done, as well as building on sharing good practice between SMEs.

Recommendation 10: Publicise new and existing initiatives through known SME communication channels, utilising current links to national government and local government, and other local organisations (including LEPs and growth funds).

It is imperative that in the event of staff illness SME owners-managers are able to access quick and effective support. In order to better communicate current and new support and services to the diverse and diffuse world of SMEs, we recommend making better use of the channels of communication and the relationships which already exist between SMEs and business services.

We suggest that moving forward there will also be an important role for Local Enterprise Partnerships (LEPs) in this agenda. We see the role of the LEPs, in driving sustainable private sector-led growth, as inclusive of the development of better quality, healthier jobs, and entirely complementary to the task of developing a healthier more productive workforce. Specifically, as all LEPs will have their own Growth Hubs by 2016, these could provide an ideal opportunity for publicising services to SMEs, such as Fit for Work. However this will only be achieved if LEPs are willing to play a stronger role and to recognise the importance of SME employee health in driving economic growth and improving local productivity.

Local authorities could also play an important role in publicising health and wellbeing initiatives. This would not require any major extra work or capacity on their part initially; it could be as simple as advertising services such as Fit for Work on the SME-relevant sections of their websites, or including leaflets and literature on services with any mailings that they send out, directing SMEs towards locally-based services.

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