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Employee well-being, mental health and productivity in Midlands firms: The employer perspective

A baseline study for the Mental Health and Productivity Pilot project

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A baseline study for the Mental Health and Productivity Pilot project

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PREFACE

This report focuses on the engagement, attitudes and behaviours of around 1,900 employers across the East and West Midlands to employee well-being and mental health. It also considers the effects of well-being and mental health on organisational performance and productivity. Data for the study was collected through telephone interviews and in-depth case studies in the three months immediately before the Covid-19 virus lockdown. The report therefore provides a pre-Covid-19 baseline which may be a useful comparator in months and years to come, when considering the impacts of the pandemic on employers and employees.

Sections of the study also seem particularly relevant to the new challenges the Covid-19 crisis has brought. Chapter 6 for example deals with employee mental health and issues around lone and home working. Employment practices relating to key workers also form part of the discussion.

This report forms part of a larger, three-year programme, funded by the Midlands Engine – the *Mental Health and Productivity Pilot (MHPP)* – the idea for which was developed long before the current Covid-19 crisis. The MHPP programme aims to develop evidence-based interventions to help employers in the Midlands support good mental health amongst their employees through a series of pilot initiatives delivered by mental health specialist practitioners and academics.

To inform these interventions the MHPP project team is undertaking a number of baseline studies – of which this is one – exploring employer perspectives on mental health, the availability of support services and advice for employers, and the quality of existing mental health support for employees. These other companion reports are and will be available from the MHPP website - https://mhpp.me/.

The team working on this report would like to thank Midlands employers for their help and support with this project as well as other partners within the MHPP team who provided valuable input to the survey questionnaires and comments on earlier report drafts.

We would be happy to discuss the results of the research further with you and hope that you find the report interesting and useful.

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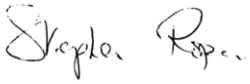

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MENTAL HEALTH & PRODUCTIVITY PILOT
MHPP
SUPPORTING WORKPLACE MENTAL HEALTH

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EXECUTIVE SUMMARY

Introduction

Poor mental health can have a significant impact on individuals, families and households. It has an enormous human cost[1] and a very significant public spending cost[2]. In this study, we explore the prevalence and nature of poor mental health in the workplace and the impact on business performance and productivity through a review of existing literature, a survey of 1,899 private sector establishments in the Midlands and in-depth interviews with 20 survey respondents. Fieldwork took place between 6th January and 20th March 2020 and therefore was completed just before the Covid-19 restrictions came into place.

Recent reports have emphasised the economic costs of poor mental health and well-being in terms of the costs to employers. Earlier this year, Deloitte[3] reported the following mental ill-health related costs:

- Absenteeism (the time workers spend off work due to ill-health) - £6.8bn;
- Presenteeism (the costs associated with workers being at work but not performing their work as expected because of ill-health) - £26.6 to £29.3bn;
- Staff turnover cost (the costs associated with replacing workers who leave employment due to ill-health) - £8.6bn.

Prevalence and causes of mental health sickness absence

Our survey found over four in five employers recorded sickness absence and the reasons for sickness absence and two-thirds measured staff turnover. The survey also explored the prevalence of the key factors associated with the costs of poor mental health:

- 41% of establishments reported at least some long-term (more than 4 weeks) sickness absence in the last year. Regression analysis shows this is more likely

[1] Sainsbury Centre for Mental Health, (2003) POLICY PAPER 8: *Mental Health at Work: Developing the business case.*
[2] McCrone et al, (2008) *Paying the price: the cost of mental health care in England to 2026*.
[3] Deloitte (2020) *Mental Health and Employers*

in larger establishments but less likely in those employing a higher proportion of graduates;

- 31% reported mental health sickness absence. Regression analysis shows this is more likely in larger establishments and in multi-site establishments;
- 33% reported presenteeism. Bivariate analysis shows this is more prevalent in Hospitality (where needing to earn money is a driver) and Business Services (where client demand is a key cause);
- An overall staff turnover rate of 10.4% was reported in the firms surveyed.

Employers are most likely to cite issues outside of work as a cause of poor mental health, rather than issues in work or issues to do with physical ill-health. However, in exploring workplace issues in more depth during the qualitative research, factors which emerged as contributing to episodes of mental ill-health included:

- Lone working or remote working;
- Client expectations on time, quality and cost;
- Job insecurity;
- Recruitment practices

The survey also explored whether the introduction of new technology had an impact on mental health and well-being in the workplace. Regression analysis shows that the introduction of new technology is positively associated with long-term sickness absence and, to a lesser extent, with mental health sickness absence. Regression analysis does not show causation, but does demonstrate a significant association. Respondents in the survey were asked whether they felt that the introduction of new technologies had impacted on staff health and well-being, and for 86% of these respondents, the impact was positive, improving employees' ability to do their work or making work easier. Introducing new technologies therefore could enhance well-being *and* job performance, as evidence in the literature review shows that improved well-being enhances cogitative abilities and generates more positive attitudes to work.

Impacts and costs of mental health sickness absence

Whilst two-thirds (67%) of establishments reported sickness absence had an impact, 55% of those reporting mental health sickness absence reported an impact on firm performance. The type of impacts typically reported in the survey were:

- Effects on the team - '*It leaves us short staffed and other members of staff have to pick up that member's work and morale takes a bit of a hit';*
- Cost of replacing absent staff - '*It costs us money to cover'*;
- Reduced service levels – *'It means … we don't provide clients with the service we need to';*
- Reduced efficiency - '*It reduces productivity. We measure turnover per employee, which takes a hit when someone is off sick for any reason'.*

Whilst this latter quote is an example of an employer formally measuring productivity, our qualitative research would suggest this is unusual. For some employers there seemed to be a reluctance to formally measure productivity:

> *'…there's a heavy reliance on me, rather than policies or systems in place, so, we don't - and to be honest with you - we wouldn't really flag that side of it. We'd accept that that's potentially cost us money….'*

This may mean the impacts of poor mental-health are under-recorded and the costs may be greater than employers think.

Using the survey data, we are able to explore the association between long-term sickness absence, mental health sickness absence and the reporting of an impact of mental health sickness absence on firm performance in the Midlands. This analysis shows:

- experiencing long-term sickness is associated with productivity which is lower by 27.2 per cent;
- sickness related to mental health is associated with productivity which is lower by 18.3 per cent;
- firms reporting a situation in which mental health impacted their performance was associated with productivity which is lower by 24.5 per cent.

These are significant associations between productivity and long-term and mental health sickness absence, but our research suggests these costs may not be known to many employers.

How do employers identify and address mental health issues?

Our research explores both how employers respond to mental health sickness absence as well as the more proactive measures they put in place to support mental health and well-being.

On the whole, employers adopt a number of responses to mental health sickness absence, including:

- Redeployment to other tasks and roles;
- Job re-design, such as reductions in caseloads or working hours;
- Line manager training.

In some examples from the qualitative research, this support was not provided, or an issue became more serious because busy line managers had not dealt with it.

Line managers are key in identifying changes in behaviour which can signal emerging mental health issues and in providing support. In terms of those taking a more proactive approach to support mental health in the workplace, 44% of establishments provided some form of support and 48% of these had provided training to line managers. Larger establishments are more likely to do so. Smaller establishments are more likely to ensure all staff have a regular conversation about health and well-being with their manager (84% in the smallest firms compared to 69% in the largest[4]).

Generally, though, proactive activities to support mental health and well-being are found in the minority of establishments (44%). Of all firms, just over a fifth (22%) had a mental health plan; 35% had a health and well-being lead at senior or Board level and 40% used data to monitor employee health and well-being. On wider measures, 46% provided healthy food and drink for staff and 29% offered support with physical activity. These were all more commonly provided by larger establishments, which were also more likely to have a budget allocated for these activities.

[4] This is of the 44% which reported they offered some form of activity to support mental health and well-being.

The qualitative research suggests that establishments in which the participant, within their position of authority, and/or owners had prior experience of dealing personally or professionally with mental health issues are more likely to take action. But the research also suggests that it takes time for a business to successfully implement the multi-strand approach identified in the literature review as important to address mental health in the workplace and boost productivity. These strands include management buy-in, staff engagement and impact measurement within an integrated plan. Moving to effective practices from a standing start will be a gradual process for most employers.

Do employers want support?

If employers do not seem to know the cost of mental ill-health in the workplace, does this mean they are not concerned by the issue? Our research finds they do believe they have a role to play in supporting the mental health of their employees, with around 80% disagreeing with the statement 'mental health is a personal issue and not one which should be addressed at work'. This was echoed in the qualitative research, with employers recognising a balance of responsibility for good mental health, for example:

> *'although I feel it's people's own responsibility to manage their mental health, I do feel that we've got a huge responsibility to help people get through those times whether that's adapting their role or giving them more support in other ways.'*

Additionally, almost two-thirds of firms said they would like to provide more mental health and well-being support to their staff (64%). This was highest in the Business Services and Other services sectors and amongst the largest firms.

Currently, the most commonly cited source of support for businesses on mental health and well-being is within their own firm (33%). Human Resources consultancies were next most likely to be referred to (23%), followed by general searches on the internet (18%). Mental health charities were cited by 14% of respondents. The routes which are 'top of mind' for employers are HR-type routes rather than external mental health or government bodies.

Overall, the results of our research suggest there is much to do to 'level up' establishments across the Midlands, as there are relatively few adopting a coherent

approach to mental health and well-being, but the impacts are costly and perhaps unrecognised.

Implications for practice

The research suggests some important considerations for policy and practice.

Getting the message right

The **costs** of presenteeism and poor mental health in the workplace absence are enormous as shown by the Deloitte research, and this research also shows that **mental health sickness absence is associated with a significant reduction in productivity.**

High staff turnover is also costly. But **putting in place the right structured and proactive activities and working practices** could reap rewards by reducing the impact of poor mental health in the workplace. This is especially the case for workplaces where risk factors are unavoidable (e.g. for those engaged in remote working).

Employers **seem to recognise their responsibility in this regard, but also appear not to be aware of the best sources of help and advice with putting the right activities into practice.** This provides a supportive and positive opportunity to approach the issue with businesses.

Using the right messengers

It is important to carefully consider the routes to reach employers. **Many employers do not currently usually consider mental health charities or government bodies when they look for support in these issues.**

We found some examples of firms **working with sector/professional bodies** on mental health issues. Working with such bodies could provide an effective means of targeting a significant number of employers with messages and solutions tailored to their circumstances and through trusted intermediaries. Overall, there is a need for **greater partnership working between employers, HR professionals, sector bodies and mental health charities.**

Employers are also likely to use the Internet when looking for information, therefore it is important to ensure that websites use key words and phrases and can be easily identified by employers seeking support.

What do employers want?

The Mental Health First Aider course is well-regarded but could be supplemented by **support for employers to help them deal with stigma and to address the frustrations of colleagues** – which may in themselves lead to further mental health problems.

One size will not fit all, however. Small firms don't necessarily want more support – **they don't want to become *obliged*** to do activities that may be more appropriate for larger firms. Being supportive without being prescriptive will be key.

The research suggests a need to build up to a coherent approach and this is unlikely to be achieved quickly from a standing start. **Supporting employers to acknowledge and overcome barriers at the outset** (stigma, resources) could be a useful stepping-stone into the many emerging sources of guidance.

Appointing a mental health lead within a firm, particularly in larger firms which experience more sickness absence due to mental health related reasons would also be an effective and practical way of taking action forward in a coherent and strategic way.

Remote working presents difficulties in terms of increased likelihood of mental health issues due to isolation or being away from home or away from access to workplace support. It also impacts on the ability of employers to identify mental health problems. Firms use a variety of ways to observe differences in the behaviour of remote workers, but ability to support them was identified as more difficult and requiring bespoke solutions. Tailoring support for remote workers could be a useful 'hook' to engage employers.

Employers do tend to **record the reasons for sickness absence but not the impact**. Encouraging greater recording and transparency may increase awareness of the issue, enhance understanding of its effects on performance, and of what firms can do to address it.

This research raises an important broader **cultural issue**. Increasing client expectations and the demands of customers are cited as causes of presenteeism and mental health sickness absence. How can an initiative recognise and tackle those complex and deep-rooted cultural factors?

Implications for research

The research provides a wealth of data on employer attitudes, behaviour and practices to employee well-being and mental health, and provides an important, pre-Covid-19 baseline. A future follow-up survey could deliver longitudinal data to allow further analysis of the factors that impact on mental health sickness absence and productivity.

However, in the shorter-term, there is an opportunity to use this research to ascertain the impact of the Covid-19 crisis on employee mental health and well-being, and to explore employer responses to it. This is particularly relevant given our findings on remote working. Fieldwork for this study finished in the week before the UK formally introduced lockdown measures. Opportunities for follow-up include:

- Returning to the 20 firms interviewed in the qualitative research in the next few months to discuss the impact of the virus on their experiences of, and approaches to managing, mental health and sickness absence;
- Re-interviewing a sample of businesses employing 'key workers' to explore their current experiences[5];
- Repeat the survey to assess the changes brought about at a wider scale.

In all future research we would suggest more emphasis on **remote working** given the recent growth in working from home, to help understand how employers are responding to these changes and the impact this is having on mental health and productivity.

Although this report is substantial, there is some **further analysis** which could be conducted, e.g. exploring whether there are different experiences for firms depending on whether they adopt a 'basket' of the high-performance working measures included in

[5] The qualitative research focussed on priority sectors in the Midlands, which does not generally correspond with Corona virus key worker sectors, so there is scope to conduct refocussed qualitative research drawing on the private sector, key worker establishments in the survey who agreed to be followed up.

the survey or defining and measuring the adoption of a 'coherent well-being offer' associated with productivity.

The research shows the **introduction of new technology** is significantly and positively associated with long-term sickness and mental health sickness. But, contrary to our hypothesis, respondents to the survey overwhelmingly report a positive impact of new technology on employee well-being. Further research on the types of new technology introduced and how they were introduced would be valuable, to deliver greater understanding of this. Again, this is particularly pertinent in the in the Covid-19 context and the associated apparent greater use of technology in the workplace this has brought.

Our research only examines the employer perspective and did not include interviews with employees. In future it would be useful to supplement the findings with **research with employees** in the same firms, to explore their perspective and fill some of the evidence gaps on the outcomes of activities and interventions.

The Covid-19 pandemic has meant that the issue of employee mental health and productivity has become much more high-profile in the few weeks since the fieldwork for this study concluded. This research provides a powerful evidence base that could be used to enable employers and policymakers to better understand the mental health impacts of Covid-19 and to design interventions that may help to mitigate the longer-term impacts on productivity and the economy.

CHAPTER 1: INTRODUCTION

1.1 The impacts and costs of poor employee mental health for employers

Poor mental health can have a significant impact on individuals, families and households. It has an enormous human cost (Sainsbury Centre for Mental Health, 2003) and also very significant public spending costs (McCrone et al, 2008). This study, however, is concerned with the impact of poor mental health in the workplace, and particularly on productivity. It also considers how and why these impacts manifest themselves, and what firms do to support the mental health and well-being of their employees.

Overall, there is strong international evidence of the large economic cost to employers of poor mental health (Bubonya et al. 2017; McTernan et al. 2013). These costs derive from different mechanisms and include:

- Absenteeism – the time workers spend off work due to ill-health;
- Presenteeism – the costs associated with workers being at work but not performing their work as expected because of ill-health or working long hours;
- The turnover costs associated with replacing workers who leave employment due to ill-health[6].

For the UK, estimates from the Stevenson-Falmer review (2019) presented the following costs from poor mental health at work:

- Absenteeism – cost estimates of £8 billion per annum
- Presenteeism – £17-26 billion[7]
- (Staff) turnover – £8 billion.

[6] Of course, there are a range of factors that can affect levels of absenteeism and presenteeism beyond mental health (from work-life imbalance, job insecurity to discrimination and physical abuse) (Darr and Johns. 2008; Bubonya et al., 2017).

[7] This range denotes different sources used to produce an assessment of cost. One uses the Vitality survey with an estimate for mental health and the other a range of sources including the Mind Workplace Well-being Index.

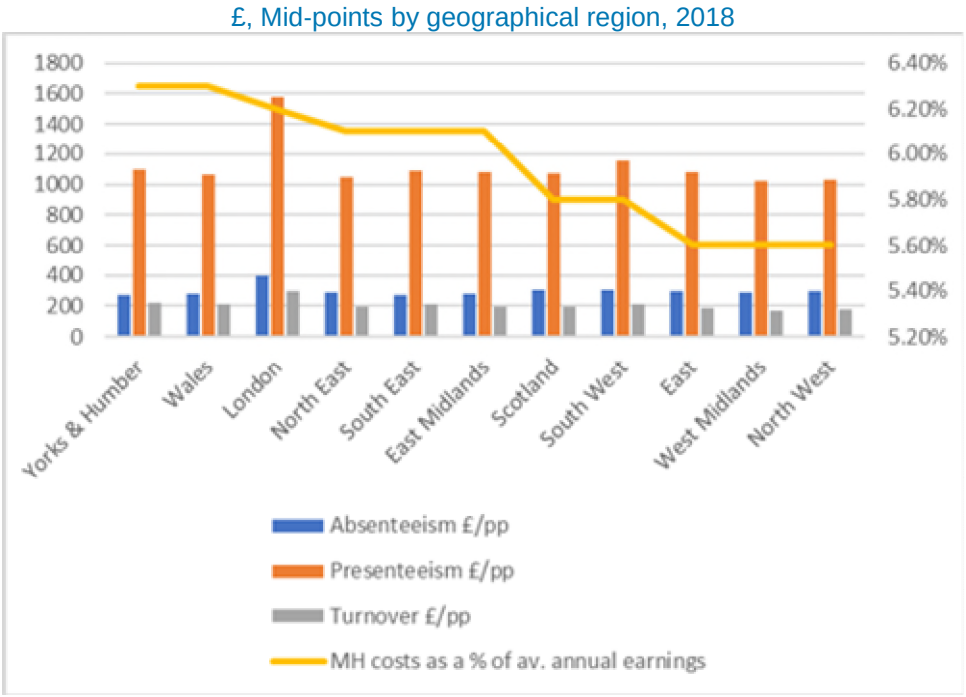
These estimates were recently updated in a new report:

- Absenteeism - £6.8 billion
- Presenteeism - £26.6 to £29.3 billion
- (Staff) turnover cost - £8.6 billion (Deloitte, 2020).

A fall in the cost of absenteeism reflects a fall in sickness absences rates (see Annex 5), but at the same time presenteeism has risen. Both the main sources of presenteeism data used in the Deloitte report show increases. The Vitality survey estimates that the days lost to presenteeism, for all health reasons, rose from 23.5 days per employee in 2016 to 31.6 in 2018. The Mind Workplace Well-being Index survey (2019) reports that 81% of employees always or usually come into the office when they are 'struggling with [their] mental health and would benefit from time off'.

Deloitte provide estimates of variation in these data by industry and region. The regional analysis shows that the average cost per employee of poor mental health to employers is lowest in the West Midlands (5.6% of average annual earnings) and fourth lowest in the East Midlands (6.1%), as shown in the graph below (yellow line). The graph also shows the cost of turnover, presenteeism and absence. All of these are higher per person in London than in any other region. In the East Midlands, the cost per person of absence is £276, of presenteeism is £1079 and of turnover is £196. The figures for the West Midlands per person are £287, £1018, £170 respectively.

Figure 1.1. Costs per employee to employers of poor mental health, by geographical region



Source: Reproduced from Deloitte (2020)

Our research also demonstrates the prevalence of these three issues in the Midlands:

- 41% of establishments in the Midlands reported at least some long-term (more than 4 weeks) sickness absence in the last year. Regression analysis shows this is more likely in larger establishments but less likely in those employing a higher proportion of graduates (Chapter 5);
- 31% reported mental health sickness absence. Regression analysis shows this is more likely in larger establishments and in multi-site establishments (Chapter 6);
- 33% reported presenteeism. Bivariate analysis shows this is more prevalent in Hospitality (where needing to earn money is a driver) and Business Services (where client demand is a key cause) (Chapter 4);
- There was an overall staff turnover rate amongst establishments in the Midlands of 10.4% (Chapter 10).

Our report also provides new evidence on the impacts of mental health on productivity. Using data from our survey, we are able to explore the association between long-term sickness absence, mental health sickness absence and the reporting of and impact of mental health sickness absence on firm performance in the Midlands. This multivariate analysis, reported in Chapter 7, shows:

- Experiencing long-term sickness is associated with productivity which is lower by 27.2 per cent;
- Sickness related to mental health is associated with productivity which is lower by 18.3 per cent;
- Firms reporting a situation in which mental health impacted their performance was associated with productivity which is lower by 24.5 per cent.

These are significant associations of productivity with long-term and mental health sickness absence, but our research suggests these costs may not be known to many employers.

However, the potential for employers themselves to take action to reduce these costs is reflected in recent academic research which concluded:

> 'The toll that mental illness takes on worker productivity results in substantial economic costs for firms, employees, and society more generally. The potential for reducing these costs rests in large part on employers developing employment policies and workplace cultures that support their mentally ill workers in not only attending work, but in also being productive while they are there' (Bubonya, Cobb-Clark and Wooden, 2017) p. 161).

The extent to which employers are developing such employment policies and workplace cultures in the Midlands is reported in Chapter 8.

1.2 Midlands Engine Mental Health and Productivity Pilot: baseline research

In 2019 the Midlands Engine awarded funding of £6.8m to a consortium of over 20 partners who are now working together to enhance workplace well-being across the Midlands.

Led by Coventry University, in partnership with the University of Warwick, the West Midlands Combined Authority and the mental health charity Mind, the Midlands Engine Mental Health and Productivity Pilot programme aims to break down barriers faced by people experiencing mental ill-health and support their return to and continuation in work (see https://mhpp.me/).

To inform the programme, one of the first pieces of work undertaken was a Literature Review exploring the relationship between mental health and productivity. This developed an evidence-based *Mental Health and Productivity Logic Model* that can shape practical interventions to boost employee health and workplace productivity. This, and the literature review findings, are summarised in Chapter 2.

This review was followed by extensive research with 1,900 employers in the Midlands to explore current experience of issues associated with mental health and well-being of employees in the workplace, how they deal with these and the impacts on business performance and productivity. Twenty of the respondents were followed up with in-depth qualitative interviews. The survey and the qualitative research assess where firms in the Midlands are positioned on the new Mental Health and Productivity Logic Model as a baseline for the pilot programme. This report presents this new and comprehensive evidence base.

The report builds on the idea that action by employers can play a key role in reducing both the personal and economic costs of poor mental health and well-being. We adopt a broad approach which recognises the potential interactions between mental health and well-being and the potential importance of both work and non-work-related factors in contributing to poor well-being and mental health.

The report addresses five main questions:

- How do employers manage and monitor sickness absence, mental health sickness absence and presenteeism? How prevalent are these issues in the Midlands?
- What are the causes of mental health problems from the employer perspective? What kinds of firms are most likely to report mental health sickness absence?
- How does mental health sickness absence impact on business performance? What kinds of firms are most likely to report an impact of mental health sickness absence?
- Are employers investing in the mental health and well-being of their employees, through leadership and resources?
- What steps are employers taking to support good mental health and well-being among their employees? How are these evaluated? Do employers use external sources of support? Would they like more support?

1.3 Report structure

The report presents the results of the Literature Review and the Mental Health and Productivity Logic Model for intervention (Chapter 2). Chapter 3 presents the demographic characteristics of respondent firms and their employees. Chapter 4 presents findings on levels of presenteeism and the actions employers take to address it. Sickness absence levels and patterns are presented in Chapter 5, and Mental Health sickness absence in Chapter 6. Chapter 7 looks at the impact of mental health sickness absence on business performance and the mechanisms by which those impacts are achieved. Chapter 8 reports on mental health and well-being attitudes and activities. Chapter 9 explores where businesses currently go for advice and guidance on mental health at work issues and whether they would like more support. Chapter 10 concludes by mapping survey results to our *Mental Health and Productivity Logic Model* to consider areas of strengths and where efforts to improve might best be concentrated and presents conclusions and implications for research and practice.

1.4 Reporting conventions

In reporting on the survey, the unit of analysis is the 'establishment' (see Annex 2). For ease of reading, this is sometimes referred to as 'firm' or 'business'. Data based on sample sizes below 30 are not reported.

CHAPTER 2: DEVELOPING A MENTAL HEALTH AND PRODUCTIVITY LOGIC MODEL

2.1 Introduction

To inform the Midlands Engine pilot programme, and the design of new primary research, we undertook a comprehensive Literature Review on the evidence of mental health and productivity and the links between mental health and productivity - if and how they are connected. In this chapter we present the results of that review and the Mental Health and Productivity Logic Model devised to shape new and existing practical interventions to boost employee health and workplace productivity.

2.2 Defining 'mental health' and 'productivity'

The two core concepts examined in this study are mental health and productivity. In both of these cases, at the outset of drafting the research, there was no core project definition of the concepts. Both mental health and productivity can be defined in different ways.

The British Occupational Health Research Foundation's (2005; 6) review on 'Workplace interventions for people with common mental health problems' defined common mental health problems as those that:

- Occur most frequently;
- Are mostly successfully treated in primary care settings;
- Are least disabling in terms of public reaction.

In their report, Deloitte (2020) referenced a definition from the World Health Organization (WHO) which defined mental health as 'a state of mental and psychological well-being in which every individual realises his or her own potential and can cope with the normal stress of life, can work productively and fruitfully, and is able to make a contribution to his or her community. Mental health is determined by a range of socioeconomic, biological and environmental factors'. (Deloitte, 2020, p6).

The same report also draws on WHO definitions of 'work related stress' as *'the response people may have when presented with demands and pressure that are not matched to*

their abilities, leading to an inability to cope especially when employees feel they have little support from supervisors and little control over work processes' (Deloitte, 2020, p6).

There is debate about whether stress should be included in definitions of mental health conditions. There is ambiguity in discussions about whether stress denotes cause or effect, and there is a complex relationship between stress and work performance. Too much stress is often deemed to be detrimental, but many consider some degree of stress to in fact be necessary for effective performance (Sinclair and O'Regan, 2007).

Co-morbidity is also an important consideration, with estimates suggesting that large numbers of individuals with long-term mental health conditions also have other health problems (Stevenson-Falmer, 2017).

In terms of the evidence base too, a diverse range of definitions were used, from the study of specific conditions, through to structuring by levels of perceived severity of condition, through to a much broader definition of well-being.

For productivity the definitional points are largely technical, as detailed below. However, there is also an important substantive question about the extent to which productivity is a widely understood or valuable metric for employers, with studies suggesting employers often do not think in terms of, or indeed measure, productivity (Green et al, 2018; Roper et al, 2019). The implications of this are that when encouraging employers to develop better approaches to mental health in the workplace, the language of productivity may not be the most effective device to encourage this.

Productivity is, however, a major concern for policymakers in the UK. Since the 2008 recession there has been an extended stagnation in labour productivity (ONS, 2017a). This is in sharp contrast to the productivity rebounds seen after the recessions in the 1980s and 1990s (Blundell *et al*., 2014; Barnett *et al*., 2014). These patterns have led policymakers and commentators to talk about the 'productivity puzzle' behind these patterns. More generally, there are historic concerns about the UK's comparative productivity performance (Mason *et al*., 2008). Productivity matters because it influences living standards over the long-term (Krugman, 1997).

Productivity measures the relationship between inputs and outputs; it is primarily a measure of efficiency. A number of different measures of productivity can be estimated. These include:

- Labour productivity (based on gross output or value-added) - measures how productively labour generates output or value-added. Changes in labour productivity are the outcome of the combined influence of a range of factors, and it is only partially influenced by the capabilities and work effort of employees. These factors include: 'changes in capital, intermediate inputs, as well as technical, organisational and efficiency change within and between firms, the influence of economies of scale, varying degrees of capital utilisation and measurement errors'.
- Capital productivity - measures how productively capital is used, based on value added. As with labour productivity, capital productivity reflects the influence of a range of factors.
- Multi or Total Factor Productivity - measures how productively the combined inputs generate gross output. The measure requires information on different types of inputs to calculate a quantity index, so its calculation has significant data requirements.

  (Source: OECD, 2001)

Productivity can be estimated at different units of analysis - workers, teams, firms, economic sectors or economy-wide; however, often at individual and firm levels there are issues with data availability (van Biesebroeck, 2015). It is more common to have reported performance data on firm-level metrics other than productivity.

2.3 Sickness absence in the UK: prevalence and nature

The scale of mental health conditions in the workplace is very significant; around 15 per cent of people at work have symptoms of an existing mental health condition (Stevenson-Farmer, 2017). The number of workers experiencing mental illness is projected to continue to grow in the future (Vaughan-Jones and Barham, 2009).

However, when asked to estimate the incidence of mental health conditions in the workforce, employers tend to significantly under-estimate its prevalence (Seymour, 2010; Sainsbury Centre for Mental Health, 2007). In 2018, survey evidence suggested that 39 per cent of Senior Managers believed that only between 0 and 10 per cent of their employees would experience a mental health condition at some point in their

working life; for HR Directors, 24 per cent reported the same; while for employers with under 50 employees the figure reporting these levels was 42 per cent. For these small employers (under 50 employees), the same survey finds that 57 per cent of firms believe they have no employees with mental health conditions, for employers with 50-249 employees the figure was 29 per cent. However, there is also evidence that employer understandings of the scale of mental health prevalence have improved over time (Shaw Trust, 2018).

2.4 Mental health and the workplace

The experience of work is recognised as an important factor in mental health issues. McTernan et al. (2013) demonstrate a link between job strain and bullying, which are related to productivity due to their impacts on depression. In the mid-2000s an estimated 10.5 million working days a year were lost in the UK due to anxiety, depression and stress directly caused by work or working conditions (Sainsbury Centre for Mental Health, 2007). Other estimates using Labour Force Survey data suggest that 11.4 million working days were lost in Britain in 2008/9 due to work related stress, depression and/or anxiety disorders. This equates to 27.3 days per affected worker (Knapp et al., 2011). It is also important to note that even where the triggers may be factors outside the workplace, work and the workplace can still have an effect on the condition, its management and recovery (Sinclair and O-Regan, 2007).

A number of studies have assessed the impact of mental health on workplace productivity, taking into account a spectrum of mental health issues (Burton et al, 2008). Differences in productivity and costs to employers are also observed as depending in part on the severity of a condition. Australian evidence indicates the cost of productivity loss due to sickness absence for a person with mild depression was nearly double that of a worker without depression; for those with moderate depression the cost was almost triple (McTernan et al., 2013:330). Woo et al. (2011) using Korean data also demonstrate the large effect on absence of major depressive disorders, while Kessler et al. (2007) also find large effects using US data. There is also evidence of a larger impact on presenteeism associated with more severe symptoms (Tsuchiya et al. 2012).

There is also considerable incidence of co-morbidity in the workforce – around 7/10 of those experiencing a long-term mental health problem also have other health conditions (Stevenson-Farmer, 2017).

2.5 Channels linking mental health and worker performance

There is significant evidence of a correlation and some causal evidence of the link between well-being and job performance. The three causal mechanisms generating this link include:

- The enhanced cognitive abilities of improved well-being;
- Improved well-being generating more positive attitudes to work (collaboration, cooperation, etc.);
- Improving general health improving energy levels (and work effort) (Bryson et al, 2014).

It is worth noting is that the operation of these channels will also to some extent be mediated by the characteristics of jobs; for example, the relative importance of cogitative functions and the extent to which effective collaboration is an important aspect of different types of work can influence the precise nature of the relationship between mental health and productivity. The relationship therefore may differ across and within sectors.

There is good evidence on the large economic cost to employers of mental health problems in the workplace - costs which stem from the combination of absenteeism, presenteeism and staff turnover. Yet there is also evidence that employers often under-estimate the incidence of mental health conditions. There are several causal channels which can link improved mental health to better work performance - including through improved cognitive abilities, more positive attitudes to work, and greater energy levels. There are therefore good economic arguments for employers to do more to support better workforce health.

2.6 Employer approaches to mental health in the workplace

Employers have a critical role to play in addressing mental health problems in the workplace. As Bubonya et al (2017:161) highlight, the potential for reducing the

economic costs of mental health 'rests largely on employers developing employment policies and a workplace culture that support their mentally ill workers in not only attending work, but in also being productive while they are there'. Yet employers often have a limited grasp of the prevalence of mental health conditions in the workforce (Seymour, 2010; Sainsbury Centre for Mental Health, 2007).

Looking after the mental well-being of the workforce should be a core business concern of employers, as whether workers perceive their employer cares about their mental well-being can 'affect workers motivation, commitment and performance' (Baptiste, 2007:301).

It is important that firms have suitable workplace policies in place to support employees suffering with mental health conditions (Howatt et al, 2018); but also, that they should seek to offer strategies to employees who do not yet experience mental health problems as a preventative measure (Burton et al, 2008). The evidence for employer actions around mental health are presented below using headings of thematic areas that the evidence base points as being potentially important: management and leadership; screening and treatment; workplace factors; and multi-strand interventions.

2.6.1 Management and leadership

There is evidence highlighting the importance of leadership and management in supporting better mental health outcomes and linking these to productivity benefits. While there is a clear need for business to invest in mental health in the workplace (Burton et al, 2008), there also needs to be management and line management support of such practices to ensure impact (Dollard et al, 2012; Howatt et al 2018; Kuroda and Yamamoto, 2018).

With leadership there is evidence that different types of leadership can influence mental health in the workplace in both positive and negative directions (Montano et al, 2017). Montano et al. (2017) in a meta-analysis of studies from a range of countries, highlight that effective communication between leaders and followers in an organisation is a key strategy for reducing mental health issues, with 'leader behaviours and characteristics of leader-follower relationship' acting as either a preventative or a risk factor of mental

health (Montano et al: 2017:344). The meta-analysis suggests the following practical implications that could influence interventions (Montano et al: 2017, 344):

- 'Organisations should attempt to prevent aggressive or abusive behaviours, as destructive leadership not only deteriorates mental health but also reduces the levels of positive mental health states;
- Leaders should motivate followers by providing the necessary tools for increasing job self-efficacy and a higher sense of personal achievement;
- A relations-oriented leadership may be enacted to reduce negative mental health states associated with the follower's socio-emotional needs'.

Management and supervisory practices are also critical elements of employers' support for better mental health outcomes at work. Dollard et al (2012) in a study of the psychosocial safety climate (policies, practices and procedures of worker psychological health and safety) of nurses in remote locations in the UK found that management support and commitment, as well as organisational commitment, are crucial for ensuring well-being at work. Kuroda and Yamamoto (2018) explore evidence from longitudinal data on 'white-collar workers' in Japan, specifically focusing on the effect of supervisors' management, communication and capability on workers' mental health and productivity. Their research indicates that good communication significantly improved mental health, enhanced staff productivity and lowered presenteeism. They highlight that the 'role of the supervisor is critical in mitigating the adverse effects of work-related stress' (Kuroda and Yamamoto, 2018:117). In a study of employees in a local government organisation in the north of England, Baptiste (2007:302) demonstrated how 'line management support and trust were pivotal to good relationships between managers and employees that subsequently promote employee well-being at work'.

2.6.2 Screening and treatment

There is evidence that identification and supporting treatment of depressive conditions by employers can be a cost-effective investment (for an overview see Burton et al, 2008). Wang and Ludman (2006) focused on the impact of depression in the US. They found that for cases of depression, enhanced treatment quality programs are cost beneficial to employers, with a cumulative benefit of $2,895 after 5 years (based in a US context). Wang et al (2007) also focus on addressing depression in the workforce in relation to workplace productivity, specifically evaluating the effectiveness of a

depression outreach-treatment programme on workplace outcomes in the US. The programme was provided by telephone, which then encourage workers to consider outpatient treatment, monitoring treatment quality and attempting to improve treatment through providing additional recommendations. The research found that those involved in the intervention went on to have better self-reported mental health, higher job retention and a higher number of hours worked. They concluded that a 'systematic program to identify depression and promote effective treatment significantly improves not only clinical outcomes but also workplace outcomes. The financial value of the latter to employers in terms of recovered hiring, training, and salary costs suggests that many employers would experience a positive return on investment from outreach and enhanced treatment of depressed workers' (Wang et al, 2007:1401).

Woo et al (2011) studied the treatment of major depressive disorders, which have large economic costs, using antidepressant medication and supportive psychotherapy in Korea. They found that after 8 weeks treatment 'absenteeism, and clinical symptoms of depression were significantly reduced and associated with significant improvement in self-rated job performance (31.8%) and cost savings of $7,508 per employee per year' (Woo et al, 2011:.475). They argue that providing support and treatment can save organisations money 'while creating a healthier, happier and more productive workplace' (Woo et al, 482), although as the authors highlight, this was relatively small sample, and only includes those diagnosed with such conditions.

2.6.3 Workplace factors

Increased job control tends to be associated with better well-being (Bambra et al, 2007). So, there has been interest in the role which workplace reorganisation and job design can play in improving health outcomes.

Workplace reorganisation has been investigated by a number of scholars (Bambra et al, 2007; Bond and Bunce, 2001, 2003). Bond and Bunce (2001) in a study of a department in the UK civil service suggest work reorganisation to improve job control could significantly improve mental health, in particular through increasing the extent individuals had choice in their work (although the study is based on a relatively small sample of administrative employees).

Bambra et al (2007) in a systematic review of experimental and quasi-experimental studies explored the health and psychosocial effects of different interventions in the workplace. They identify the following interventions in the studies: workers trained for new roles, increasing task variety, more teamwork, more time to plan work, bonus scheme, increased operator control on production line, more on the job training, ergonomic improvements, more and smaller teams with sub-supervision. The systematic review found that interventions had different impacts by sector. For example, increasing task variety had little impact on those working in nursing, but a modest positive effect on health for those working on a production line. Again, this highlights the importance of considering the varied nature of different jobs for finding suitable mental health support strategies. Interventions that improved team working and provided more collective responsibility and decision-making power scenarios tended to improve the work environment in most studies included in the review, although the health benefits were not always clear.

2.6.4 Multi-strand interventions

A number of studies consider not a single intervention or workplace change but a package of measures. Mills et al (2007) evaluated the impact of a multicomponent workplace health promotion programme on employee health risks and productivity. The results suggested that a well-implemented multi-strand workplace health promotion programme can produce significant changes in health risks and productivity. The intervention involved each participant in the study receiving a personalised health and well-being report that gave them a wellness score and information and advice tailored to his or her readiness to change health-related behaviour. Workers were also given access to a personalised health well-being and lifestyle web portal that included articles, assessments and interactive online behaviour change programmes, as well being sent hardcopy materials on prevalent health risks. Analysis suggested this reduced absenteeism and increased productivity (calculated by the annual salary costs of extra productive time). The research was based on a multinational corporation in the UK, in office-based professions and service delivery jobs.

Howatt et al (2018) in a study of Canadian workplaces have suggested that the key considerations for addressing mental health in the workplace and boosting productivity were: buy-in from leadership; an understanding of the needs of employees, a mental

health strategy that is integrated into the organisations' overall strategies; encouraging open conversations and reducing stigma through education, and training managers to understand and support employees with mental health problems. A key outcome from this research was advice for employers to broaden their concept of workplace mental health to ensure that all mental health issues were supported, but also that actions taken were proactive rather than reactive. The research also highlighted that for an intervention to have a successful outcome there needed to be an emphasis on joint responsibility: 'the development of a strong organisational culture and positive mental health outlook in the workplace is shared between employer and employee' (Howatt et al, 2018: 22).

2.7 A logic model for intervention

Rationale: Improved mental health can drive better firm productivity

This section presents the Mental Health and Productivity Logic Model for intervention based on the evidence reviewed. Figure 2.1 provides a simplified logic chain for the relationship between improving mental health in the workplace and better organisational performance. At the individual worker level, improved mental health can contribute to improved performance through a combination of the channels previously identified. In turn, this improvement in worker performance can contribute to broader organisational productivity.

Figure 2.1: Simplified Mental Health and Productivity Logic Model

This simplified logic chain is based on a more detailed logic model (which is presented at the end of this Chapter in Figure 2.2). The model follows the Wisconsin Model format – structuring a linear process through inputs, activities, outputs and outcomes (alongside a set of underpinning assumptions and external factors).

The model articulates the need, following from the evidence, as: 'Poor mental health has significant economic and social costs. Through targeted actions firms can help support better mental health whilst becoming more productive'.

- Inputs – the core inputs to improving mental health in the workplace revolve around leadership and strategy, i.e. the strategic organisational commitment to create well-being policies and practices, the allocation of time and resources to support these policies and practices, and, where appropriate, drawing on external resources (financial, expertise, tools, etc.) to support this.
- Activities – the activities are geared around tackling work-related causes of mental health conditions, support for clinical issues and encouraging positive lifestyle choices. These activities include those orientated towards a better assessment of need and risk assessment of mental health issues; initiatives to reduce workplace stress and improve job design; training and engagement with mental health programmes for line managers and a proactive approach; support for or linking to treatment; and, tackling mental health stigma in the organisation.
- Outputs – at the organisational level the outputs will include a coherent well-being 'offer', better assessment of provision and gaps, improved knowledge and trust in line management relationships, more access to treatments, better understanding of the prevalence of mental health problems and more mental health conversations.
- The outcomes – at the individual level will include improved employee well-being (generating reduced absenteeism and presenteeism). It should be borne in mind here that while an aim is to reduce, on average, absenteeism, not all absence is negative and can be a critical part of the recovery process. So, absence reduction should be viewed as following from good practice rather than explicitly targeted. Absence is also tied-up with a range of work factors, for example those in more precarious employment are less likely to take sick leave, so a long-view about underlying workforce well-being, performance and commitment also needs to be taken. While at the organisational level outcomes include performance and productivity gains as well as improved retention.
- The assumptions underpinning the model are an acceptance of the need/business case at organisational level; a broader commitment to job quality; and that the short-term benefits of reduced absenteeism and presenteeism will also be associated with positive longer-term benefits for firms and workers.
- External factors which influence the nature of the relationships examined in the logic model include the characteristics of the firm and wider economic and institutional factors.

The Mental Health and Productivity Logic Model forms a framework for intervention. Employers have a crucial role to play in addressing mental health problems in the workplace and the model helps to explain how these actions can link together and bridge

to improve productivity. It shows that there is a need for businesses to invest, but also for supportive leadership and management structures to be in place to support beneficial practices. There is also evidence that employer support for screening and support for mental health conditions could offer a good return on investment. Changes to workplace factors and workplace organisation can also play a role in improving worker mental health and well-being, while multi-strand interventions can help support better outcomes across a broader group of workers and form part of a more proactive approach.

2.8 Summary

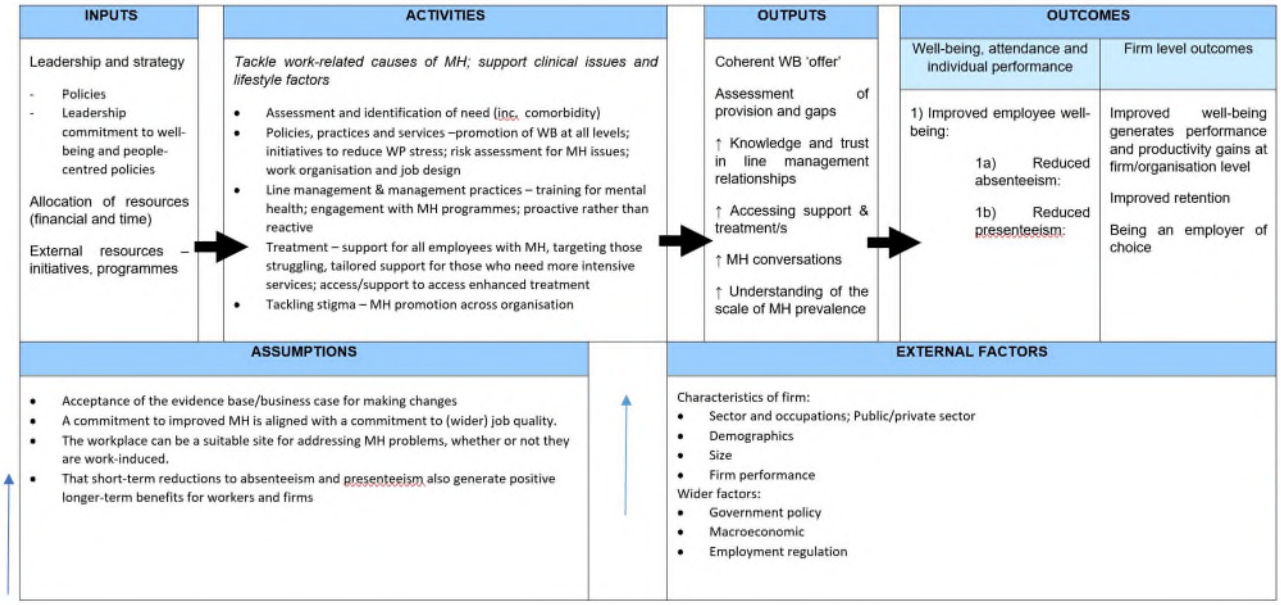
The Literature Review provides evidence of a high number of working days lost to mental health conditions and a high cost to employers. The channels by which mental health contributes to business performance are identified as enhanced cogitative abilities of improved well-being; more positive attitudes to work (collaboration, cooperation, etc.), and improved energy levels (and work effort). There is a case for employers not just to support people with existing conditions, but also to proactively enhance mental health and well-being that may help play a role in prevention.

A number of activities are identified as having a positive impact on business performance including positive senior leadership and management; screening and treatment activities; workplace factors and multi-strand interventions, combining leadership, understanding the needs of employees, an integrated mental health strategy, encouraging open conversations and reducing stigma through education, and training managers to understand and support employees with mental health problems, an emphasis on joint responsibility across employer and employee.

We explore these issues as they emerged in our research on Midlands-based firms in the chapters that follow.

Figure 2.2: Full logic model for improving mental health in the workplace

Situation/Need: Poor mental health has significant economic and social costs. Through targeted actions firms can help support better mental health whilst becoming more productive.



CHAPTER 3: CHARACTERISTICS OF FIRMS SURVEYED IN THE MIDLANDS

Before detailing the analysis of the employer research, we begin with a brief description of the key characteristics of employers surveyed. We do this in sections covering: firm demographics; employee demographics; and management and performance. Details of the survey approach and questionnaire can be found in Annexes 2 and 3.

3.1 Firm demographics

Figures 3.1 to 3.3 show the profile of respondents by size, sector and age in the East and West Midlands. Responses are weighted to provide a representative view of private sector businesses in both regions. Unweighted sample counts are included in Annex 2.

Almost half of the (weighted) group of respondents employ 10 to 19 employees, reflecting the dominance of this size of firm in the business population (48%); around a third employ between 20 and 50 employees (32%); 17% employ 50 to 249 employees and just over 2% employ 250 or more. The figures are very similar in the East and West Midlands.

Though the survey excluded the very smallest firms with less than 10 employees, the number of employees is likely to impact on the responses as smaller firms are often found to be less likely to have Human Resource functions or dedicated staff. Having fewer employees, they may also be less likely to experience issues related to staff sickness and mental health.

Figure 3.1: Profiling respondent firms: size

	East Midlands	West Midlands	All firms
	%	%	%
10-19	48	48	48
20-49	33	32	32
50-249	17	17	17
250 plus	2	2	2
Total	100	100	100
Base:	866	1033	1899

Base: All firms
Note: Responses are weighted to provide representative results for each region.

Figure 3.2 goes on to detail the (weighted) industry sector of respondents. Again, given that the survey was designed to represent the population of businesses in the Midlands on the basis of sector, the survey respondents reflect the distribution of private sector firms by sector overall (see Annex 2). Half of private sector establishments in the Midlands are in Wholesale and Retail or Other Services. The East Midlands has slightly more firms in Production and Construction and fewer in Business Services when compared to the West Midlands.

Figure 3.2 Profiling respondent firms: sector

	East Midlands	West Midlands	All firms
	%	%	%
Production	13	13	13
Construction	5	4	5
Wholesale, retail	26	26	26
Hospitality	11	11	11
Business Services	18	20	19
Other services	27	26	26
Total	100	100	100
Base	*866*	*1033*	*1899*

Base: All firms
Note: Responses are weighted to provide representative results for each region.

Figure 3.3 shows the (weighted) age structure of respondent firms. Reflecting the broader population of firms, the majority of respondents (56%) have been in business for over 20 years and therefore can be considered to be well-established firms; over a quarter are between 11 and 20 years old and the remaining 17% were formed between 3 and 10 years ago.

Figure 3.3 Profiling respondent firms: business age

	East Midlands	West Midlands	All firms
	%	%	%
3-5 years	5	5	5
6-10 years	12	11	12
11-20 years	26	28	27
20-plus years	57	55	56
Total	100	100	100
Base:	*866*	*1033*	*1899*

Base: All firms
Notes: Businesses less than three years old were excluded from the survey.
Responses are weighted to provide representative results for each region

A majority of the establishments in the survey are single-site organisations – i.e. the only location in the organisation (58%) while 42% are one of a number of branches of a larger organisation. Smaller sized establishments, employing fewer people, are more likely to be single-site organisations (68%) as are establishments in the Construction sector (75%).

Figure 3.4: Profiling respondent firms: single or multi-site

	The only site in the organisation	One of a number of sites
All Firms	58	42
East Midlands	60	40
West Midlands	57	43
Production	66	34
Construction	75	25
Wholesale, retail	57	43
Hospitality	46	54
Business Services	62	38
Other services	55	45
10-19	68	32
20-49	55	45
50-249	40	60
250 plus	34	66

Base: All firms
Note: Responses are weighted to provide representative results for each region.

3.2 Employee demographics

A number of characteristics of employees are also explored in the survey.

The survey explored the age profile of employees within the firm in order to explore whether this impacts on likelihood of sickness absence or mental health issues. The proportions in the three age bands identified are very similar across the East and West Midlands with around one in 5 employees aged under 25, 55% aged between 25 and 49, and 26% aged 50 or more, as shown in Figure 3.5.

Figure 3.5: Profiling the workforce of respondent firms: age

	East Midlands	West Midlands	All firms
Under 25 years	19	20	19
25-49 years	55	54	55
50-plus years	26	26	26
Total	100	100	100
Base	*866*	*1033*	*1899*

Base: All firms
Note: Responses are weighted to provide representative results for each region.

Figure 3.6 shows other characteristics of employees in the firms. Women comprise 52% of the workforce in the firms surveyed; 13% of employees are from a non-white ethnic group; and 2% have a long-term disability affecting the amount or type of work they do. The West Midlands has a higher proportion of employees with a long-term disability (2.5%) than the East Midlands (1.8%) and a higher proportion of employees from a non-white ethnic background (14.3% in the West Midlands compared to 10.7% in the East Midlands).

Figure 3.6 also shows that around three in ten of employees are qualified to degree level, with this proportion varying little between the East and West Midlands.

Figure 3.6: Profiling the workforce of respondent firms: gender, ethnicity, disability and qualifications

	East Midlands	West Midlands	All firms
	%	%	%
Female share (%)	52	52	52
Ethnic share (%)	11	14	13
Disabled share (%)	2	2	2
Graduate share (%)	29	30	30
Base:	866	1033	1899

Base: All firms
Note: Responses are weighted to provide representative results for each region.

3.3 Firm management

This section describes some features of management of the firms as explored through the survey.

Figure 3.7 shows that 62% of firms are family owned in the Midlands, with a higher proportion in the East Midlands of which 65% are family owned at compared to 60% in the West Midlands.

The survey also explored the types of contracts employees are on. One in six firms have at least some staff on zero hours contracts, this proportion being slightly higher in the West Midlands at 17% compared to 16% in the East Midlands. A lower proportion of firms are employing staff on temporary contracts (10%) with little variation between the East and West Midlands.

Finally, to gain some sense of technological adoption in firms and any impacts on staff well-being the survey explored whether firms had recently introduced any new technologies to aid business performance. Almost half of firms (46%) in both East and West Midlands had introduced new technologies for this purpose.

Figure 3.7: Management practices in respondent firms

	East Midlands	West Midlands	All firms
	%	%	%
Family owned (% firms)	65	60	62
Zero hours contracts (% firms)	16	17	16
Temporary contracts (% firms)	10	10	10
Introduced new technologies (% firms)	46	46	46
Base	866	1033	1899

Base: All firms
Note: Responses are weighted to provide representative results for each region.

Figure 3.8 shows the proportion of firms adopting a variety of different 'high performance work practices' explored in the survey. These are measures commonly used to profile the working environment of an organisation with potential implications for employee well-being and mental health.

Almost all firms (97%) said they provided good physical working conditions for staff; this was followed by 93% of firms providing development opportunities for staff and 90% of firms providing a healthy work-life balance for employees. 86 per cent of firms reported that employees have variety in their work with around three-quarters offering flexible working. There was little variation between the East and West Midlands on any of these measures.

Figure 3.8 High performance work practices in respondent firms

	East Midlands	West Midlands	All firms
	%	%	%
Employees have control over work (% firms)	75	77.3	76.4
Employees have variety in work (% firms)	86	85.7	86.0
Employees have flexible working (% firms)	76	75.4	75.6
Good physical working conditions (% firms)	97	97	97
Healthy work life balance (% firms)	90	90	90
Development opportunities (% firms)	93	93	93
Base:	*866*	*1033*	*1899*

Base: All firms

Notes: Responses are weighted to provide representative results for each region.
For high performance work practices, we report the proportion of firms indicating that they either 'agree strongly' or 'agree slightly' that they have each practice in place in the enterprise.

3.4 Business performance

Finally, in this chapter, Figure 3.9 presents data on employment and turnover growth in the firms surveyed. Around three in ten (31%) firms reported employment growth in the last 12 months, with this being *slightly* more likely in the East Midlands (32%) compared to the West Midlands (31%). A higher proportion reported a growth in turnover (46%) and again firms in the East Midlands (47%) were more likely to report this than firms in the West Midlands (45%).

Figure 3.9: Percentage of respondents reporting growth in sales and employment over the last year

	East Midlands	West Midlands	All firms
	%	%	%
Growth in employment (% firms)	32.0	30.8	31.4
Growth in turnover (% firms)	47.1	44.6	45.7
Base:	*866*	*1033*	*1899*

Base: All firms

Note: Responses are weighted to provide representative results for each region.

3.5 Summary

There is some variation across the Midlands in terms of industry profile and ownership. Business establishments in the East Midlands firms are more likely to be family owned and to report growth in employment and turnover. Establishments in the West Midlands are more likely to employ people with disabilities and people of non-white ethnic origin.

We will explore the ways in which some of these factors impact on the key survey questions throughout the report, through bivariate and multivariate analysis.

CHAPTER 4: PRESENTEEISM

4.1 Introduction

As we have seen, presenteeism, where individuals attend work when they are unwell and/or work beyond contracted hours, is recognised as a major contributor to the increased costs of mental health for employers (Chapter 1).

What are the levels of presenteeism in firms in the Midlands, what causes it and what are firms doing to address this phenomenon?

4.2 The extent and nature of presenteeism

Figure 4.1 shows that 33% of firms reported some presenteeism in their firm. This was consistent across the Midlands but varied by size and sector of firm. Small firms are less likely to report presenteeism (29% of the smallest establishments compared to 41% of those employing 50-249 employees) and Construction sectors are least likely to report presenteeism (23%, compared to 42% in Business Services and 37% in Hospitality).

Figure 4.1: Extent of presenteeism

	East Midlands	West Midlands	All firms
	%	%	%
All	32	35	33
Production	32	35	33
Construction	31	17	23
Wholesale, retail	28	26	27
Hospitality	36	39	37
Business Services	40	43	42
Other services	28	38	33
10-19	24	32	29
20-49	36	36	36
50-249	45	39	41
250 plus	34	35	34

Base: All firms - 1899
Note: Responses are weighted to provide representative results for each region.

Those reporting presenteeism were asked about the form this took. Figure 4.2 shows that around two thirds of employers cited employees working when unwell (63%) and working beyond contracted hours (69%). The largest firms are more likely to report both of these characteristics of presenteeism the causes of which are explored in the next section.

Figure 4.2 Nature of presenteeism

	Staff working when unwell	Staff working beyond contracted hours
	%	%
All	62	69
East Midlands	64	68
West Midlands	62	69
Production	62	66
Construction	45	67
Wholesale, retail	69	64
Hospitality	59	65
Business Services	62	71
Other services	61	74
10-19	61	65
20-49	57	70
50-249	72	73
250 plus	77	69

Base: 654 firms reporting presenteeism
Note: Responses are weighted to provide representative results for each region.

4.3 Causes of presenteeism

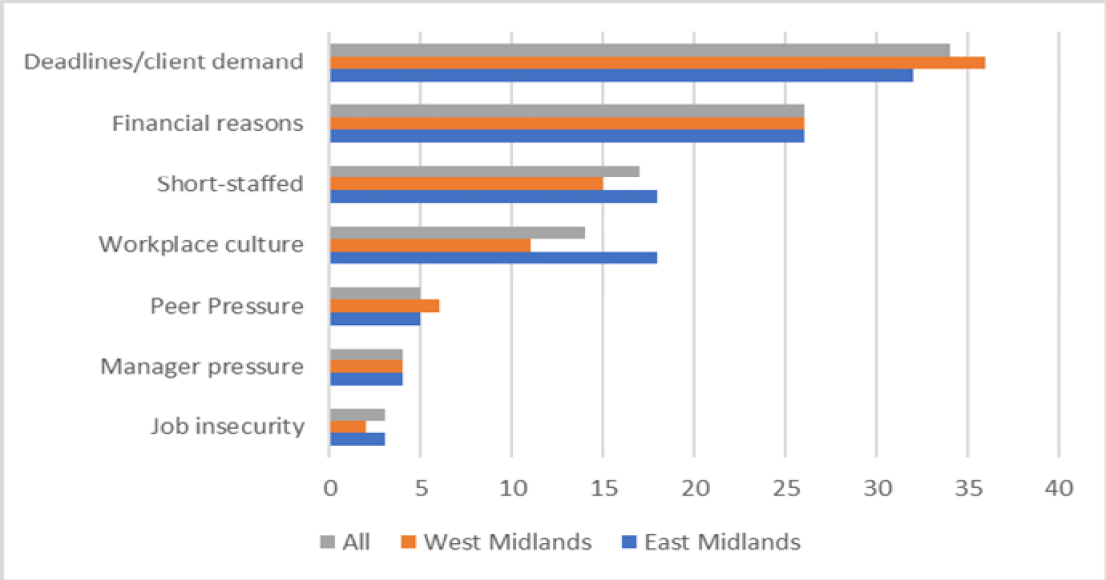
Firms reporting instances of presenteeism were asked the causes of this. Multiple responses were allowed and are shown in Figure 4.3. Deadlines or meeting client demand was by far the most commonly reason cited (34%), followed by staff working to earn more money (26%). The prevalence of these causes suggests push and pull factors – the push of a financial imperative to earn more money, and the pull of the employer need to meet deadlines. There are no major differences by region, except that firms in the East Midlands are more likely to cite workplace culture as a cause of presenteeism (18% compared to 11% in the West Midlands and 14% overall).

Few participants in our qualitative research reported presenteeism as an issue, but one who did so attributed it to staff enthusiasm for their work, demonstrating the complexity involved in interpreting the issue and recognising it as a 'problem':

We're a charity, we've got lots of missionaries here who their work is never done, and absolutely committed to it. So, we're not a place that would have high levels of absence to some degree, but presenteeism is a sign that maybe people need to take some time out.

Assistant Director – HR, Large, Other Services, East Midlands

Figure 4.3 Causes of presenteeism



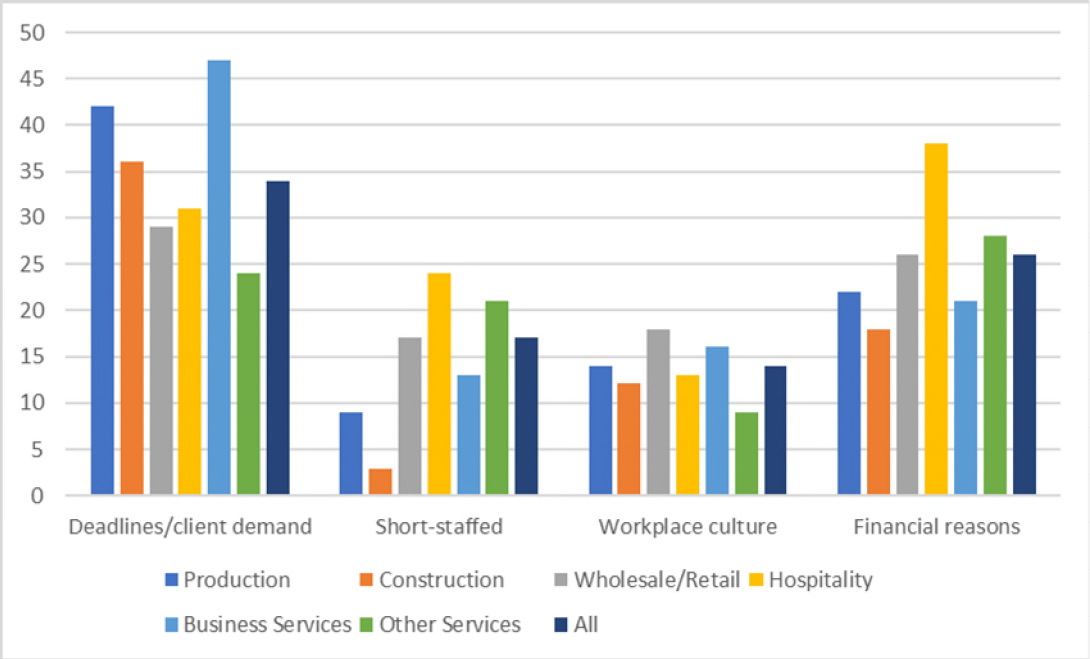
Base: 654 firms reporting presenteeism

Notes: i) Responses are weighted to provide representative results for each region.
ii) QI3: Multi code accepted. Not read out.

There are some variations by sector. Figure 4.4 shows the four most commonly cited reasons by sector. Firms in Production (42%), Construction (36%) and Business Services (47%) are more likely than average to cite deadlines or client demand as a reason for presenteeism. Firms in Hospitality are much more likely to report being short staffed as a reason (24% compared to an average of 17%). Firms in Other Services are also more likely than average to report this reason (21%). Workplace culture was more likely to be a reason in Wholesale and Retail firms than average (18% compared to the average of 14%). Firms in Hospitality are most likely to cite financial reasons for presenteeism (38% compared to an average of 26%).

Thus, in the sectors in which presenteeism is most prevalent, there are different causes cited. In the case of the Business services sector, client demand is most likely to be cited as the cause of presenteeism, a 'pull' factor; in Hospitality, the 'push' factor of 'financial reasons' is the most commonly cited cause, but shortage of staff is also more likely than average to be cited in this sector.

Figure 4.4 Causes of presenteeism by sector (four most common reasons)

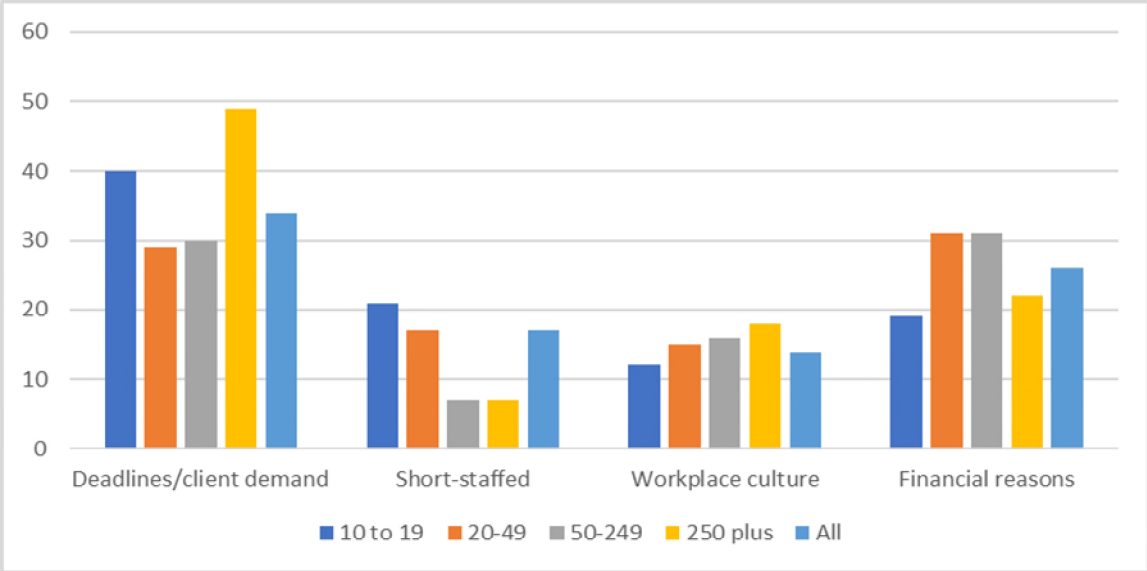


Base: 654 firms reporting presenteeism

Notes: i) Responses are weighted to provide representative results for each region.
ii) QI3: Multi code accepted. Not read out.

The larger firms are more likely to cite client demand as a reason for presenteeism (49% in those employing 50-249 employees, compared to 34% in the smallest). Smaller firms are more likely to cite being short-staffed than larger firms (21% of those employing 10-19 compared to 7% of those employing 50-249 employees). The smallest firms are also more likely to report presenteeism because of deadlines and less likely for individual financial reasons as shown in Figure 4.5.

Figure 4.5 Causes of presenteeism by size (four most common reasons)



Base: 654 firms reporting presenteeism

Notes: i) Responses are weighted to provide representative results for each region.
ii) QI3: Multi code accepted. Not read out.

4.4 Firm responses to presenteeism

The majority of firms (60%) are taking steps to address presenteeism. Those in Other Services are most likely to be taking steps as are the larger firms, as shown in Figure 4.6. A higher proportion than average is taking steps in the Hospitality sector, but firms in Business Services, despite reporting higher levels of presenteeism, are no more likely than average to be taking steps to address the issue.

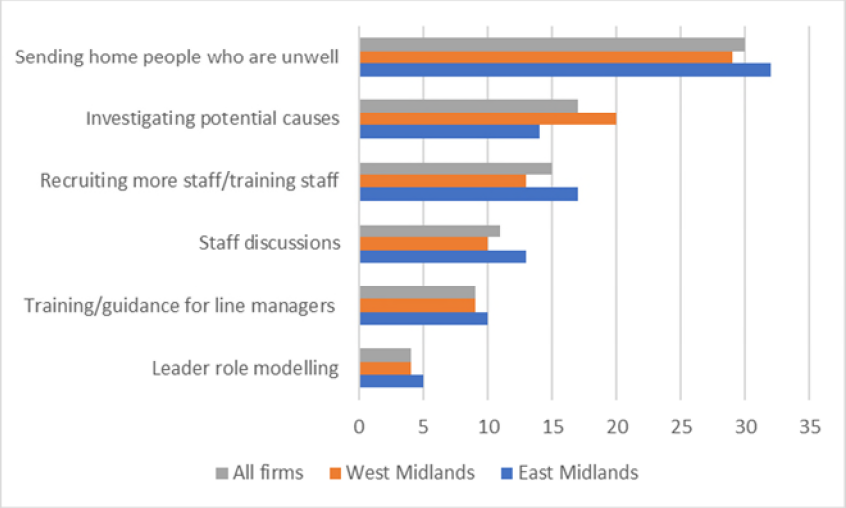
Figure 4.6 Proportion taking steps to address presenteeism

	Proportion taking steps to address presenteeism
	%
All	60
East Midlands	62
West Midlands	58
Production	42
Construction	59
Wholesale, retail	52
Hospitality	64
Business Services	60
Other services	74
10-19	56
20-49	64
50-249	67
250 plus	69

Base: 654 firms reporting presenteeism
Note: Responses are weighted to provide representative results for each region.

The survey asked those firms which are taking steps what steps they are taking to address presenteeism. The most commonly cited response is to send people home if they are working when unwell (30% of those who take steps to address presenteeism), followed by an investigation into potential causes (17%); recruiting more staff (14%); having discussions with staff (11%); providing guidance for line managers (9%) and just 4% reported leaders 'role modelling' behaviour by not working when ill (Figure 4.7).

Figure 4.7 Actions taken to address presenteeism

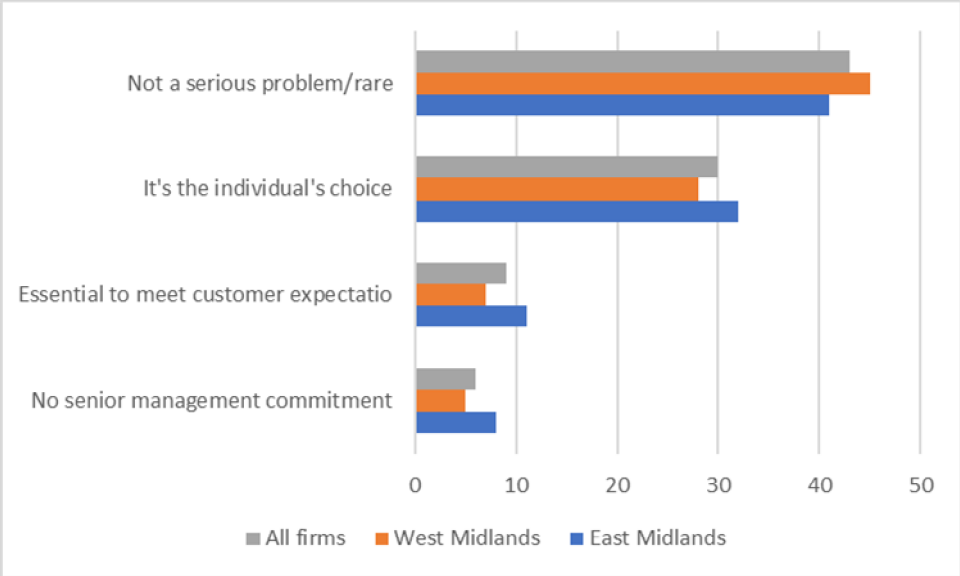


Base: 387 firms taking action to address presenteeism
Notes: i) Responses are weighted to provide representative results for each region.
ii) QI5: Multi code accepted. Not read out.

In the two sectors in which presenteeism was most prevalent, both were more likely than average to send people home if they were working when unwell. This was most commonly reported in Hospitality, which *might* be in keeping with the fact that the most common cause was people working for financial reasons. Business Services were more likely than average to offer training to line managers to recognise presenteeism.

We asked the 38% of firms which reported presenteeism but which were not taking steps to address it, the reasons for this. The response is shown in Figure 4.8. Firms are most likely not to be addressing presenteeism because the problem is not regarded as serious or it is seen as rare (43%), and it is up to the individual to work those hours (30%). Reasons associated with the business itself, such as essential to meet customer demand and lack of senior management commitment are much less commonly cited.

Figure 4.8 Reasons for not taking action to address presenteeism



Base: 242 firms not taking action to address presenteeism
Note: Responses are weighted to provide representative results for each region.

4.5 Summary

A third of establishments in the Midlands reported presenteeism, either defined as staff working beyond their contracted hours or, less frequently, staff working when unwell. The most commonly identified reason for this behaviour was to meet customer demand. A worker's need for additional wage is the next most common reason, followed by being short-staffed and the culture of the workplace. Pressure from managers or peers and job insecurity are rarely mentioned by employers as a cause of presenteeism.

Larger firms and firms in Hospitality and Business Services sectors are most likely to report presenteeism. Client demand is the biggest cause in the Business Services sector, but a need to earn more money is the biggest cause in the Hospitality sector. These suggest different characteristics of the presenteeism problem depending on context, and the complexity of the issue. Firms in the Other Services sector are most likely to be taking steps to address presenteeism.

The data suggests that for a small but important minority, the workplace is experienced as busy and pressured with deadlines and external demands to meet, and that this drives presenteeism.

Most employers reporting presenteeism are taking steps to address it, most commonly sending home workers if they are unwell, investigating causes and even recruiting more staff. Very few, however, reported that managers modelled good behaviour, which suggests that an example of presenteeism is being set in many firms by managers which may have an influence on other employees.

For those not taking steps, they were most likely to say the problem was not particularly serious or that it was a choice of the employee. A different perspective on the issue may come from employees themselves, or it might well be the case that the problem is not serious from an individual's perspective too. The survey could not explore this in depth, as it did not include interviews with employees. However, our results do suggest that presenteeism is a substantial issue, and in a significant number of workplaces in the Midlands, there are staff working long hours or when unwell for financial reasons.

CHAPTER 5: SICKNESS ABSENCE IN THE MIDLANDS

5.1 Introduction

In this chapter we explore the levels, nature and impacts of sickness absence in the Midlands, as important context for deeper exploration of mental health sickness absence in Chapter 6. The chapter begins by reporting on the procedures firms have in place regarding monitoring sickness absence and their approach to statutory sick pay.

5.2 Reporting sickness absence

To assess the degree of formality in approach to managing sickness absence, the survey explored measurement of sickness absence. Figure 5.1 shows that 85% of firms record sickness absence, this being more evident in the West Midlands at 87% compared to the East Midlands at 82%. The Figure also shows variation in the measuring or monitoring of sickness absence by sector, ranging from 94% in 'Other Services' to 77% in Construction. With regard to size of establishments, generally, the more employees, the more likely they are to measure sickness absence, with 80% of the smallest and 89% of the largest measuring or monitoring sickness absence, though the proportion of those employing 50-249 is highest at 94%.

Figure 5.1 Proportion of firms which regularly measure or monitor sickness absence

	East Midlands	West Midlands	All firms
	%	%	%
All	82	87	85
Production	86	84	85
Construction	84	71	77
Wholesale, retail	73	85	80
Hospitality	73	87	80
Business Services	84	86	85
Other services	92	96	94
10-19	76	83	80
20-49	87	89	88
50-249	92	96	94
250 plus	91	87	89

Base: All firms – 1899
Note: Responses are weighted to provide representative results for each region.

The survey also recorded whether firms recorded the reasons for sickness absence, shown in Figure 5.2. Five in six establishments record the reason for sickness absence, either at their own establishments (81%) or elsewhere in the organisation (4%). Firms in the West Midlands are slightly more likely to record reasons than those in East Midlands.

Firms in Other Services (86%) are most likely to record the reasons for sickness absence and firms in Wholesale, retail (76%) least likely.

Again, smaller firms are less likely to record the reasons for sickness absence (19% in smallest firms reported that they did not record the reasons for sickness absence) but the respondents in establishments employing more than 250 employees were most likely to report that they did not know if the reasons for sickness absence are recorded (7%).

Figure 5.2 Proportion of firms recording reason for sickness absence

	Yes – at this establishment	Yes – elsewhere in organisation	No	Don't know
All firms	81	4	14	2
East Midlands	79	4	15	2
West Midlands	82	4	13	1
Production	81	4	14	1
Construction	76	3	19	2
Wholesale, retail	75	4	19	2
Hospitality	77	4	16	3
Business Services	84	4	11	2
Other services	86	4	9	1
10-19	76	3	19	1
20-49	82	4	12	2
50-249	91	4	4	1
250 plus	81	5	8	7

Base: All firms – 1899
Note: Responses are weighted to provide representative results for each region.

5.3 Statutory Sick Pay (SSP)

Firms were asked if they offered sick pay above the levels of Statutory Sick Pay (SSP), as this is sometimes associated with higher levels of sickness absence because staff feel able to take time off when unwell. Figure 5.3 shows that 31% offer sick pay above the statutory level for all staff, and 16% for some staff only.

Establishments in the Business Services sector are most likely to offer sick pay above the statutory minimum for some or all staff (62%). At 36%, Hospitality reports the lowest proportion of firms offering additional sick pay. As we saw in the previous chapter, this sector also had the highest proportion of presenteeism caused by staff needing to work extra hours or when unwell for financial reasons.

By size, larger firms are most likely to offer sick pay above the statutory minimum with 65% of the largest establishments offering sick pay above SSP for all staff, compared to 37% of those employing 50-249 employees and 29% in both the two smallest size bands.

Figure 5.3 Proportion of firms offering sick pay above the level of Statutory Sick Pay

	For all staff	For some staff	No	Don't know
All firms	31	16	49	4
East Midlands	30	16	50	5
West Midlands	32	16	49	3
Production	36	21	40	3
Construction	22	21	54	3
Wholesale, retail	30	15	50	5
Hospitality	13	23	61	3
Business Services	45	17	35	3
Other services	30	10	58	3
10-19	29	13	53	5
20-49	29	17	51	3
50-249	37	20	40	3
250 plus	65	19	12	5

Base: All firms – 1899.
Note: Responses are weighted to provide representative results for each region.

5.4 Long-term and repeated sickness absence

Two in five firms (41%) said they have had staff off for more than 4 weeks in the last 12 months. This was slightly higher in the West Midlands than in the East Midlands. This rate also varied by sector, with the highest levels reported in Other Services (53%) and the lowest in Hospitality and Construction (both 31%). There are no clear sectoral patterns when looking across Figures 5.3 and 5.4. However, larger firms were more likely to report staff being off for more than 4 weeks, with 70% of those employing over 50 employees reporting long-term absence compared to 25% in the smallest firms employing between 10 and 19 employees (Figure 5.4).

Figure 5.4: Proportion of firms reporting long-terms sickness absence.

	East Midlands	West Midlands	All firms
	%	%	%
All	39	43	41
Production	43	48	46
Construction	27	34	31
Wholesale, retail	35	42	39
Hospitality	32	31	31
Business Services	34	34	34
Other services	50	54	52
10-19	23	27	25
20-49	43	50	47
50-249	73	68	70
250 plus	63	75	70

Base: 1845 – all establishments except those which reported no sickness absence (from D3)
Note: Responses are weighted to provide representative results for each region.

Understanding the correlates of long-term sickness

We undertook **regression analysis** to test the factors linked to the probability of experiencing long-term sickness (see Chapter 7 for further detail on the regression analysis and Figure 7.2). This allows us to present a more robust analysis of association, when all other factors are controlled for, but not to infer causation.

This showed that long-term sickness absence was *less* likely in:

- Establishments with a high proportion of graduates
- Establishments with flexible working options.

Establishments *more* likely to report long-term sickness absence are:

- Those which had introduced new technologies
- Larger establishments
- Establishments with a senior lead responsible for health and well-being (see Chapter 8 for a full discussion on mental health activities).

A third of firms which had people off sick in the last 12 months reported staff taking repeated absence (33%), with little regional variation (Figure 5.5). Greater variation is evident by sector, ranging from 41% in Other Services to 28% in Construction. There was also variation by number of employees with 22% of those in the smallest firms reporting repeated absence compared to 58% of firms employing between 50 and 249 employees and a slightly smaller proportion, 53% in the largest establishments. Respondents in the largest establishments were most likely to report that they didn't know whether staff had taken repeated sickness absence - 15% in those employing more than 250, compared to 4% in 50 to 249, and less than 2% in the smaller firm bands

Figure 5.5: Proportion of firms reporting repeated sickness absence

	East Midlands	West Midlands	All firms
	%	%	%
All	33	34	33
Production	32	29	30
Construction	30	25	28
Wholesale, retail	28	30	29
Hospitality	30	31	31
Business Services	35	32	33
Other services	39	43	41
10-19	21	22	22
20-49	33	37	35
50-249	62	55	58
250 plus	56	51	53

Base: 1845 – all establishments except those which reported no sickness absence (from D3)
Note: Responses are weighted to provide representative results for each region.

5.5 Impact of sickness absence

The majority of firms which reported sickness absence in our survey said that there was an impact on the operation or performance of the business (67%, Figure 5.6). Although small businesses were much less likely to report repeated or long-term sickness absence (by up to 45 percentage points) there was less variation in the reporting of impact by size. Just less than two-thirds (63%) of the smallest firms reported an impact of sickness absence on the business compared to 72% of the largest and 76% of those employing between 50 and 249 staff.

This indication that sickness absence impacts on firms regardless of whether or not they report long-term or sickness absence also appears to hold for sector. Business Services was least likely to report an impact (63% of firms reporting sickness absence in the sector) and firms in Wholesale and retail were most likely (70%), although this latter sector reported below average long-term and repeated sickness absence.

Figure 5.6: Proportion reporting a business impact due to sickness absence

	East Midlands	West Midlands	All firms
	%	%	%
All	67	67	67
Production	65	68	66
Construction	71	59	65
Wholesale, retail	70	70	70
Hospitality	70	63	66
Business Services	63	64	63
Other services	67	71	69
10-19	61	65	63
20-49	69	68	68
50-249	71	73	76
250 plus	67	75	72

Base: 1845 – all establishments except those which reported no sickness absence (from D3)
Note: Responses are weighted to provide representative results for each region.

5.6 Summary

Most establishments in the Midlands regularly monitor sickness absence (85%), and 81% record the reasons for sickness absence. Though less likely to happen in smaller establishments, still over 4 in 5 of those employing between 10 and 19 employees measure sickness absence and three-quarters record the reason for sickness absence.

Establishments in Hospitality, Construction and Other Services are less likely than average (47%) to offer sick pay higher than SSP for some or all staff. There is a theory that this leads to less likelihood to take time off for sickness. This seems to be borne out in the Hospitality sector which reported high levels of presenteeism and financial reasons as a cause of presenteeism (Chapter 4) and below average levels of long-term and repeated sickness absence. However, Other Services was the sector most likely to report long-term and repeated sickness absence, so the connection is not entirely clear.

Four in ten of those reporting sickness absence reported that at least some of that was long-term (4 weeks or more – 41%) and a third (33%) reported repeated sickness absence. Both are more prevalent in larger firms, as one would expect with a greater number of employees. And whilst large establishments are more likely to report an impact of sickness absence, the percentage point gap between large and small establishments is much lower than the gap observed for rates of long term or repeated absence.

Having explored sickness absence, the report now moves into exploring what proportion of sickness absence is associated with mental health issues and what impact that might have on businesses in the Midlands.

CHAPTER 6: MENTAL HEALTH SICKNESS ABSENCE

6.1 Introduction

In this chapter, we report on evidence from both the qualitative and quantitative research on the extent of mental health sickness absence in the Midlands, what causes it and how businesses respond to mental health sickness absence. The chapter begins by exploring what employers understand by good mental health and poor mental health, to give context to the discussion.

6.2 Defining good mental health in the workplace

Both the survey and the qualitative research explored what mental health in the workplace looked like from an employer perspective.

When asked what they understood by 'good mental health and well-being in the workplace', three broad themes emerged from survey respondents: being happy, feeling supported, and feeling able to cope and to communicate with others.

Happiness was generally linked to the general environment in which employees should find themselves:

> *'Happy employees working to the best of their ability and not concerned about issues in work. Not overtired and not asked to do things beyond their capabilities.'*
>
> *'Where staff feel happy and comfortable in their working environment.'*
>
> *'… being content with what you are doing. If you have issues, certain stresses (deadlines, etc.), knowing that you know how to deal with it. Being able to communicate with each other and the senior members of the business. Not feeling cooped up and having flexible working.'*

Employer support was often seen as a key component of individual employee mental well-being:

> *'It is about recognising if staff are low and about having a chat, regular supervisions and making sure that they are supported.'*
>
> *'A supportive environment. A sensitive team that is supportive of individuals in that team. Also, protecting the confidentially and being proactive in pre-empt negative outcomes in people's mental health.'*

'Watching for stress levels. If we have any illnesses knowing what the reasons are and if it is work related due to the kind of work they are doing. It covers those things.'

Communication, both among employees and with line managers and others, was also often mentioned as an important factor for mental health and well-being:

'The ability for staff to communicate freely if they are struggling or have issues they would like to share.'

'Employers having an understanding of issues, how to support staff and where to send them for help. Also, having a company ethos around the issue and to make sure employees know they can speak up about their needs.'

'That staff can talk freely about their mental health without stigma attached to it. Managers and employers understand the implications of mental health and are able to support anybody that feels that they have got some mental health problems.'

In the qualitative research we explored these factors in more depth. Staff feeling **supported** by employers and feeling **comfortable** in a workplace with good morale and a friendly, supportive environment were again raised. For example:

'To me, it means people being the best that they can be at work, not feeling anxious. A bit of stress is all right, but actually knowing what they need to know. So, know what their job is, feel confident in what they're doing, knowing that they have support from their line manager, and where to go if they have any challenges or any concerns.'
Assistant Director – HR, Large firm, Other Services, East Midlands

'I think a good morale within the workplace and a nice, sort of close knit, friendly sort of workforce, obviously there's a balance to be had isn't there. But yeah, I think an open sort of forum if you like. […] with a good, high morale where everyone is pleased with what they're sort of doing…'
Works Manager, Medium sized firm, Advanced Manufacturer, East Midlands

Participants also acknowledged the importance of a holistic approach, which acknowledges that **physical health and issues from outside work may also have a bearing on workplace mental health**:

'… supporting people, understanding that mental health is as much of a … health and well-being as physical health.'
Head of Human Resources, Large firm, Hospice, West Midlands

'… it's not just the actual environment that you're working in, it's everything that affects that person, so it's whether they feel stressed with the job and that's sort of causing them issues, whether this happens outside of their work. I think you have to be aware of everything to be a good employer.'
Managing Director, Small, Property Development, West Midlands

There were also examples, in small firms, where employers had not given much thought to the matter, but broadly had the same understanding:

> *'It's, and honestly, probably not something we think that very much... but basically, means that they relax, to focus while working.'*
>
> Owner Manager, Small IT Firm, East Midlands

These responses reflect the linkages between good mental health and productivity highlighted in research reviewed in the Literature Review and discussed in Chapter 2.

6.3 Defining and identifying (screening) mental health problems

Our research has explored how employers define mental health problems in a variety of ways. In the pilot survey we conducted ahead of the main survey, we asked respondents their definition of mental health problems. The responses included a fairly wide range of conditions:

- ***'It varies enormously from stress to panic attacks.'***
- ***'When people can't function without the help of a doctor.'***
- ***'Depression.'***
- ***'Clinical depression, low mood, or senior serious psychiatric issues.'***
- ***'It is the mental well-being of a person.'***
- ***'Depression, anxiety, panic attacks, schizophrenia.'***
- ***'Dementia, depression, schizophrenia. Bipolar, alcohol abuse.'***
- ***'Most people have mental depression, autism, all sorts of things, anxiety, so many, very wide scope.'***

Thus, in the survey questionnaire, the interviewers gave examples of what was meant by mental health problems as 'bipolar disorder, depression, anxiety or stress'. Although there is some ambiguity in the classification of 'stress', this is in keeping with the definition used by the ONS in the Labour Force Survey and in keeping with responses to a question on how employers defined mental health problems in the pilot survey.

The qualitative research allowed us to explore this issue in greater depth with respondents. We explored how employers identified mental health problems ('screening' in our Mental Health and Productivity Logic Model).

A **change in behaviour** is a key indicator of mental health issues:

> *'I get to know them fairly well. So, when people's behaviours change or attitudes, you can tell...*'
>
> Health & Safety Officer, Medium sized firm Other Services, West Midlands

> *'… when people have suddenly start doing things which they don't normally do for example, or maybe it's the whole sort of you know, why are they quiet, they're not normally quiet, […] so it's about knowing people.'*
>
> HR Compensation & Benefits Adviser, Large firm, Logistics, West Midlands

> *'…my experience is dealing with people, makes me understand that actually there is usually an underlying reason for people's either poor performance or absent or low mood or lack of interest, motivation, engagement sort of thing.'*
>
> Head of HR, Large firm, Electrical Installation, East Midlands

Line managers are key to identifying mental health issues which people themselves may not even be aware of:

> *'And I think it's about the relationship the line manager has with that individual, which is absolutely key. And some of that happens really, really well and some of it, it just… and sometimes it's the employee maybe not even recognising themselves at that moment in time either.'*
>
> Assistant Director – HR, Large firm, Other Services, East Midlands

> *'I think responsibility wise; management team probably take on more as to the responsibility of it because it's our job to ensure that our departments, our teams are okay.'*
>
> Practice Administrator, Medium, Veterinary Practice, West Midlands

When team members **work remotely, observing behaviour changes can be more of a challenge**:

> *'It's about making sure that most have check-in, so you haven't got the visual clues that you have when you've got people in the office, so it's having even more regular check-ins, mostly if someone's not responding to an email or noticing it, just like those little kind of tweaks that you might not necessarily be aware of you in the office. But if you're remote, you've got to be much more attuned to how somebody is.'*
>
> Assistant Director – HR, Large firm, Other Services, East Midlands

How do employers define mental health problems? The case of a small IT firm

Some definitions provided by employers in our research may not generally be considered mental health problems, but the research is intended to explore this issue from the perspective of the employer. The research identified an example of how people with conditions which are not associated with mental ill health might **present similar management issues** as people with mental health problems.

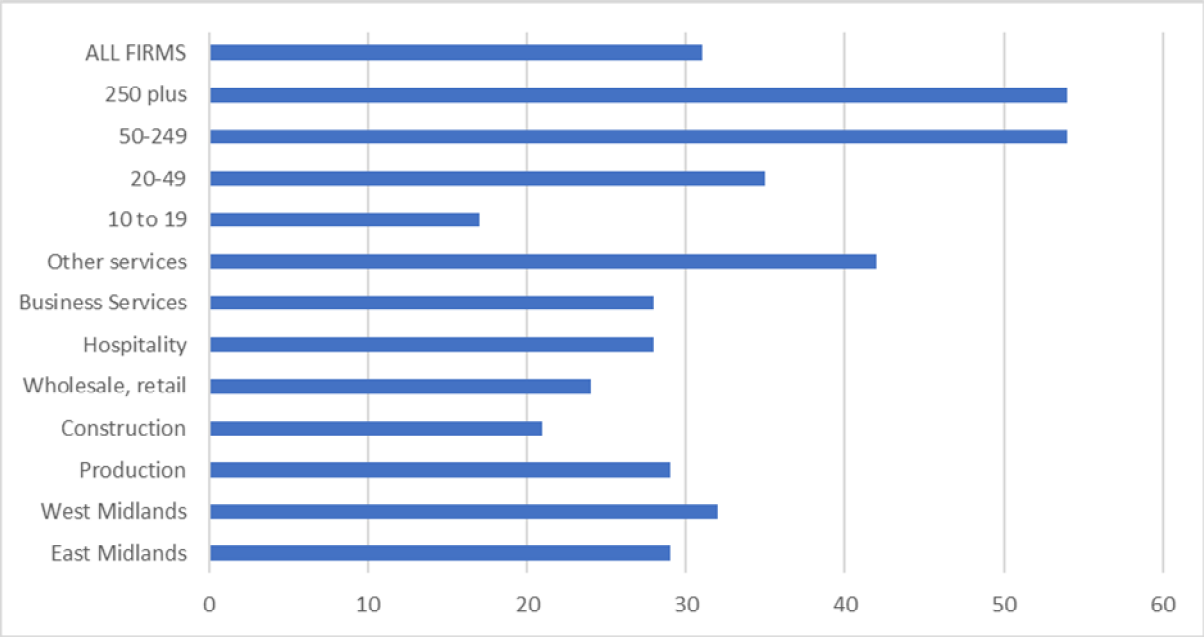
In the IT sector, one employer discussed a member of staff who was '*high-functioning Asperger's'*, and who self-identified as '*neuro-diverse*'. The employer reported there is a high prevalence of people with these kinds of conditions in the IT industry, working as programmers able to '*look for patterns*'. The employer reported that when there was a suspicion of a hack this employee '*just loved the prospect of having to pour through and you know pages and pages and pages of code looking for something that didn't fit'*. This person could do work others couldn't do.

Whilst the employer recognised this was not a mental illness, the employee did present issues in the workplace which the employer reported as being akin to mental health issues in terms of which tasks could be allocated to him and how he worked with the wider team. Whilst the employer responded by only allocating relevant work to the employee and sought advice from a specialist website on supporting teamworking, this was not recognised as necessary or valid by the employee. The employer recognised the huge value and input of this employee and sought to work around their condition.

6.4 Prevalence of mental health sickness absence in the Midlands

Three in ten (30%) establishments reported that some staff had been off for reasons of mental health problems. Figure 6.1 shows that the proportion of firms with staff off sick in the last 12 months for mental health problems varied little by region, with wider variation by sector and size. For example, 21% of firms in the Construction sector with sickness absence in the previous 12 months reported that some of that was due to mental health problems, compared to 42% in the Other Services sector. Larger firms were more likely to report mental health sickness absence, with 54% of those reporting sickness absence in the two largest size-bands saying some of this was for reasons of mental ill-health compared to 17% in the smallest firms.

Figure 6.1: Proportion of firms with sickness absence reporting mental health problems



Base: 1845 – all establishments except those which reported no sickness absence (from D3)
Note: Responses are weighted to provide representative results for each region.

What factors are linked to mental health sickness absence?

As with long-term sickness absence, we conducted **regression analysis** on the reporting of mental health sickness absence (see Figure 7.2). We found that establishments more likely to report mental health sickness absence are:

- Larger
- In multi-site organisations
- Employing more people with long-term disabilities
- Those which use data to monitor sickness absence (Figure 7.4)
- Those which had introduced new technologies (figure 7.4).

Establishments less likely to report mental health sickness absence in the regression analysis employ a larger share of older workers (figure 7.2), and are firms where employees have control over their work (figure 7.4), but both of these associations are relatively weakly significant.

Again, it is important to note that the regression analysis demonstrates a correlation but it does not allow us to infer causality.

The regression analysis, described in the box above, highlighted that **the introduction of new technologies** is associated with mental health sickness absence. The survey is able to shed further light on this. Survey respondents who had introduced new technologies recently were asked whether their introduction had had any notable effect, positive or negative, on staff health and well-being. Of those firms that reported an effect (495 firms) 86% were positive. These positive effects were characterised as improving work by making it easier or more efficient (42%), reducing stress (15%), reducing workload or improving well-being or work/life balance (12%), improving staff communications, comfort or safety (11%), and improving staff morale or job satisfaction (10%). For example:

> *'The staff liked that this new technology gave them more visibility/sight into what was in the pipeline for the business.'*
>
> *'It has had a positive impact that resulted in better communication. It ensured work was being done in an informed manner and the team members feel valued.'*
>
> *'… it's streamlined the work they're doing so it's less repetitive and less stressful for them.'*
>
> *'We have recently had self-scanning installed in our branch so this has reduced staff going off sick with bad backs as it has reduced manual handling. Staff are much happier. It has had a positive impact. The new technology has been a new operating system and software. It generally gives more efficiency from a business point of view, but also an individual working point of view.'*

In the qualitative research, where new technology had been introduced, this was usually positive. However, in one case, this posed more challenges where there were older workers:

> *'As people get older and expect to be given more responsibility and put in positions where they have that responsibility, they don't necessarily always have a greater ability to deal with it, and that's something, a problem that we've encountered… particularly in our industry because we're extremely technologically based and technology moves on very quickly and processes move on, and awareness and knowledge of that needs to grow and I don't think it necessarily does…We have our own developers as part of the project team and every week, every month, there is something new, and that might well impact on people's day to day working practices. If you've been doing something in a particular way for 20 years that can be a difficult situation.'*
>
> Owner Manager, Small, IT, East Midlands

For most firms reporting mental health sickness absence, it accounted for the minority of their sickness absence overall, at 17% of total sickness absence (Figure 6.2). There is little variation by region.

Figure 6.2 Proportion of sickness absence accounted for by mental health problems

Base: 378 firms reporting mental health sickness absence in the last 12 months who could provide a response
Note: Responses are weighted to provide representative results for each region.

6.5 Long-term and repeated mental health sickness absence

Around four in ten (44%) establishments reporting mental health sickness absence said that none of this lasted for 4 weeks or more and a similar proportion (37%) reported that at least some mental health sickness absence was long-term. A fifth (18%) of respondents did not know, as shown in Figure 6.3. The table shows that smaller firms and those in the Hospitality sector are less likely to report long term mental health sickness absence, whilst those in West Midlands, larger firms, Wholesale and Retail and Business Services are more likely to report long-term mental health sickness absence.

Figure 6.3 Proportion of firms reporting long-term sickness absence

	None	Some	Don't know
All firms	44	37	18
East Midlands	44	35	21
West Midlands	44	39	17
Production	42	38	20
Construction	*na*	*na*	*na*
Wholesale, retail	40	40	20
Hospitality	56	33	11
Business Services	39	40	21
Other Services	46	37	18
10 – 19	59	28	13
20-49	46	40	15
50-249	34	42	24
250+	*na*	*na*	*na*

Base: 566 firms reporting mental health sickness absence in last 12 months
Notes: i) Responses are weighted to provide representative results for each region.

ii) Responses for Construction sector and for establishments employing 250+ are not presented because the base size is too low.

Figure 6.4 shows that two in five firms reporting mental health sickness absence in the last 12 months reported staff taking **repeated** absence (39%). Firms in the East Midlands are more likely to report incidences of repeated mental health sickness absence (41% compared to 37% in the West Midlands), in contrast to the pattern for long-term mental health sickness absence reported above. There were also differences by sector and size. The sector reporting the lowest proportion of repeated mental health sickness absence is Production (27%) while Business Services shows the highest proportion (49%). There was less variation by size for this measure.

Figure 6.4: Incidence of repeated mental health sickness absence

	%
ALL Firms	39
East Midlands	41
West Midlands	37
Production	27
Construction	*na*
Wholesale, retail	37
Hospitality	46
Business Services	49
Other Services	38
10-19	38
20-49	39
49-250	38
250+	*na*

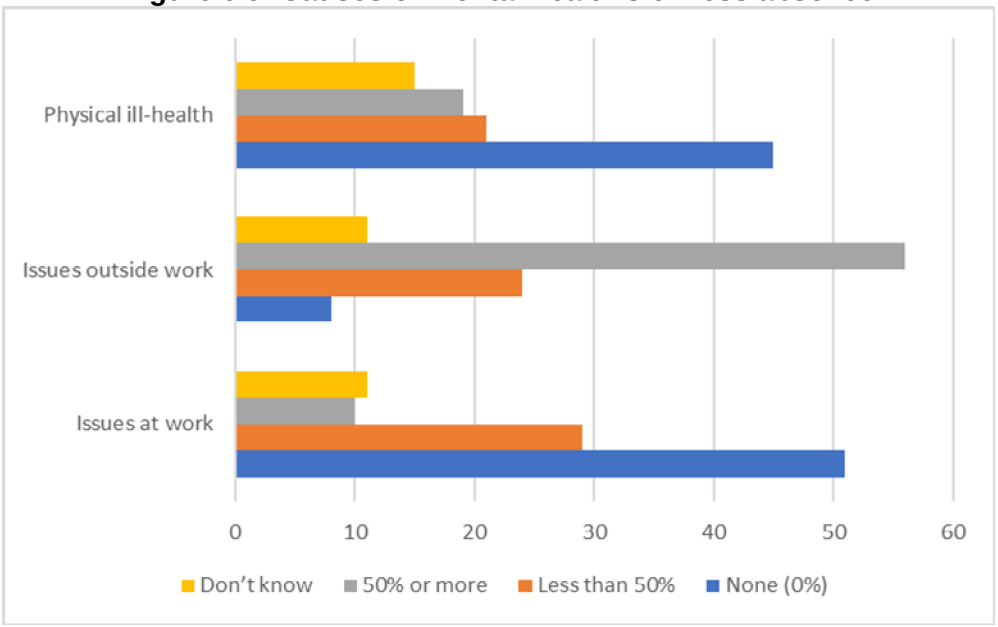
Base: 566 firms reporting mental health sickness absence in the last 12 months

Notes: i) Responses are weighted to provide representative results for each region.
ii) Responses for Construction sector and for establishments employing 250+ are not presented because the base size is too low.

6.6 Causes of mental health sickness absence: quantitative evidence

The survey explored what employers perceived to be the causes of mental health absence, by asking what proportion of mental health sickness absence they believed was caused by issues at work; issues outside work or by physical health problems. As the following Figures show, firms were more likely to cite **problems outside work** as the cause of mental health sickness absence (Figure 6.5), with 56% of firms stating that half or more of the mental health sickness absence in their firms was attributable to external factors. 10% reported that half or more of the mental health sickness absence in their firms were due to **issues in work** and 19% to **physical illness**.

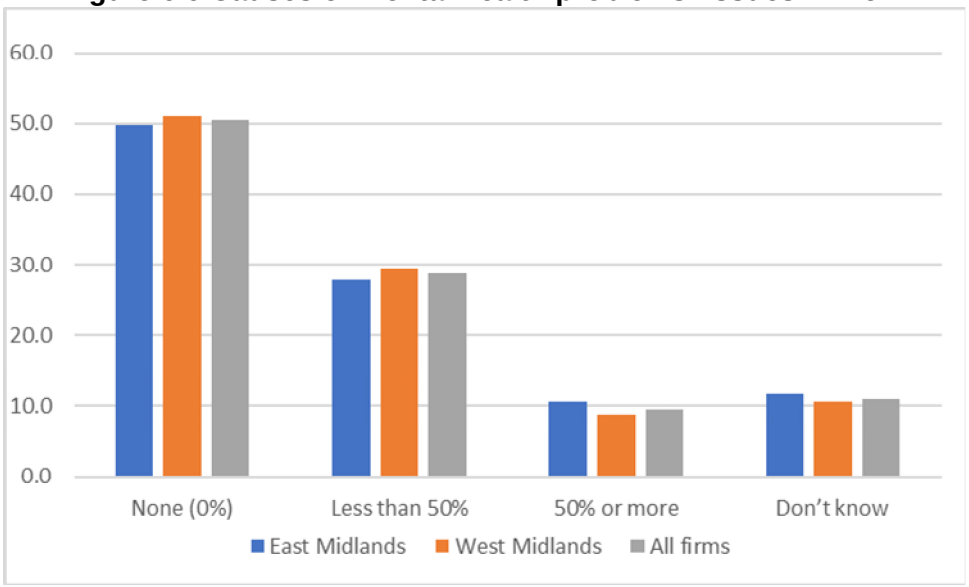
Figure 6.5: Causes of mental health sickness absence



Base: 566 firms reporting mental health sickness absence in the last 12 months
Note: Responses are weighted to provide representative results for each region.

Figures 6.6 to 6.8 also show that the patterns are similar by region, however firms in the East Midlands are slightly more likely to report that they don't know the reasons for sickness absence, as shown in in all three Figures. This may be because these firms are less likely to monitor sickness absence (Figure 5.2).

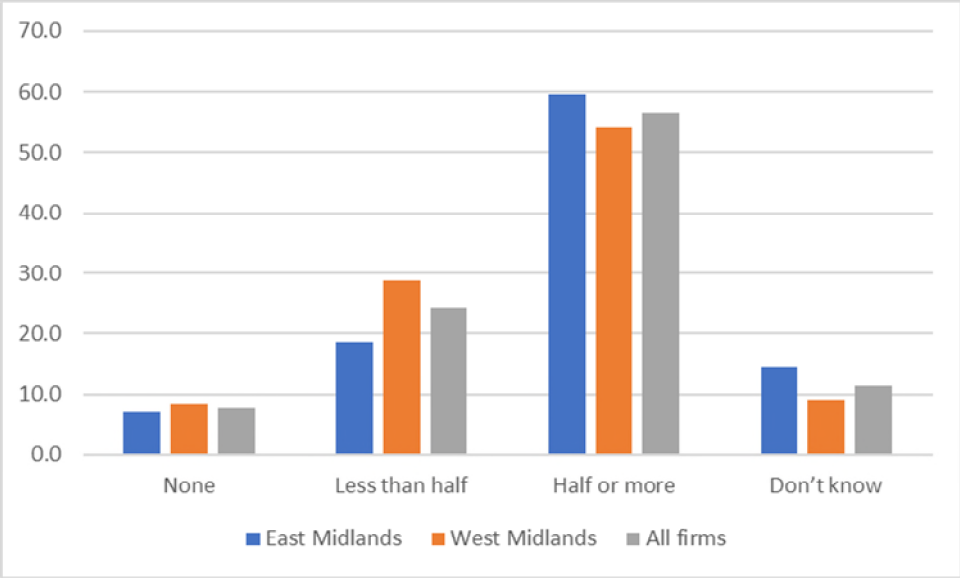
Figure 6.6 Causes of mental health problems: issues in work



Base: 566 firms reporting mental health sickness absence in the last 12 months
Note: Responses are weighted to provide representative results for each region.

Firms in the East Midlands are more likely to cite issues outside of work, with 59% of those reporting some mental health sickness absence saying that issues outside work accounted for at least half of all mental health sickness absence compared to 54% in the West Midlands (Figure 6.7).

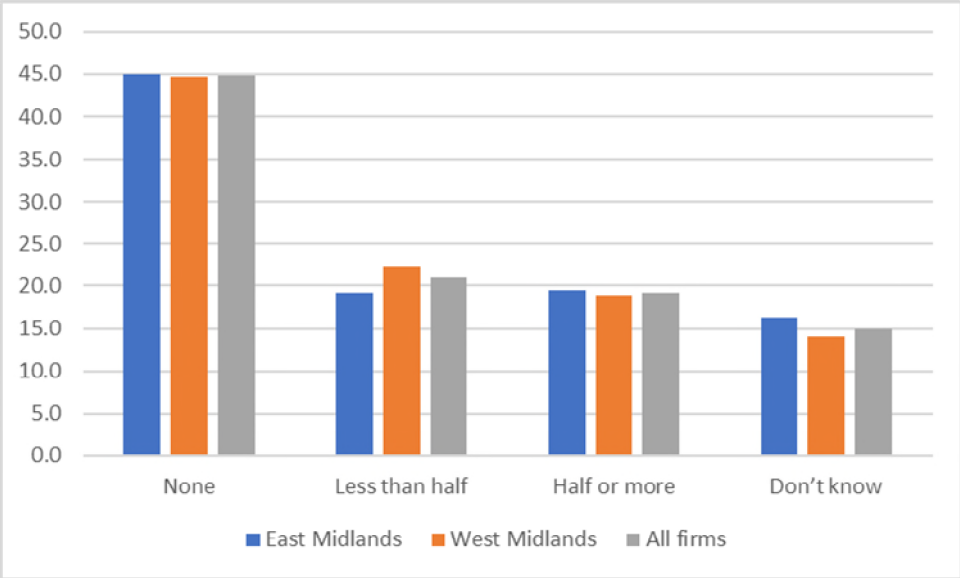
Figure 6.7 Causes of mental health problems: issues outside work



Base: 566 firms reporting mental health sickness absence in the last 12 months
Note: Responses are weighted to provide representative results for each region.

Firms in the East Midlands are again more likely to report 'don't know' when asked what proportion of mental health sickness absence might be attributed to physical health issues as shown in Figure 6.8. Across both regions, 45% report that no mental health sickness absence is attributable to physical health issues. This may be surprising given the reported levels of co-morbidity reported in the literature review in Chapter 2, but this is the employer perspective and they may not have complete information.

Figure 6.8 Causes of mental health problems: physical health



Base: 566 firms reporting mental health sickness absence in the last 12 months
Note: Responses are weighted to provide representative results for each region.

6.7 Causes of mental health sickness absence: qualitative evidence

Although in the in-depth interviews employers did not report the workplace as a key factor in causing mental health issues, the qualitative research was able to explore in more depth the factors which caused or could cause mental health problems in the workplace. Employers in the qualitative research raised a range of factors including **recruitment practices, lone working, job insecurity, client pressure and broader societal factors**.

Earlier in the chapter we reported on the case of an IT firm which reported a high prevalence of people working in the sector on the autism spectrum, and having skills particularly valued within the industry. In terms of **recruitment**, another participant in the qualitative research, working in the logistics sector, explained how they recruited a lot of ex-army personnel, for similar reasons, as they were felt more likely to have the skills needed:

> *'A lot of HGV drivers that we get have been in places like Afghanistan. And typically, in the army, you know, they teach you to drive heavy good vehicles in the army and that when they leave the army, it's quite a natural thing for them to come into the transport industry, because that's a lot of what they've done. So, they come into transport industry and they come in with quite a lot of problems such as Post-Traumatic Stress Disorder.*
>
> Health and Safety Officer, Large Transport firm. East Midlands

Lone-working, remote working, being 'on the road' were factors associated with mental health problems by the interviewees.

> *'Problems with mental health are profound... across the industry. As well as things like alcoholism and drug use which you wouldn't expect… It is a sort of problem that people don't really talk about but it is there which obviously increases people's mental health issues. Being away a lot, staying in hotels and stuff, the sort of temptation to mask that with drinking is huge…'*

> *'Whether it's true or not, we do find that if you work remotely it can sometimes be a bit of a lonely role.'*
> Head of Data & MIS, Training provider, Medium size firm, Construction, East Midlands

> *'We've got another team of care employees who work out in the community. So that's really important for us … that we're hot off the press in regards to spotting signs there, especially in their work life. We've got a couple of people who only work nights so they have very little sometimes to do with their colleagues and their manager.'*
> Head of HR, Large Hospice organisation, West Midlands

Insecure contracts are also cited as another reason:

> *'Until quite recently, there were only ever three-month contracts. So, you do three months and then you have to move somewhere else or go to a different company or go to a different part of the country. You're never kind of in a secure environment…..*

> *…..one of the things that was sort of flagged up as a mental health issue that...if you don't have a permanent job... you can't get a house….you can't get…. Credit...it affects so much of people's lives.'*
> Office Manager, Medium, Construction, East Midlands

This company had recently introduced permanent contracts, which we pick up later in the Chapter.

Another firm cited the pressures of **client expectation** which have increased in recent years and which may lead to more pressure on staff generally:

> *'Your clients can cause a lot of stress, as well. Especially when they haven't been able to confirm a diagnosis or, you know, it's not a good outcome. There's nothing we can do … So some people, you know, cope really well and others are just crumble if a client starts shouting at them.'*
> Practice Manager, Medium-sized Veterinary Practice, West Midlands

> *'Then there are mental health issues in terms of pressure that we may or may not put on our employees and what our expectations of people are and how... do we cause mental health issues with anxiety and stress and things like that?'*
> HR Manager, Large manufacturing firm, West Midlands

Some participants looked beyond immediate factors. One suggested that the **general environment** is also more stressful for people these days:

> *'But in my opinion, we're living in a far more troubled world, and I think that's reflecting in what I'm saying in the company.'*
>
> Health and Safety Officer, Large Transport, East Midlands

Finally, the **complexity of the cause** of mental health problems was also acknowledged:

> *'And from our experience, it's not necessarily just work, it's… well it never is just work, it's usually life and work. I believe you've got that one stress bucket and everything goes in there, and it's just, what is the thing that overflows it? So, it could be everything.'*
>
> Assistant HR Director, Large Services, East Midlands

6.8 Responses to mental health sickness absence

In exploring how businesses respond to mental health sickness absence, the survey asked businesses how effectively they managed mental health sickness absence. The majority of firms in the survey report that mental health sickness absence is managed very or fairly effectively in their firm (88%, Figure 6.9). Firms in hospitality are less likely to report that they manage it well compared to other sectors, but generally the main difference shown in the table by sector and size is the variation between reporting very or fairly effective management. For example, smaller firms are more likely to report that their management of mental health sickness absence is *very* effectively managed; establishments in the Production sector are more likely to say that their management of mental health sickness absence is *fairly* effectively managed.

Figure 6.9 Effectiveness of management of mental health sickness absence

	Very effectively	Fairly effectively	Neither	Fairly ineffectively	Very ineffectively
All firms	40	48	5	4	2
East Midlands	40	47	5	4	5
West Midlands	41	49	5	3	1
Production	33	55	7	3	1
Construction	*na*	*na*	*Na*	*na*	*na*
Wholesale, retail	39	48	8	3	2
Hospitality	37	42	11	6	2
Business Services	43	48	2	4	2
Other Services	43	48	2	3	3
10 – 19	48	39	4	2	3
20-49	38	52	5	4	2
50-249	37	52	5	3	3
250+	*na*	*na*	*Na*	*na*	*na*

Base: 566 firms reporting mental health sickness absence in last 12 months

Notes: i) Responses are weighted to provide representative results for each region.
ii) Responses for Construction sector and for establishments employing 250+ are not presented because the base size is too low.

The qualitative research gathered further data on employer's reactive approaches to mental health issues in the workplace.

One participant noted that it was important to be aware that **people's ability to do their jobs may naturally vary over time**, depending upon their circumstances and experiences:

> *'But that you have to be mindful that people are people, and that actually being aware of people maybe not being as efficient or effective at a certain point, doesn't make them any less. I think that for me is the very is the really key and important thing.'*
>
> Health & Safety Officer, Business Services, Medium size organisation, West Midlands

Many seem to work around mental health absences and **re-configure work** to share the load, or to allocate tasks appropriate to the skills and abilities of the individual, as seen in the IT example earlier in the Chapter. In one case, reallocation occurred in order to prevent an employee going off sick and some measures were put in place:

'…they have a case load of learners, so some learners were taken from them and given to other trainers, so they had less people that they were physically having to see.'
Head of Data & MIS, Training provider, Medium sized organisation, East Midlands

'If somebody's run down, where they're struggling with stress whether it's work-related and personal, when somebody's been off for a long period of time, we'd look at what we might do to support them coming back. And sometimes that's about changing their hours of work, sometimes it's about changing their levels of responsibility. '
Head of HR, Large Hospice organisation, West Midlands

There was also evidence of **job redeployment**:

[The employee said…] ..'I don't want to be an engineer, I don't want to be outside, I don't want to be driving round the country, I don't want to work on my own …', so why don't we move him, start another probationary period in an office based role and that seems to be working for us now, and for him.'

Head of HR, Large, Electrical Installation, East Midlands

'So whether that plan is that during, you know, in that instance, the plan is that during school holidays, you know, they maybe work reduced hours […] and that helps them for the next two years to get to a…a state with family life that they're feeling in control of it, so that when they come in to work, they're not just worrying, things like that.'
Managing Director, Digital Agency, West Midlands

Line manager training to give them confidence to have, what can be, difficult conversations

'I think sometimes people are worried about saying the wrong thing or knowing what they can say and being… you know, am I prying too much into your personal life? Those kinds of things. So, it's just kind of going… giving… make sure line managers, who feel less confident, know about how to have those conversations.'

'And not being afraid of having those challenging conversations because there are some difficult conversations to have and if the person gets angry, the person gets upset, that's fine, but let's listen to what they're saying. Because you're all doing it from a position of concern, that support. And it's just trying to find the right ways of doing things.'
Assistant Director – HR, Large, Other Services, East Midlands

'…it is relying down to our managers and our team leaders to talk to employees, […] have you asked them why it is, is there anything at home, is there anything at work, is that getting the- we know as a HR department know what should be getting our managers and our team leaders to have those conversations and it's saying it's okay to have those conversation.'
HR Adviser, Large Logistics firm, West Midlands

One firm **offered permanent contracts** to everyone, recognising the difficulties and insecurities temporary contracts can have. This is very unusual in the particular sector given

the variable and seasonal nature of the work, but as this was seen to cause difficulty for their employees, it was the approach they took.

Another firm admitted these issues are **not dealt with in a timely fashion**, but because of the pressure of delivering in a time pressured industry. Line managers might call on the support of a central specialist team, but sometimes this is after a problem has developed, rather than being called to deal with an issue before it becomes a problem:

> *'I don't think, from my company perspective, I don't think [that] was managed that particularly well. Our transport teams are under a lot of pressure, and people often forget this, you know, the thing… well, you want to helping this guy, you want to be doing this, you want to be doing that, but the fact is [the managers] are also under a lot of pressure. Transport industry, in our case, is very time-specific and it can be very frustrating; the traffic, the weather, and they don't have a lot of time to deal with drivers' problems directly.'*

Additionally, this participant reported difficulties associated with the **value of some types of work and some types of worker**:

> *'The nature of the industry is it makes investment, and I know they should invest in people, it makes investment in anything quite difficult because, you know, there's not—it's a very competitive area. But I think, fundamentally, I think that's where the change should take place. I think HGV drivers should be seen far more as a — the job should be far greater recognised. And once the job's better recognised, rates and pay go up, then companies have the ability to invest more and think more often. And I don't think people think more much of HGV drivers but they have a very, very difficult tasks to do. And I think that's—that's for me where we should deal with it, you know, recognising HGV drivers on what they do. I mean, HGV drivers typically get paid £10, £11 an hour to drive a 44-ton vehicle, you know, on a motorway at a 56-miles an hour. There's a huge amount of legislation they have to be aware of, like these driver's hours and they paid £11 an hour. Whenever you got that, both the HGV driver doesn't feel particularly that it is well thought of and companies don't have sufficient funding to invest in them, and that's the core problem.*
>
> *And in fact, the pressures on the drivers are getting considerably greater. You know, they've introduced now considerable fines at the side of the road for driver operating outside the working time directive and driver's hours, and those fines are presented directly to the driver, so there's all—a lot of more pressure on the drivers, there's no doubt about that. And I don't see my industry dealing with mental health problems particularly well.'*
>
> Health and Safety Officer, Large, Transport, East Midlands

The qualitative evidence suggests a very wide range of activities are employed to address or prevent mental ill health in the workplace and that employers are responsive to employee needs, based on the personal circumstances of the individual, how that can be accommodated

in the workplace and the willingness of owners and managers (and society more broadly) to invest in the health and well-being of their workers.

6.9 Summary

One in three establishments in our survey reported mental health sickness absence. This is more prevalent in the West Midlands, in Other Services and in larger firms. Long-term mental health sickness absence is also more common in these firms, along with Wholesale and retail. However, patterns for repeated sickness absence are slightly different. While there is no difference by size, it is more common in the East Midlands, and in the Business Services sector.

Regression analysis shows that larger establishments, those in multi-site organisations, those which employ more people with disabilities, those which use data to monitor sickness absence and those which had introduced new technologies are all more likely to report mental health sickness absence, although this doesn't infer causation. Sector does not emerge as an explanatory factor. With regard to technology, the research suggests that the impact of new technologies is largely positive on mental health, with 86% of survey respondents reporting a positive impact by, for example, making work easier and resolving issues and problems staff had had.

In terms of causes, employers are most likely to report factors outside of work (illustrated in the qualitative research as being associated with pre-existing conditions, such as PTSD, or having a 'difficult life'). The qualitative research, however, also highlighted issues in work which can cause mental health problems relating to the nature of the job role (e.g. remote or lone-working), client expectations, work-life balance, working conditions and the levels of reward and recognition afforded to part of the economy and the workers therein. Identifying mental health problems is also more problematic when people are remote working, as employers pick up on changes in behaviour to identify potential problems and to start to address them.

The employers interviewed appeared to give careful consideration to how they address mental health problems in the workplace as they arise, based on the needs of the individual and the operation of the business. Some employers had invested considerably in this, with one example of a firm introducing permanent contracts, but other examples were observed where investment was less likely.

Overall, the importance of client expectations, in terms of increasing expectations of quality of service, reductions in cost or speed of delivery, seem to be placing a burden on businesses and on at least some of their employees, as highlighted in the discussion on presenteeism.

CHAPTER 7: THE IMPACT OF MENTAL HEALTH SICKNESS ABSENCE

7.1 Introduction

In this chapter, we present data on the vital question of the impact of mental health sickness absence on firm performance, drawing on the quantitative and qualitative research – how and why does mental health sickness absence impact on firm performance? We first explore the proportion of firms reporting an impact on performance of sickness absence and identify what the impacts are. We elaborate on this with recourse to evidence from the qualitative research which allows us to consider the issue in more depth.

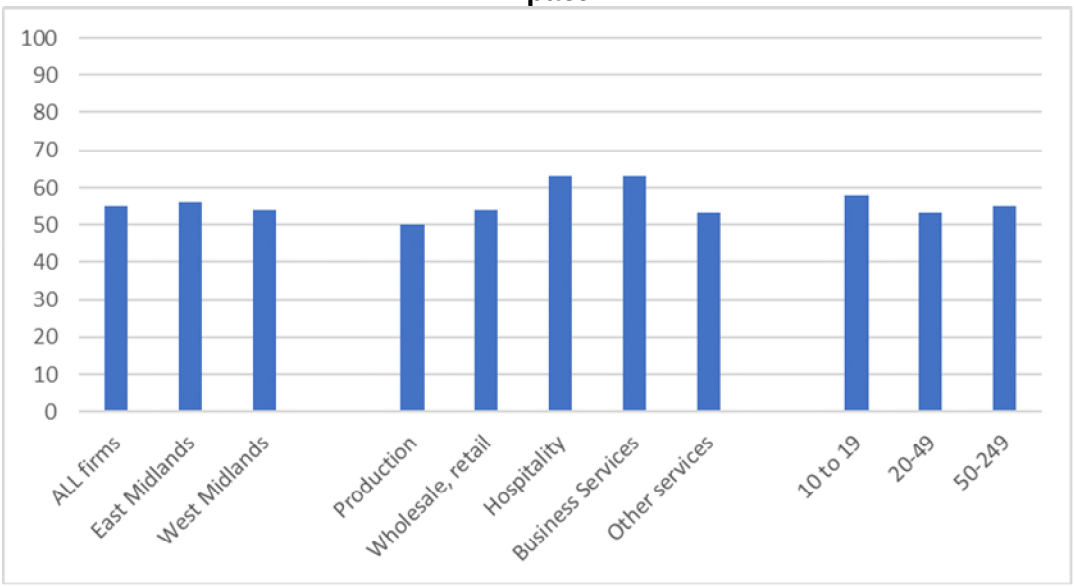
This is followed by multivariate analysis of the survey data. This focuses on two questions. First, how are indicators of sickness and poor mental health linked to productivity? And, second, what factors are associated with firms' experience of sickness absence and poor mental health. For example, how is the introduction of new technologies or high-performance work practices related to mental health issues. Note that in each case, as our analysis is based on cross-sectional data, it measures *associations* rather than *causal linkages*.

7.2 Impacts of mental health sickness absence: survey evidence

Just over a half (55%) of firms which reported some mental health sickness absence reported there was an impact (Figure 7.1). Firms in the East Midlands are slightly more likely to report an impact compared to the West Midlands. In terms of sector there was wider variation, ranging from 50% in the Production sector to 63% in Hospitality and Business Services.

The range was less by size, but the proportion of employers reporting an impact increased with size ranging from 53% of those employing 20 to 49 employees up to 58% of those employing between 10 and 19 employees.

Figure 7.1: Proportion of firms with mental health sickness absence reporting an impact



Base: 566 firms reporting mental health sickness absence in last 12 months

Notes: i) Responses are weighted to provide representative results for each region.
ii) Responses for Construction sector and for establishments employing 250+ are not presented because the base size is too low.

We asked survey respondents that reported an impact what sorts of impacts they felt that mental health absence had had on their organisations in an open question. Of the 308 responses, 25% said it had resulted in more work for others; 19% that they had had to recruit or find cover; 14% reported reduced efficiency or productivity and 12% reported reduced quality or service offer. This is illustrated in the following quotes:

> *'Colleagues having to pick up individuals work, and this impacts on their health and well-being.'*
>
> *'It leaves us short staffed and other members of staff have to pick up that member's work and morale takes a bit of a hit.'*
>
> *'Pressure on other employees is the main issue.'*

The **cost of filling in for absent staff**, as well as the **difficulty of finding appropriate cover** is also often cited:

> *'We have to find cover for [the] role and then pay them for that work (in addition to the sick pay that those who are sick need).'*
>
> *'When they don't turn up it causes economic issues, like the cost of replacement*.'

Reduced efficiency is also a commonly cited effect of mental health absence, and the knock-on effect on sales and service levels is often a cause for concern:

'It reduces productivity. We measure turnover per employee, which takes a hit when someone is off sick for any reason.'

'When she can't come in, then she cannot do her work and we cannot provide the service. We only had one lady employed in this position, she would provide activities for the service. It had an impact on our customer service...'

'Down time in productivity which has an impact on turnover, and of course the additional pressure of other employees.'

7.3 Impact of mental health sickness absence: qualitative evidence

In the qualitative research, the same three themes of reduced efficiency, additional costs and impact on other staff emerged.

Participants talk of the impact that mental health issues can have on **business performance, productivity and efficiency in general terms**:

'[Performance] dropped off, definitely […] if someone is…I don't know…not able to complete as much work as before or is…or is out of the office. You know is not coming into work at all, then yes, that very does…that very much does sort of increase the workload on the other people.'

Marketing Director, Small, manufacturer, West Midlands

'So as far as productivity and efficiency is concerned, it certainly suffered. So, in that respect, yeah, it definitely affected the business.'

Works Manager, Medium, Advanced Manufacturer, East Midlands

'I think we would say efficiency declined because they were working at less than optimum occasionally. ….[we're a small firm]..– don't employ anybody to sit and do nothing, so others have to take over.'

(Owner manager, Small, Information and Communication, East Midlands)

They emphasise the **effects it can have on other members of the team,** in terms of providing cover (especially for specialist roles) and working alongside someone struggling with mental health issues.

'That puts a massive amount of pressure on because we haven't really got any flexibility within our staff.'

Practice Administrator, Medium, Veterinary Practice, West Midlands

'… actually it was like, walking on eggshells at times and that put a real pressure on the team, so from a team perspective as well, that put extra pressure on us, so it's- and it's hard when you can see someone who is clearly starting to struggle that they bury themselves in their work because they think that's what's helping them.'

HR Compensation & Benefits Adviser, Large, Logistics, West Midlands

The **frustration of colleagues** was often reported and employers did not know how to respond to this, being careful not to breach privacy, but finding some colleagues unsympathetic.

> *'But definitely frustration, because I think, you know…you know, if you get to another week where the person has been sick, you know, workloads have to be rearranged and it just causes a frustration really, doesn't it?'*
>
> Head of HR, Large, Electrical Installation, East Midlands

> *'And that we had one driver –I had a word with a few of the other drivers –and they called him "suicide Dave" and that's because he actually had a problem on one occasion and try to take his own life. Not here, but at home. So, HGV drivers, in general, are not very sympathetic to other people with mental health problems.'*
>
> Health and Safety Officer, Large Transport firm. East Midlands

As the survey reports, almost half of firms reported **no impact** of mental health sickness absence. This is illustrated in the qualitative research where some businesses seem to accept the need to work around mental health sickness absence and a reluctance to report a business impact. In one firm, a charity there was a more positive reaction from colleagues:

> *'I would say here people …just want to be very supportive.'*
>
> Assistant Director – HR, Large, Other Services, East Midlands

The qualitative research also found **little evidence of formal recording of the business impact** of mental health sickness absence. For example:

> *'…there's a heavy reliance on me, rather than policies or systems in place, so, we don't—and to be honest with you - we wouldn't really flag that side of it. We'd accept that that's potentially cost us money, that wouldn't fall that much part of the process. So, we wouldn't really record that.'*
>
> Health and Safety Officer, Large, Transport, East Midlands

7.4 Multivariate analysis of productivity, long-term sickness absence and mental health sickness absence

In this section we report a multivariate analysis of the factors which are linked to establishments' productivity and experience of long-term sickness absence, mental health sickness absence and their reporting of whether there is an effect on performance (Figure 7.1). Whilst findings of the multivariate analyses on long-term sickness absence and on mental health sickness absence have been referenced in earlier sections of the report, this section provides fuller details.

This analysis is useful as it enables us to identify which factors are most important and which are most strongly related to firms' experience of mental health issues etc. We consider two questions. First, in Section 7.4.1 we consider whether in our survey data there is a significant association between firms' experience of sickness absence and mental health sickness absence and productivity. A significant association here would indicate the importance of sickness and mental health absence for productivity. Second, in Section 7.4.2, we consider which firm characteristics are linked to sickness absence, mental health sickness absence and their effect on performance and we consider four other hypotheses. These are:

> Hypothesis 1: Firms using zero hours contracts and/or temporary contracts are *more likely* to experience sickness absence, mental health and performance issues.
>
> Hypothesis 2: Firms employing high performance work practices are *less likely* to experience sickness absence, mental health and performance issues.
>
> Hypothesis 3: Firms introducing new technologies are *more likely* to experience sickness absence, mental health and performance issues.
>
> Hypothesis 4: Firms taking specific steps towards good mental health will be *less likely* to experience sickness absence, mental health and performance issues.

Note, however, that as our data is cross-sectional – captured at one point in time – our results cannot be interpreted as causal relationships, but simply as correlations or associations. Nonetheless the analysis does highlight which firm characteristics are most strongly linked to mental health issues and its consequences.

7.4.1 Modelling the links between sickness and mental health absence and productivity

Simple regression models (OLS) relating log turnover per employee to a range of firm characteristics, sickness and mental health indicators are reported in Figure 7.2. Each model includes one of the sickness and mental health indicators to avoid issues related to potential multi-collinearity. In each case the sickness and mental health indicators have a significant and negative association with productivity controlling for a range of other firm characteristics. The implied scale of the effects (at mean productivity for the sample) is substantial:

- experiencing long-term sickness is associated with productivity which is lower by 27.2 per cent;

- sickness related to mental health is associated with productivity which is lower by 18.3 per cent;
- and, firms reporting a situation in which mental health impacted their performance was associated with productivity which is lower by 24.5 per cent.

Estimating variants of these models suggest consistent negative – although not always significant – associations between productivity, sickness and mental health.

Figure 7.2: Factors linked to the productivity (log turnover per employee)

	Log turnover per employee	Log turnover per employee	Log turnover per employee
Long-term staff sickness	-0.315***		
	(0.121)		
Sickness related to mental health		-0.203*	
		(0.123)	
Mental health issues affect performance			-0.281*
			(0.147)
Graduate share (%)	0.000	0.000	0.000
	(0.002)	(0.002)	(0.002)
Workforce aged 25-49 (%)	0.001	0.002	0.002
	(0.004)	(0.004)	(0.004)
50-plus years (%)	-0.005	-0.004	-0.004
	(0.004)	(0.004)	(0.004)
Multi-plant firm (0/1)	0.541***	0.526***	0.515***
	(0.118)	(0.122)	(0.122)
Regional market priority (0/1)	-0.067	-0.086	-0.08
	(0.135)	(0.139)	(0.139)
Ethnic share (%)	0.000	0.001	0.001
	(0.003)	(0.003)	(0.003)
Female share (%)	0.007***	0.008***	0.008***
	(0.003)	(0.003)	(0.003)
Disabled share (%)	-0.005	-0.005	-0.005
	(0.012)	(0.013)	(0.013)
Family owned (%)	-0.066	-0.005	-0.01
	(0.119)	(0.122)	(0.123)
Construction	0.299	0.413*	0.410*
	(0.234)	(0.242)	(0.241)
Wholesale, retail	0.139	0.144	0.151
	(0.159)	(0.162)	(0.162)
Hospitality	-0.002	0.036	0.046
	(0.274)	(0.283)	(0.283)
Business Services	0.117	0.143	0.154
	(0.165)	(0.170)	(0.170)
Other services	1.038***	0.996***	1.000***
	(0.240)	(0.244)	(0.244)
20-49 employees	0.082	0.029	0.014
	(0.125)	(0.129)	(0.129)
50-249 employees	-0.512***	-0.552***	-0.561***
	(0.140)	(0.145)	(0.143)
250 plus employees	-1.452***	-1.410***	-1.284***
	(0.230)	(0.240)	(0.253)
Number of observations	1226	1177	1172
BIC	5020.373	4832.868	4815.527

Note: Reference categories are the production sector (including manufacturing) and small firms with 10-19 employees. Observations are weighted to give representative results. Models exclude 5 per cent of firms at each extreme of the productivity distribution. * denotes significant at 10 per cent; ** at 5 per cent and *** at 1 per cent.

7.4.2 Firm characteristics, mental health and performance issues

In Figure 7.3 we report three statistical (probit) models of the probability of experiencing long term sickness, mental health absence and performance effects from mental health issues. The coefficients in the Figure are marginal values and have a straightforward interpretation. Note also that the most statistically robust relationships are those indicated by one or more '*'s. For example, the coefficients in the second column of results suggest that firms which were part of multi-plant firms were 10.4 per cent more likely to experience mental health sickness absence controlling for a range of other factors.

In general terms there are few significant firm characteristics. The implication is that experience of long-term sickness absence and mental health sickness absence is not systematically linked to a range of other firm characteristics including: the female or ethnic share of the workforce, family ownership and sector. Some other factors prove more important:

- Firms with a higher proportion of graduates were marginally less likely to experience long-term sickness absence;
- An older workforce (50 plus) is associated with a marginally *lower* likelihood of reporting mental health impacts on performance;
- Having more disabled workers is associated with higher probabilities of reporting mental health impacting on performance;
- Multi-site establishments are positively associated with mental health sickness absence and reporting impacts of mental health absence;
- Larger firm size is significantly associated with higher probabilities of experiencing long term sickness, mental health absence and the probability that mental health absence had impacted business performance.

Most of these effects are relatively small in magnitude but the effects of firm size are much larger. For example, firms with 50-249 employees are 20.2 per cent more likely to have experienced mental health and productivity issues than firms with 10-19 employees.

7.4.3 Testing hypotheses relating to contracts, work practices and management practices

To test each of our three hypotheses we add related variables to the baseline models in Figure 7.3. This leads to some variation in sample sizes due to missing variables in the survey dataset. The key results are as follows:

- **Zero hours contracts and temporary contracts have no significant association with long-term sickness, mental health sickness absence or the reporting of mental health and performance issues**. (Figure 7.4). We therefore find no support for Hypothesis 1.
- **High performance work practices – particularly flexible working, employee control of work patterns, healthy work life balance – have a significant negative association with mental health and sickness issues** (Figure 7.5). However, none of these factors have a significant association with the prevalence of mental health and performance issues. This provides support for Hypothesis 2.
- The introduction of **new technologies is positively associated with sickness absence and mental health issues** but has **no significant impact on the likelihood of experiencing performance issues** related to mental health (Figure 7.5). This provides support for Hypothesis 3, but this is challenged by reporting in Chapter 6 which shows respondents themselves reported a positive impact on well-being of new technologies. Thus, as stated throughout, we cannot be certain of causality, but the picture is likely to be more complex than expressed in Hypothesis 3.
- The **adoption of mental health support measures is only weakly associated with long-term sickness absence or mental health issues**. Where effects are significant they are positive with the strongest associations being for the existence of a senior lead for health and well-being (positively associated with long-term sickness absence and the reporting of an impact of mental health sickness absence) and for use of data to monitor health and well-being (positively associated with mental health sickness absence). This latter finding perhaps reflects better recording of mental health issues (Figure 7.6). Overall, this provides little support for Hypothesis 4 in that initiatives reduce the likelihood to report these issues, however, as stated, we cannot report causality.

Figure 7.3: Factors linked to the probability of experiencing long term sickness, mental health and performance: firm characteristics

	Long-term staff sickness	Sickness related to mental health	Mental health issues affect performance
Graduate share (%)	-0.001***	0.001	0.001
	(0.000)	(0.000)	(0.000)
Workforce aged 25-49 (%)	-0.001	0	-0.001
	(0.001)	(0.001)	(0.001)
50-plus years (%)	-0.000	-0.002*	-0.001*
	(0.001)	(0.001)	(0.001)
Multi-plant firm (0/1)	0.043	0.104***	0.054**
	(0.029)	(0.030)	(0.023)
Regional market priority (0/1)	-0.020	-0.001	0.001
	(0.032)	(0.033)	(0.026)
Ethnic share (%)	-0.001	-0.001	-0.001
	(0.001)	(0.001)	(0.001)
Female share (%)	0	0.001	0
	(0.001)	(0.001)	(0.000)
Disabled share (%)	0.003	0.014***	0.007***
	(0.003)	(0.003)	(0.002)
Family owned (%)	0.021	0.004	-0.012
	(0.029)	(0.029)	(0.024)
Construction	0.009	-0.014	-0.037
	(0.056)	(0.058)	(0.042)
Wholesale, retail	0.052	-0.056	-0.007
	(0.038)	(0.038)	(0.032)
Hospitality	0.012	-0.065	0.005
	(0.060)	(0.054)	(0.047)
Business Services	0.021	-0.008	0.034
	(0.040)	(0.042)	(0.036)
Other services	0.036	0.045	0.067
	(0.056)	(0.059)	(0.051)
20-49 employees	0.051*	0.196***	0.107***
	(0.029)	(0.033)	(0.027)
50-249 employees	0.119***	0.316***	0.202***
	(0.037)	(0.047)	(0.045)
250 plus employees	0.151**	0.446***	0.370***
	(0.076)	(0.100)	(0.126)
Number of observations	1408	1353	1348
Equation chi2	38.516	138.813	74.229
p	0.002	0	0
Pseudo R^2	0.025	0.113	0.081
BIC	1820.697	1573.122	1252.82

Note: Reference categories are the production sector (including manufacturing) and small firms with 10-19 employees. Observations are weighted to give representative results. * denotes significant at 10 per cent; ** at 5 per cent and *** at 1 per cent.

Figure 7.4: Factors linked to the probability of experiencing long term sickness, mental health and performance: zero hours and temporary contracts

	Long-term staff sickness	Sickness related to mental health	Mental health issues affect performance
Zero house contracts (0/1)	0.018	0.014	-0.002
	(0.045)	(0.045)	(0.035)
Temporary contracts (0/1)	-0.030	-0.008	-0.027
	(0.050)	(0.049)	(0.036)
Graduate share (%)	-0.001***	0.001	0.001
	(0.000)	(0.000)	(0.000)
Workforce aged 25-49 (%)	-0.001	0	-0.001
	(0.001)	(0.001)	(0.001)
50-plus years (%)	-0.000	-0.002*	-0.001*
	(0.001)	(0.001)	(0.001)
Multi-plant firm (0/1)	0.042	0.105***	0.054**
	(0.029)	(0.030)	(0.023)
Regional market priority (0/1)	-0.022	-0.002	0.001
	(0.032)	(0.033)	(0.026)
Ethnic share (%)	-0.001	-0.001	-0.001
	(0.001)	(0.001)	(0.001)
Female share (%)	0	0.001	0
	(0.001)	(0.001)	(0.000)
Disabled share (%)	0.003	0.014***	0.007***
	(0.003)	(0.003)	(0.002)
Family owned (%)	0.021	0.004	-0.012
	(0.029)	(0.029)	(0.024)
Construction	0.008	-0.014	-0.038
	(0.056)	(0.058)	(0.042)
Wholesale, retail	0.052	-0.056	-0.007
	(0.038)	(0.038)	(0.032)
Hospitality	0.009	-0.068	0.007
	(0.061)	(0.055)	(0.049)
Business Services	0.019	-0.009	0.032
	(0.040)	(0.042)	(0.036)
Other services	0.032	0.042	0.067
	(0.056)	(0.059)	(0.051)
20-49 employees	0.052*	0.196***	0.108***
	(0.029)	(0.033)	(0.027)
50-249 employees	0.120***	0.314***	0.206***
	(0.038)	(0.047)	(0.046)
250 plus employees	0.156**	0.447***	0.380***
	(0.075)	(0.101)	(0.126)
Number of observations	1408	1353	1348
Equation chi2	38.802	139.296	74.499
p	0.005	0	0
Pseudo R^2	0.026	0.113	0.081
BIC	1834.65	1587.388	1266.54

Note: Reference categories are the production sector (including manufacturing) and small firms with 10-19 employees. Observations are weighted to give representative results. * denotes significant at 10 per cent; ** at 5 per cent and *** at 1 per cent.

Figure 7.5: Factors linked to the probability of experiencing long term sickness, mental health and performance: high performance work practices

	Long-term staff sickness	Sickness related to mental health	Mental health issues affect performance
Employees have control over work (% firms)	-0.047	-0.064*	0.005
	(0.033)	(0.036)	(0.026)
Employees have variety in work (% firms)	0.029	-0.063	-0.043
	(0.042)	(0.046)	(0.037)
Employees have flexible working (% firms)	-0.108***	-0.053	-0.035
	(0.030)	(0.035)	(0.028)
Good physical working conditions (% firms)	-0.023	-0.057	-0.049
	(0.087)	(0.089)	(0.066)
Healthy work life balance (% firms)	-0.092**	-0.008	-0.068
	(0.042)	(0.049)	(0.042)
Development opportunities (% firms)	0.045	0.058	0.002
	(0.058)	(0.055)	(0.045)
Introducing new technologies (% firms)	0.088***	0.047*	0.019
	(0.028)	(0.028)	(0.022)
Graduate share (%)	-0.001**	0.001**	0.001**
	(0.000)	(0.001)	(0.000)
Workforce aged 25-49 (%)	-0.001	0.000	-0.001
	(0.001)	(0.001)	(0.001)
50-plus years (%)	0.000	-0.002*	-0.001**
	(0.001)	(0.001)	(0.001)
Multi-plant firm (0/1)	0.036	0.102***	0.055**
	(0.030)	(0.030)	(0.024)
Regional market priority (0/1)	-0.021	0.005	0.003
	(0.033)	(0.034)	(0.026)
Ethnic share (%)	-0.001	-0.001	-0.001
	(0.001)	(0.001)	(0.001)
Female share (%)	0.000	0.001	0.000
	(0.001)	(0.001)	(0.000)
Disabled share (%)	0.004	0.014***	0.007***
	(0.003)	(0.003)	(0.002)
Family owned (%)	0.024	-0.001	-0.016
	(0.030)	(0.031)	(0.024)
Construction	0.013	-0.008	-0.037
	(0.058)	(0.059)	(0.043)
Wholesale, retail	0.061	-0.048	-0.012
	(0.039)	(0.040)	(0.032)
Hospitality	0.030	-0.062	-0.001
	(0.059)	(0.056)	(0.046)
Business Services	0.014	-0.017	0.021
	(0.041)	(0.043)	(0.036)
Other services	0.054	0.062	0.069
	(0.056)	(0.062)	(0.052)
20-49 employees	0.051*	0.191***	0.105***
	(0.030)	(0.034)	(0.028)
50-249 employees	0.112***	0.304***	0.202***
	(0.038)	(0.048)	(0.046)
250 plus employees	0.180**	0.371***	0.280**
	(0.077)	(0.118)	(0.129)
Number of observations	1349	1298	1294

Equation chi2	70.564	139.315	83.749
p	0	0	0
Pseudo R^2	0.049	0.123	0.093
BIC	1748.831	1552.496	1241.624

Note: Reference categories are the production sector (including manufacturing). Observations are weighted to give representative results. * denotes significant at 10 per cent; ** at 5 per cent and *** at 1 per cent.

Figure 7.6: Factors linked to the probability of experiencing long term sickness, mental health and performance: Mental health related activities

	Long-term staff sickness	Sickness related to mental health	Mental health issues affect performance
Mental health plan in place (0/1)	-0.030	0.01	-0.011
	(0.038)	(0.037)	(0.028)
Senior mental health lead (0/1)	0.054*	0.018	0.053**
	(0.032)	(0.031)	(0.025)
Use data for MH monitoring (0/1)	0.030	0.073**	0.017
	(0.029)	(0.029)	(0.023)
Reporting of MH approach (0/1)	-0.002	-0.005	-0.014
	(0.047)	(0.043)	(0.033)
In house MH support (0/1)	0.011	0.03	-0.005
	(0.044)	(0.046)	(0.035)
Budget for MH and well-being (0/1)	0.012	-0.038	-0.038
	(0.046)	(0.043)	(0.030)
Awareness raising activities (0/1)	0.052	-0.041	0.041
	(0.048)	(0.047)	(0.043)
Training for line managers (0/1)	-0.016	0.004	0.004
	(0.049)	(0.047)	(0.037)
Stress or risk audits (0/1)	-0.010	0.058	-0.021
	(0.040)	(0.043)	(0.029)
Multi-plant firm (0/1)	0.020	0.104***	0.063***
	(0.029)	(0.029)	(0.022)
Regional market priority (0/1)	-0.003	0.001	0.013
	(0.030)	(0.031)	(0.024)
Ethnic share (%)	-0.001	0.000	-0.001
	(0.001)	(0.001)	(0.001)
Female share (%)	0.000	0.001*	0.000
	(0.001)	(0.001)	(0.000)
Disabled share (%)	0.003	0.012***	0.007***
	(0.003)	(0.003)	(0.002)
Family owned (%)	0.023	-0.007	-0.011
	(0.028)	(0.029)	(0.022)
Construction	0.006	-0.001	-0.043
	(0.054)	(0.055)	(0.037)
Wholesale, retail	0.058	-0.043	-0.008
	(0.036)	(0.037)	(0.029)
Hospitality	0.040	-0.026	0.019
	(0.050)	(0.051)	(0.043)
Business Services	-0.031	0.005	0.035
	(0.039)	(0.039)	(0.033)
Other services	0.017	0.02	0.038
	(0.054)	(0.056)	(0.046)
20-49 employees	0.041	0.183***	0.090***
	(0.028)	(0.031)	(0.026)
50-249 employees	0.136***	0.298***	0.194***
	(0.035)	(0.044)	(0.042)
250 plus employees	0.118	0.433***	0.369***
	(0.086)	(0.102)	(0.123)
Number of observations	1565	1506	1501
Equation chi2	41.543	159.873	86.925
p	0.01	0	0

Pseudo R^2	0.024	0.119	0.089
BIC	2077.784	1768.359	1402.153

Note: Reference categories are the production sector (including manufacturing) and small firms with 10-19 employees. Observations are weighted to give representative results. * denotes significant at 10 per cent; ** at 5 per cent and *** at 1 per cent.

7.5 Summary

Just over half of establishments (55%) report an impact of mental health sickness absence, but this masks a range of types of impact and how deeply felt those impacts are.

The types of impact most likely to be reported are impacts on colleagues; impacts on costs; and (largely, non-specific) efficiency and productivity problems. These points were also cited in the qualitative research, which also suggested a difficulty that employers had in tackling stigma amongst colleagues. The qualitative research also found that there was little formal recording of the impacts of mental health sickness absence, and there is also a suggestion that, with the willingness of other colleagues, employers will work around mental health sickness absence so that it apparently does not impact on business performance.

However, the multivariate analysis allows us to look beyond this and to provide evidence of the scale of the impact on productivity. Experiencing long-term sickness is associated with productivity which is lower by 27.2 per cent; sickness related to mental health is associated with productivity which is lower by 18.3 per cent; and, firms reporting a situation in which mental health impacted their performance was associated with productivity which is lower by 24.5 per cent.

In terms of what types of firms are most likely to report sickness absence (general and mental health) and an impact of mental health sickness absence, the multivariate analysis suggests that establishment size matters. Multi-site and larger firms across all sectors are significantly more likely to experience long-term sickness and mental health sickness absence and to report that mental health sickness absence impacts on business performance. This may simply be a scale effect related to firms' number of employees. While the qualitative research points to the importance of being able to know colleagues personally as a means of dealing *promptly* with health and well-being issues, this was seen to be more problematic in larger establishments, and this would seem to be borne out in the multivariate analysis, illustrating the difficulties of managing larger organisations.

In Chapters 5 and 6, we reported the regression analysis which showed that the introduction of new technologies is positively associated with long term sickness absence and with mental health sickness absence, supporting hypothesis three that the introduction of new technologies impacts on mental health and long-term sickness absence. We also reported that respondents themselves reported a positive impact on staff well-being when new technology was introduced, demonstrating that one cannot infer that the introduction of new technologies *causes* long-term or mental health sickness absence. Indeed, the new technologies may have been brought in to aid mental well-being, and examples of this were noted. In this chapter we see that the introduction of new technology is *not* significantly associated with mental health sickness absence impacting on business performance, when other factors are controlled for. In terms of the channels of well-being to productivity (detailed in Chapter 2), one might have expected the regression analysis to show some association between the introduction of new technology mental health sickness absence impacting on performance, but this has not been the case.

Management practices around flexibility and healthy work life balance are particularly associated with lower sickness absence, supporting part of our hypothesis on the likely effects of 'high performance working', as is a higher proportion of graduates in employment. Our hypothesis that firms using zero hours and temporary contracts would be more likely to report sickness absence did not hold in the statistical analysis (though job insecurity was cited as a risk factor in the qualitative research). However, there may be other factors at play regarding the motivation of employees to take time off when ill, such as affordability and security.

CHAPTER 8: ATTITUDES AND ACTIVITIES

8.1 Introduction

In this chapter we explore what firms in the Midlands are doing to more proactively support the mental health and well-being of their staff. The survey explored a number of activities businesses might do support good mental health and well-being in the workplace, drawing on measures from the Mental Health and Productivity Logic Model and other guidance (Annex 6). In this chapter, we describe results of the survey and the qualitative research, beginning with an exploration of attitudes towards mental health of employers in the Midlands.

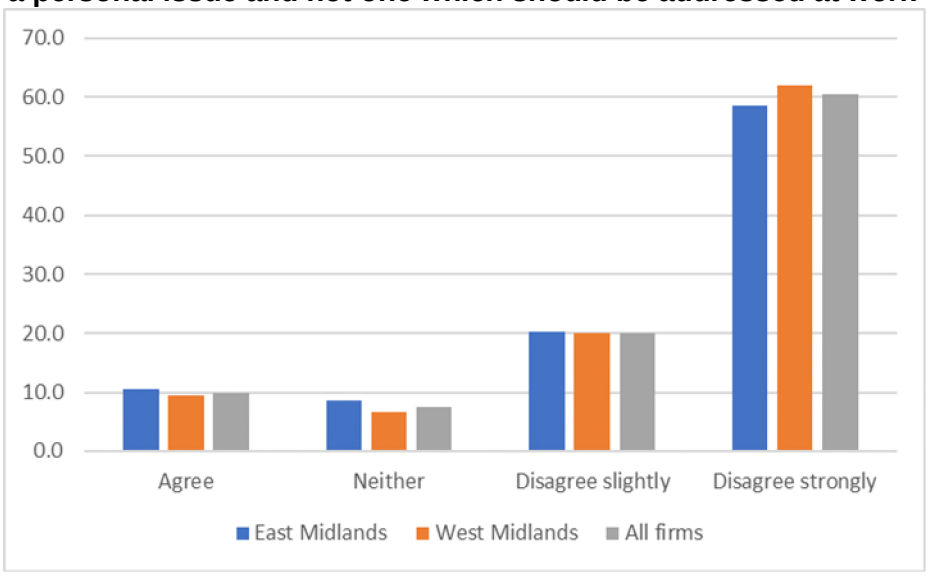
8.2 Attitudes toward mental health

Before exploring activities, our research explored business attitude toward mental health in the workplace and what they felt was their responsibility for the mental health of their employees.

All firms in the survey were asked whether they agreed or disagreed with the statement 'mental health is a personal issue and not one which should be addressed at work'.

The majority of firms disagreed strongly with this statement (60%), suggesting strong support for engaging with employee mental health (Figure 8.1).

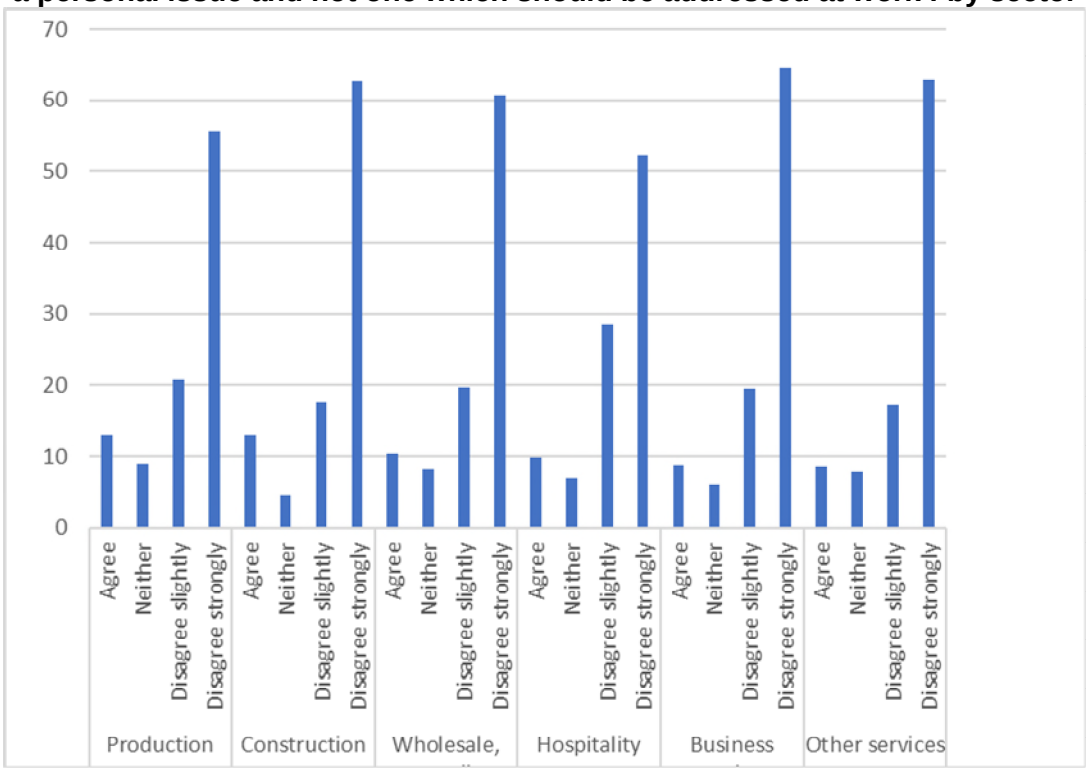
Figure 8.1: Proportion of firms that agree/disagree with the statement 'mental health is a personal issue and not one which should be addressed at work'



Base: All Firms - 1899
Note: Responses are weighted to provide representative results for each region.

Whilst respondents overwhelmingly disagreed with the statement, there are some difference by size and sector. Figure 8.2 shows that in Business Services sector are most likely to disagree strongly (65%) and there are higher levels of agreement in Construction and Production (13%) compared to the average of 10%.

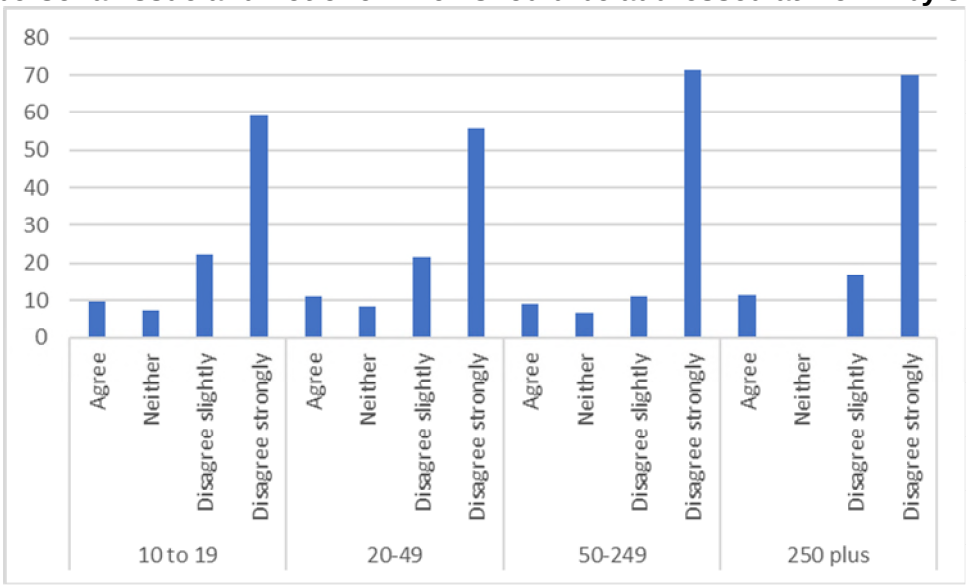
Figure 8.2: Proportion of firms that agree/disagree with the statement 'mental health is a personal issue and not one which should be addressed at work': by sector



Base: All Firms - 1899
Note: Responses are weighted to provide representative results for each region.

Firms in the 20-49 size band are most likely to agree with the statement and therefore less likely to disagree, as shown in Figure 8.3.

Figure 8.3: Proportion of firms the agree/disagree with the statement 'mental health is a personal issue and not one which should be addressed at work': by size



Base: All Firms- 1899
Note: Responses are weighted to provide representative results for each region.

The qualitative research also explored business attitude to mental health and the balance of responsibilities between employers and employees.

One employer articulated that they felt there was an imperative to be proactive, noticing behaviour changes which may indicate difficulties (screening), whilst recognising **a balance of responsibility**:

> *'I feel that we should be able to be proactive rather than reactive. I think we should be able to, you know, know our team so that we can understand and notice behaviours that maybe make us think that they need some extra support. And although I feel it's people's own responsibility to manage their mental health, I do feel that we've got a huge responsibility to help people get through those times whether that's adapting their role or giving them more support in other ways.'*

And the same participant went on to emphasise the importance of the **attitude of the leader**:

> *'I've got two bosses who are really committed to investing in, you know, we've spent quite a lot of money on that and clearly, it's worth it. It's our team … other practices .. maybe don't have the finances to be able to do it or the bosses that feels that it's valuable. That's another thing.'*
>
> Practice Manager, Veterinary practice, Medium, East Midlands

The **buy-in of bosses/owners** was crucial in other cases too:

> ‘ [the owner is].. *.is the sort of person who’s very approachable and you want to be around. As a person, he’s very reflective. He likes to go on these courses on, you know, how you can better yourself and how you can handle certain situations. So, he definitely sort of lives by it.’*
>
> Office Manager, Small, Business Services, East Midlands

‘I think the overall responsibility of everybody’s welfare has to sit with the managing director of the business. […] the person at the top of the tree has ultimate responsibility.’
Managing Director, Small Property development firm, West Midlands

And the importance of **firms being small enough to know each other**, with supportive management also occurred:

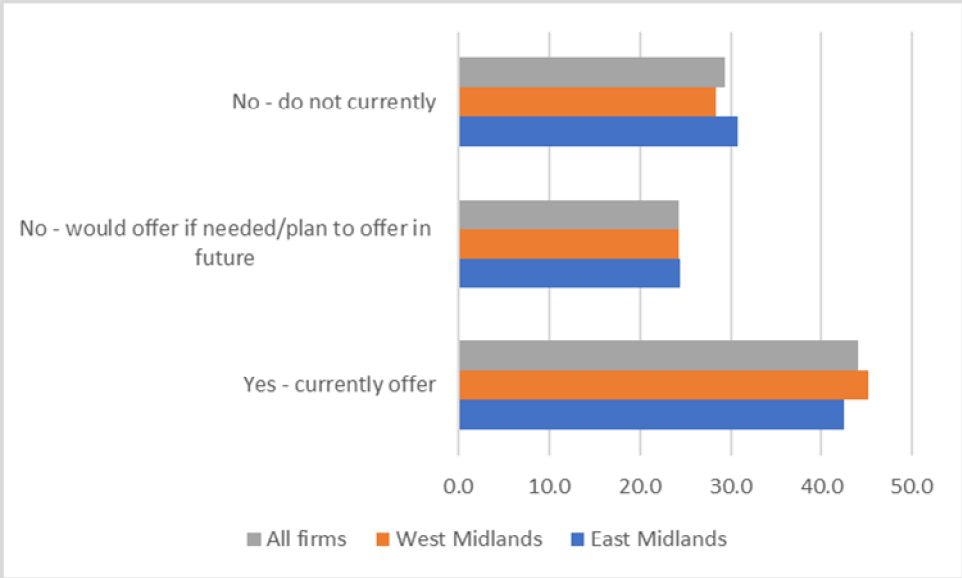
> *‘…basically, it’s a family-run family so we’re quite close-knit, obviously autonomous in terms of everybody knows who everybody is so we can all kind of help each other out.’*
>
> Head of Data & MIS, Training provider, Medium, East Midlands

> *‘Because there's only about 60 people in our team. I get to know them fairly well. So when people's behaviours change or attitudes, you can tell with some people who are usually really bubbly if they have been downed or they're struggling, they might go quite unsure.’*
>
> Health & Safety Officer, Medium sized Business Support Agency, West Midlands

8.3 Mental health activities

In exploring what activities firms do to support the mental health of their employees, the survey began by asking whether firms offered some form of (undefined) mental health activity in the workplace. Just over two in five, 44%, of firms offered some form of mental health activity in the workplace; 24% do not currently, but plan to or would if it was needed. Almost three in ten (29%) do not and do not intend to. The likelihood to offer activities to promote good mental health was slightly higher in the West Midlands than in the East Midlands, as shown in Figure 7.4.

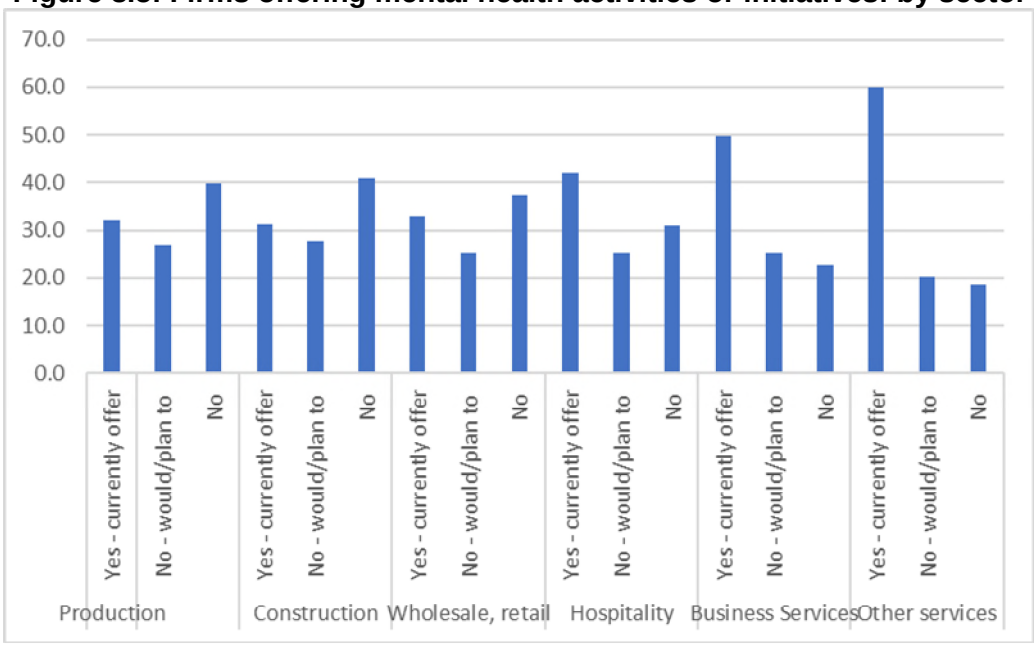
Figure 8.4: Firms offering mental health activities or initiatives



Base: All firms - 1899
Note: Responses are weighted to provide representative results for each region.

Firms in the Other Services sector (60%) are most likely to offer activities to promote good mental health and firms in Construction are least likely to (31%), as shown in Figure 8.5.

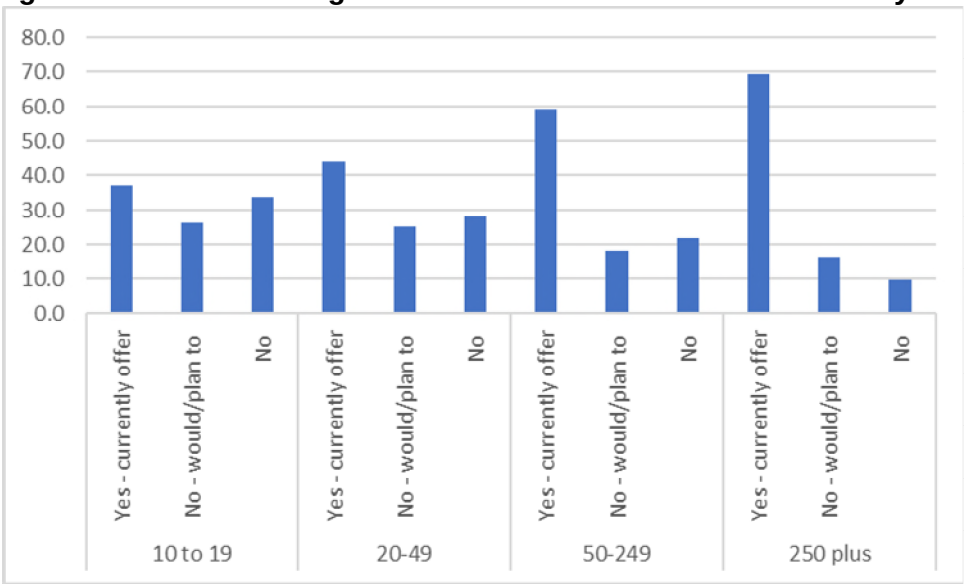
Figure 8.5: Firms offering mental health activities or initiatives: by sector



Base: All firms - 1899
Note: Responses are weighted to provide representative results for each region.

By size band, the larger firms were much more likely to offer activities to promote good mental health, as shown in Figure 8.6, with 69% of the largest firms offering such activities compared to 37% of the smallest.

Figure 8.6: Firms offering mental health activities or initiatives: by size



Base: All firms - 1899
Note: Responses are weighted to provide representative results for each region.

In designing the survey, we wanted to ensure we checked whether some activities were offered or available. Therefore, for 3 key aspects of mental health support in the workplace – the existence of a mental health plan, a senior level health and well-being lead and whether data was used to monitor health and well-being, questions were asked regarding these activities regardless of the response to the above question. The questions indicate the degree of planning of activities, senior leadership support and monitoring of mental health, which would suggest a fairly sophisticated approach by itself, if all were applied. These three measures are important to the Mental Health and Productivity Logic Model and are also common to some of the guidance employer summarised in Annex 6.

Two in five firms (40%) of all firms reported using data to monitor employee health and well-being and this was the most commonly reported of the three activities, followed by a health and well-being lead at Board or senior level (36%) and a mental health plan at 22%. Firms in the West Midlands are more likely to offer all of these activities (Figure 8.7). Firms in Other Services, Hospitality and Construction are more likely than average to have a mental health plan (27%, 26% and 25% respectively). Firms in Other Services are most likely to have a health and well-being senior level lead (46%) and to use data to monitor employee health (56%), and by some margin, compared to other sectors.

The larger firms are most likely to report these activities as seen in Figure 8.7.

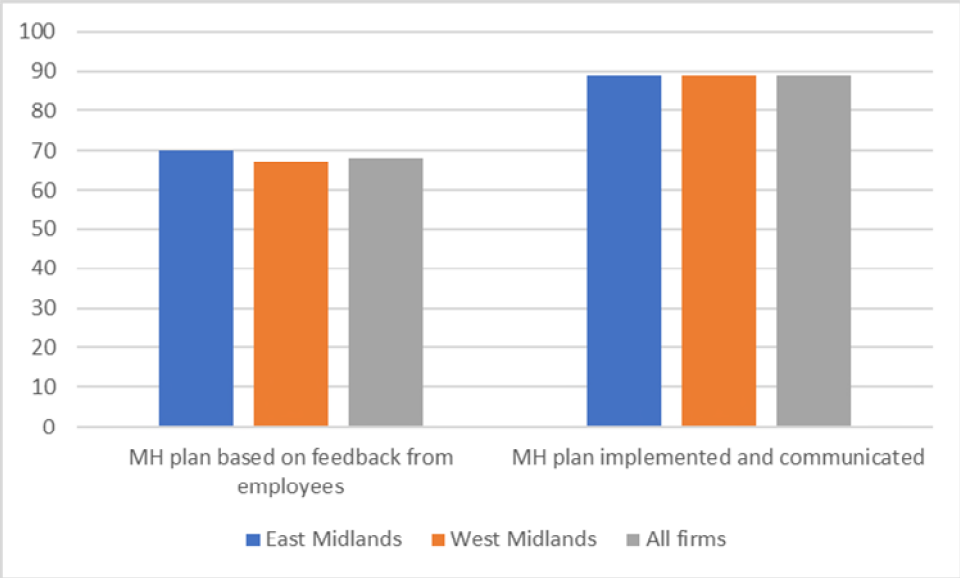
Figure 8.7 Provision of mental health plan, leadership and monitoring

	Mental health plan	A health & well-being lead at board or senior level	Use data to monitor employee health and well-being
	%	%	%
All Firms	22	36	40
East Midlands	20	35	38
West Midlands	24	37	41
Production	18	31	41
Construction	25	32	33
Wholesale, retail	17	28	31
Hospitality	26	32	28
Business Services	22	40	37
Other services	27	46	56
10-19	15	28	30
20-49	26	39	44
50-249	32	47	57
250 plus	40	59	63

Base: All firms - 1899
Note: Responses are weighted to provide representative results for each region.

The evidence says it is not enough to merely have a mental health plan, but that this needs to be developed in consultation with staff, put into implementation and effectively communicated to staff when ready. The survey followed up those respondents who reported a mental health plan to ascertain the extent to which these activities took place. The results are positive in that 70% of firms with a mental health plan consulted with their staff in the development of the plan and 89% reported implementing and communicating the plan, as shown in Figure 8.8.

Figure 8.8: Mental health plan development and implementation



Base: All firms with mental health plan - 433
Note: Responses are weighted to provide representative results for each region.

The qualitative research provided useful examples of how firms have introduced some form of mental health and well-being strategy and two of these are presented below. In one firm, there was a response to an employee survey which identified a desire from employees for more well-being activities. This did not come from a 'standing start' as the firm already delivered well-being activities, and indeed, this was consistent with the overall purpose of the firm and its own activities, but, until a year ago, it had done so without a coherent staff well-being strategy.

In the second example, a firm was prompted to introduce more proactive supportive approaches by a mental health crisis experienced by an employee. At the point of interview, they were looking to build on the activities introduced thus far by developing a mental health strategy.

The two examples are similar, but are at slightly different stages of development and implementation, but together, they suggest that:

- Time is needed for the effective implementation of a mental health and/or well-being strategy;
- There needs to be leadership support;
- There need to be engagement and co-operation of staff; and
- Best practices will likely evolve over time rather than appear where there is nothing to build on.

Introducing a Well-being Strategy – large organisation, Other Services

One of the firms we interviewed for the case study research had recently introduced a Well-being Strategy, and we were able to follow up with some interviews with employees too. The organisation provides an interesting example of the reasons for introducing such a strategy and factors in place in the firm which may help in implementation.

The introduction of the **Well-being Strategy** was in response to a staff engagement survey in which Well-being scored poorly and in having relatively high absence rates.

The rationale was recognised by the employees, with one reporting that this is a caring organisation, and in addition: '*the organisation can save time, money and productivity and those things'.*

The organisation already had a range of activities aimed at promoting physical health and well-being, which is in keeping with the service it provides. These including a physical activity scheme, encouraging staff to undertake 30 minutes of exercise a day with free or subsidised activities such as yoga, football and badminton provided. Staff can also take extra paid time at lunchtime to do these activities.

The organisation used internal expertise on Well-being and external partners to support the drafting of the strategy which identifies SMART objectives and organises activities into 3 Pillars – Physical; Social and Emotional.

To deliver the strategy, the organisation established a Workplace Well-being Working Group which comprises 10 staff (almost 10% of all staff) and has utilised the LRS Workplace Health Needs Assessment that looks at individual lifestyle factors and causes of stress.

Other specific **actions** include: mapping current activity to identify gaps; reviewing all policies and procedures; reviewing and developing training; enhancing the working environment and raising awareness, communicate and engage.

The Well-being group are Well-being Champions and have been trained as Mental Health First Aiders, which was well received and provided attendees helpful guidance on how to support people at work.

Emphasis was placed on **communicating** the Strategy to staff through a launch at an Awayday, briefings, intranet and lunchtime briefings.

They are awaiting the next engagement survey to assess the impact of the Well-being Strategy, which would be around 18 months after introduction. It would appear though to have **solid building blocks in place** which, in themselves stem from:

- An organisation that is practicing for its own staff what it promotes for other people (physical activity and well-being);
- A supportive board and senior leadership and strongly held moral and legal duty of care;
- A supportive working environment where colleagues are happy to help others;
- A small but long established HR team;
- A number of existing well-being activities.

Developing a mental health strategy: how one organisation identified the need and worked with employees to formalise their approach to mental health in the workplace

Following the mental health crisis of an employee, which impacted significantly on others, this medium sized business services organisation in the West Midlands has been experimenting in recent months with a variety of initiatives aimed at raising awareness of mental health issues:

'This was our very first…we've had people who were stressed before, but this was our very first sort of mental health kind of crisis situation. But it developed over time.'

'So, we are quite a supportive and open organization, we are there for our employees. We want them to be happy and safe at work. So, we …initially…we offered a lot of support and like inside and outside of work, …would do things to try and help them. It got to the point where we physically, we couldn't do anything else. And nothing seemed to be helping.'

'… we'd gone through the GPs and things. They…it was a difficult situation because the person would say things like 'I want to hurt myself; I want to jump in front of that car,' or things like that. But then they weren't very keen to access the support that was there. So, it was quite difficult to encourage them to go to counselling. It was difficult to get them to go the GP and to take the steps that the GP suggested.'

This experience alerted the management team to the need for a more proactive approach to mental health issues, and demonstrated the importance of employer support for mental health and well-being of employees:

'Yes, the previous experience, and I think all the upcoming research that has been done over the past few years, has really helped to see that actually mental health is huge and anything that we can do to support that within work is a benefit to everyone.'

As a result, they have tried a range of activities and initiatives to reduce stigma around mental health and to offer support to their wider team:

'… we've definitely tried to make mental health not such a taboo subject. We know that we would have mental health and it would fluctuate. And then some of the activities that we do, try and equip employees so that if they know they get into a point where they need additional support or they think, I'm not myself. What can I do to try and help? Yeah. So, we run workshops and things to try and help that.'

'During mental health first aid week, they did five different activities, one for each day. And that was…that covered things like going for a walk at lunch and being aware of their surroundings and getting physical activity. They did an activity on wearing a mask at work and how we can mask what we're feeling. But actually, that's not necessarily good, because you need to be yourself.'

There have also been specific initiatives aimed at line managers, both to raise awareness and to offer ideas for supporting team members:

'So, managers are much more aware now. Quite of few of them would've attended 'Mental Health Lunch and Learn' where our director of HR would've gone through some of the sort of symptoms of mental health and how you can help manage that.'

'We operate monthly, one to one. So, the managers will have catch ups with their teams on a monthly basis. With each individual. And that helped. So, you could sort of see if things are developing. You can try and nip them in the bud straight away. If someone's really struggling their managers can alter the workload, or offer them more flexibility.'

The organisation has tracked the success and uptake of these activities, with a '*log of interactions'* which has shown that some activities have been more successful than others. This has made them realise that a more formal approach to mental health initiatives in the workplace may be appropriate, and as a result they are now working on establishing a mental health strategy to inform their approach to mental health:

'We [already] have a stress policy. So, people know what to do if they're feeling stressed or that their workload's too much. We don't have a [mental health] policy at the moment. We're in the process of writing a mental strategy. We're looking at putting a program of events surrounding specific [mental health] issues in over the next 12 months. And the strategy will help form that programme.'

Respondents who reported that they did offer mental health activities were asked in more detail about the activities offered and about their organisation's approach to mental health and well-being, reported in Figure 8.9.

In terms of activities, in-house mental health support and signposting to other services (66%) and awareness raising for staff on mental health issues (65%) were most commonly reported. These were followed by training for line managers on mental health issues (48%) and internal and external reporting of their approach to mental health (39%). A third had employee mental health champions (33%) and a quarter (25%) had a budget for mental health and well-being activities.

By region, firms in the West Midlands were more likely to offer these services than those in the East Midlands, particularly mental health champions, 38% of firms in the West Midlands which reported offering some mental health activities compared to 28% in East Midlands. In-house support or signposting was offered by 70% of these establishments in the West Midlands compared to 61% in the East Midlands.

By sector, the pattern is mixed. Firms in Construction are most likely to offer training for line managers (56% compared to the average of 48%), but least likely to have a budget for mental health and well-being activities (13% compared to the average of 25%). This may reflect the site-based nature of the work and what is pragmatic.

Business Services firms are most likely to have a budget (33%) and employee mental health champions (40%) but are less likely than average to undertake reporting of their mental health activities.

By size, the larger firms are more likely to offer all of these particular supportive and reactive mental health activities and are more than twice as likely as average to report a budget for mental health and well-being activities.

Figure 8.9 Provision of mental health support activities

	Awareness raising for staff on MH issues	Training for line managers in managing MH	Employee mental health champions	Internal and external reporting of your approach to MH	In-house MH support and signposting to other services	Budget for MH and well-being activities
	%	%	%	%	%	%
All Firms	65	48	34	39	66	25
East Midlands	64	46	28	39	61	25
West Midlands	66	49	38	39	70	25
Production	64	43	32	37	67	32
Construction	70	56	35	40	56	13
Wholesale, retail	53	43	28	32	50	17
Hospitality	63	53	21	40	68	19
Business Services	65	49	40	34	68	33
Other services	72	48	37	46	74	26
10-19	58	37	25	33	55	21
20-49	66	55	33	41	68	25
50-249	73	51	46	47	80	28
250 plus	78	74	52	38	82	53

Base: All firms reporting some mental health activities - 833
Note: Responses are weighted to provide representative results for each region.

Amongst those firms which reported providing some form of mental health activities, it was more common to refer to organisational practices, rather than the activities cited in Figure 8.9 above. For example, 94% of firms reported encouraging conversations about mental health in the workplace and the 93% the provision of workplace adjustments where needed to support mental health (a legal requirement and examples from the qualitative research are discussed in Chapter 6). Eight in ten (80%) reported ensuring all staff have a regular conversation about health and well-being with their manager and 59% reported risk assessment or stress audits (Figure 8.10).

Construction firms are at or above the average for nearly all of these practices, except it is the sector least likely to have risk assessments/stress audits.

Smaller firms are more likely to ensure all staff have a regular conversation about health and well-being (84%), and this may relate to some of the issues discussed in earlier in this Chapter

regarding the ease of knowing colleagues in a small workplace and the supportive approach of many owner managers reported in the qualitative research.

Figure 8.10 Provision of organisational practices to support good mental health

	Encourage open conversations about mental health the workplace	Workplace adjustments where needed to support MH	Ensure all staff have a regular conversation about H&WB with their manager	Risk assessment /stress audits
	%	%	%	%
All Firms	94	93	80	59
East Midlands	96	93	80	59
West Midlands	93	94	80	59
Production	96	89	68	46
Construction	94	96	79	46
Wholesale, retail	94	93	68	62
Hospitality	98	93	75	55
Business Services	94	95	80	54
Other services	93	94	91	66
10-19	96	94	84	57
20-49	94	92	81	61
50-249	92	95	72	60
250 plus	97	96	69	59

Base: All firms reporting some mental health activities- 833
Note: Responses are weighted to provide representative results for each region.

8.4 Other well-being activities

Finally, some other well-being activities were asked about in the survey which are about broader activities associated with good mental health and well-being, such as physical health, resilience and financial well-being, thus covering a broad spectrum of other factors associated with well-being as identified in the Mental Health and Productivity Logic Model and in much of the guidance for employers on good mental health management. All firms were asked this question and the results are shown in Figure 8.11.

Almost half of firms provide healthy food or drinks (46%); three in ten provide financial well-being advice (30%) and incentives for physical exercise (29%). A quarter (26%) provide training to build personal resilience.

In contrast to some of the findings on mental health activities, these broader activities are less likely to be offered in the Construction sector, which again may be associated with site-based working. The Hospitality sector is most likely to provide healthy food (65%); Business Services is most likely to offer physical activity incentives (27%) and financial well-being advice (37%), and Other services is most likely to offer training for building resilience (36%).

The larger the firm, the more likely they are to offer all these activities, as seen in Figure 8.11

Figure 8.11 Provision of other well-being activities

	Physical activity such as gym memberships	Healthy food and drinks	Training to build personal resilience	Financial well-being advice
	%	%	%	%
All Firms	29	46	26	30
East Midlands	30	46	24	29
West Midlands	28	47	27	31
Production	30	32	19	26
Construction	20	25	14	27
Wholesale, retail	25	41	16	25
Hospitality	29	65	33	37
Business Services	39	45	27	31
Other services	27	56	36	32
10-19	21	43	22	26
20-49	29	48	25	31
50-249	46	52	35	36
250 plus	67	58	43	47

Base: All firms - 1899
Note: Responses are weighted to provide representative results for each region.

8.4.1 Mental health activities – evidence from qualitative research

The qualitative research also explored the types of activities offered by employers. There are a **wide range of activities**, including more formal activities such as the provision of an Employee Assistance Programme; employee engagement and communication activities through Awaydays and social gatherings; the provision of spaces for colleagues to relax; encouraging staff to leave their desks at lunchtime, bird-feeding tables and office dogs, as illustrated in the following quotes:

'… we have brew Mondays, we have things like, gym or GP benefits, so all employees will either have a sports membership or private health care, so that's all offered to all employees, we do try and do a lot of employee engagement, which is all linked to mental health if you like, it's about- but it's more about releasing often, not directly saying it's mental health.'

HR Benefits & Compensation Adviser, Logistics, Large firm, West Midlands

'…we have a lot of things in place …. We have like push bikes on the side that you can take out at lunch time. We sort of insist on people having the break from their desk that they go and sit, either in the meeting room, which is quite nice, it's got to take a big sort of large screen TV if you wanted to put the TV. We're right in the middle rural Shropshire, so we got a lot of bird feeding stations.. We've got a garden for the staff to use, picnic benches to sit outside on.'

Marketing Director, Manufacturing, Small firm, West Midlands

'…we do have an office dog…… quite often if people who have just, you know, if they've come off the phone to a customer that's annoyed them or something, and sometimes they just come in and they'll just have a little cuddle with him.'

Head of Data & MIS, Training provider, Medium size firm, East Midlands

Another key feature **is training of line managers**. The survey reports that 48% of firms which had undertaken mental health activities have provided training for line managers and this is important to facilitate healthy conversations:

'I think sometimes people are worried about saying the wrong thing or knowing what they can say and being… you know, am I prying too much into your personal life? Those kinds of things. So it's just kind of going… giving… make sure line managers, who feel less confident, know about how to have those conversations and the importance of having regular one-to-ones, where if you're having those regular one-to-ones, and that regular time with your team, you'll know what your team… how they work, what style works for them, change your personal approach to each individual, and start to get to know them as individuals.'

Assistant Director – HR, large, Other Services, East Midlands

A number of participants in the qualitative research had undertaken **Mental Health First Aid** courses. Government is investing £15m to get people trained to MHFA and, according to the Mental Health First Aiders website, as of January 2020, 1 in 80 of the population had been trained[8]. Mental Health First Aiders will have completed a two-day MHFA course delivered by a quality assured instructor who has completed the MHFA England Instructor Training programme accredited by the Royal Society for Public Health. The course and materials aim at teaching anyone how to help a person with a mental health problem. It does not teach people to treat or diagnose mental health or substance use conditions. Instead, the training

[8] https://mhfaengland.org/mhfa-centre/news/feb-2020/

teaches people how to offer initial support until appropriate professional help is received or until the crisis resolve, like traditional first aid.

The training was well received by those in the qualitative research, in **giving people the confidence to know what they can and what they cannot do** for example:

> *'my key learning was, it's not about solving issues for people, it's about signposting them to, you know, external resources that...that can properly help them. 'Cause I think you sometimes take the weight of the world on your shoulders and think, oh, I need to solve this, but actually, you can't.'*
>
> Head of HR, Large, Electrical Installation, East Midlands

> *'I did the [mental health first aider] training probably about 18 months ago when we had someone who was struggling with mental health and it was the first sort of really difficult case that we'd come across […] it's just …knowing what to do. If anyone with a crisis point, or even before that point, where we can sign post them and what some of the symptoms are and trigger points.'*
>
> Health & Safety Officer, Business Services, Medium size org, West Midlands

> *'…that I took kind of mental health first aid course, two-day course. So, I think that just sort of helped me get a bit more of an understanding and also just give other people, other employees and there is somebody that they could come to speak to if they want to.'*
>
> Works Manager, Manufacturing, Small org, East Midlands

> *'… we sort of did the mental- we call mental health allies that you could you know, you had a couple of allies at the start and you can go and talk to them, but people didn't really embrace that, I think- but when you say that you're a mental health first aider, it's a different- people think about it differently […] so now we're going down the mental health first aiders, because I think also I think people think first aider mental- okay, they know what they're doing, yeah.'*
>
> HR Benefits & Compensation Adviser, Logistics, Large organisation, West Midlands

However, the **training does not appear to cover one of the key impacts identified by employers (Chapter 7) which is addressing frustration amongst other staff**.

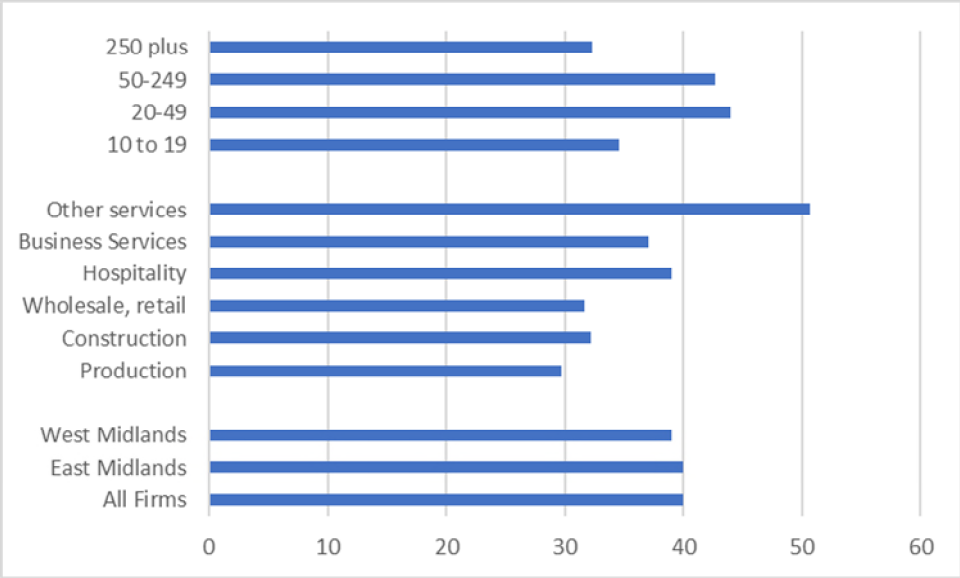
8.5 Impact of mental health and well-being activities

Just over a third of firms which provided some form of mental health and well-being support[9] took steps to evaluate their health and well-being activities (40%), with little difference by region. Firms in Other Services were most likely to evaluate (51%), compared to 30% in

[9] i.e. any of the mental health activities in Figures 7.4 – 7.10, and/or any other well-being activities in Figure 7.11 and/or engagement with any initiatives in Figure 8.5.

Production. Medium-sized firms are most likely to evaluate their mental health and well-being activities as 44% employing between 50 and 249 employees evaluated activities and 43% employing 20 to 49. Surprisingly, 33% of the largest employers evaluated activity, which is lower than the proportion the smallest firms (35%), as seen in Figure 8.12.

Figure 8.12: Proportion of active firms which evaluate their activities



Base: All firms which provided some form of mental health and well-being activity - 1303
Note: Responses are weighted to provide representative results for each region.

The survey also explored the impact of the mental health activities for all those firms which reported providing at least one of these activities[4] – regardless of whether or not the firm had taken steps to evaluate their activities.

The biggest impacts are reported on improved mental health and stress management at work and improved job satisfaction (both 57%). Improved business performance was next most likely to be cited (50%) followed by reduced incidence of stress or mental health sickness absence (49%), improved customer services (47%) and improved staff retention (46%). Help with staff recruitment was only cited in 29% of firms which implemented at least one mental health activity, though it may be that this was not an intention of the activity. The results are presented in Figure 8.13.

Figure 8.13: Impact of mental health and well-being activities

Base: All firms which provided some form of mental health and well-being activity - 1303
Notes: i) Responses are weighted to provide representative results for each region.
ii) QH2: Read out.

In the qualitative research, few could describe the impact of their activities, though some were taking steps to formally measure these activities. This was most likely to be where the activities were being delivered under a formal plan or by a designated HR person. Metrics include measurement of attendance of associated events/training and webpage hits; reduction in staff sickness in specific cases due to the impact of Return to Work interviews and additional one-to-one meetings. One participant noted that activities were less likely to have an impact when people were remote working and not having access to the office, the facilities available or the relationships.

8.6 Summary

Employers in the Midlands almost unanimously recognise they have a role to play in supporting employees with mental health issues. They play both reactive and proactive roles in supporting the health and well-being of their employees. In smaller firms, the owner manager seems to promote a culture of supportiveness through leading by example; in larger firms, senior managers or boards will play this role and they are more likely than smaller firms to train line managers on issues associated with mental health.

The qualitative research suggests a *functional* difference to these approaches. This is something beyond sectoral description of a firm's activities. For example, in firms where the whole method of the organisation was about health and well-being or where there were

safeguarding procedures in place for customers, this was normal and accepted practice and was perhaps easier to adapt and introduce to staff. In firms without these practices, it was less easy to gain buy-in for health and well-being activities or supportive approaches to mental health issues across the firm.

However, mental health activities are currently offered by the minority of establishments in the Midlands, with almost three in ten not offering, nor intending to offer such activities. These firms are more likely to be found in the Production, Construction and Wholesale, retail sectors and in smaller firms, though the sector pattern is complex and may again be related to factors such as access to a common location (for access to services such as healthy food, or open conversations, for example).

The qualitative research supports wider literature which suggests that activities delivered under a coherent plan are more effective, but only 22% of establishments in the Midlands have such a plan. Organisational practices are more commonly reported, such as conversations with managers or in the workplace generally about mental health – figures driven by the smaller firms in the sample – where the qualitative research has shown, people are more likely to know their colleagues better.

The issue of remote working, common in the qualitative research, was not explored in the survey and this should be considered for future research. Remote working presents more issues for employees and they are less likely to be able to take up the activities on offer.

On the whole, the research suggests that employers are engaged with the topic and appreciate that they have a role, but are perhaps less clear about what that role could be or how to go about it. These issues are explored further in the next chapter.

CHAPTER 9: SUPPORTING EMPLOYERS

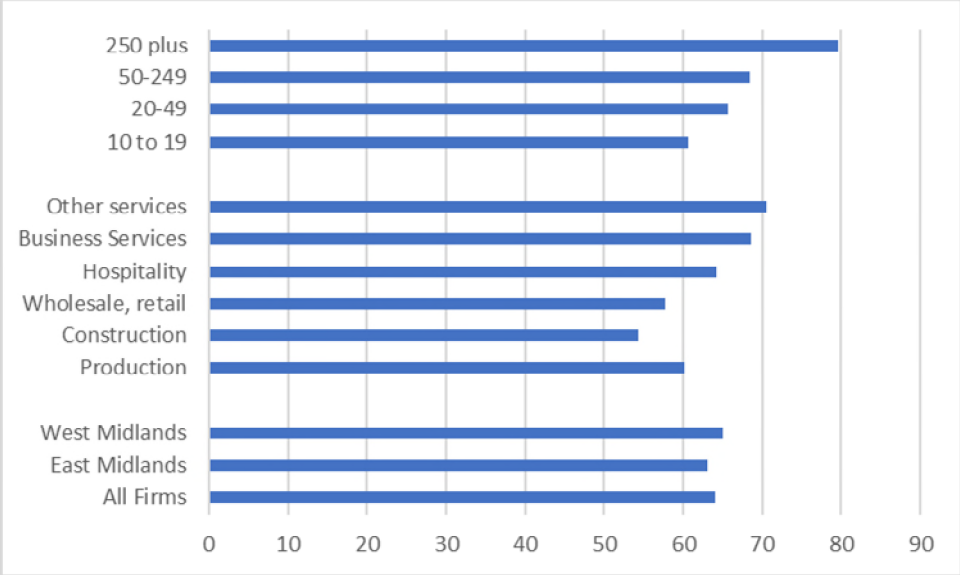
9.1 Introduction

To what extent do business establishments in the Midlands currently engage with a range of support services for mental health in the workplace and what sort of support do they want? Given that the minority of establishments offer activities to support mental health and well-being, does this mean they are not interested in doing so? We have also seen that they do think employers have a role to play in the health and well-being of their staff. This chapter explores whether firms would like to provide more mental health support and where they would go for that support.

9.2 Businesses want support

Almost two-thirds of firms said they would like to provide more mental health and well-being support to their staff (64%, Figure 9.1). This was highest in the services sectors and amongst the largest firms (Figure 8.1). The largest establishments are most likely to want to provide more mental health support (80%) and smaller establishments least (61%). By sector, establishments in Construction are least likely to want to provide more support (54%) and Other Services most likely (71%)

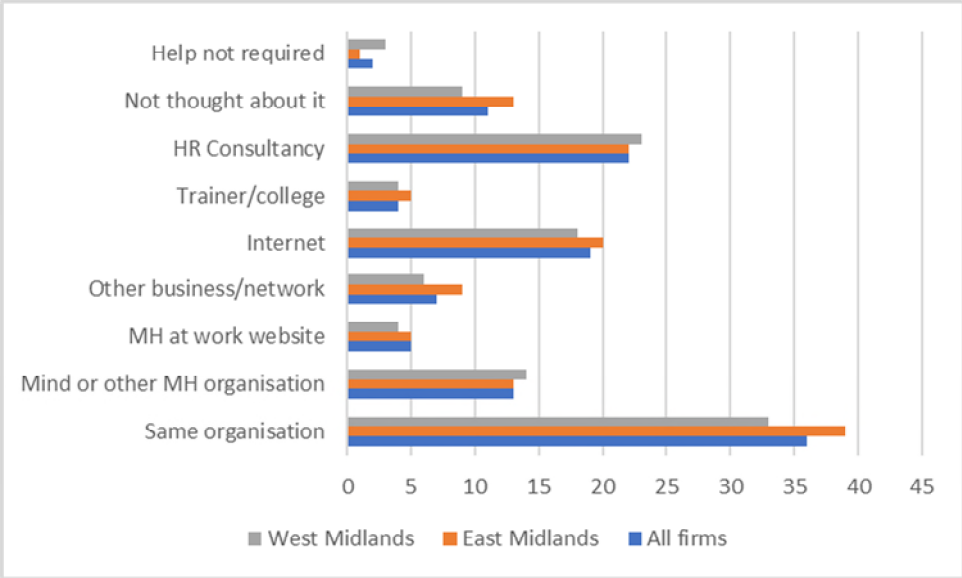
Figure 9.1: Proportion of firms which would like to provide more mental health support



Base: All firms- 1899
Note: Responses are weighted to provide representative results for each region.

Currently, the most commonly cited source for advice for all firms was 'elsewhere within the firm' (33%). HR Consultancies were next most likely to be referred to (23%) followed by general searches on the internet (18%). Mental health charities were cited by 14% of respondents (Figure 9.2). One in ten had not given the issue thought and 3% said help was not required. The most common sources for employers are colleagues or HR type routes, rather than mental health charities or government organisations.

Figure 9.2 Where firms would look for advice on mental health issues

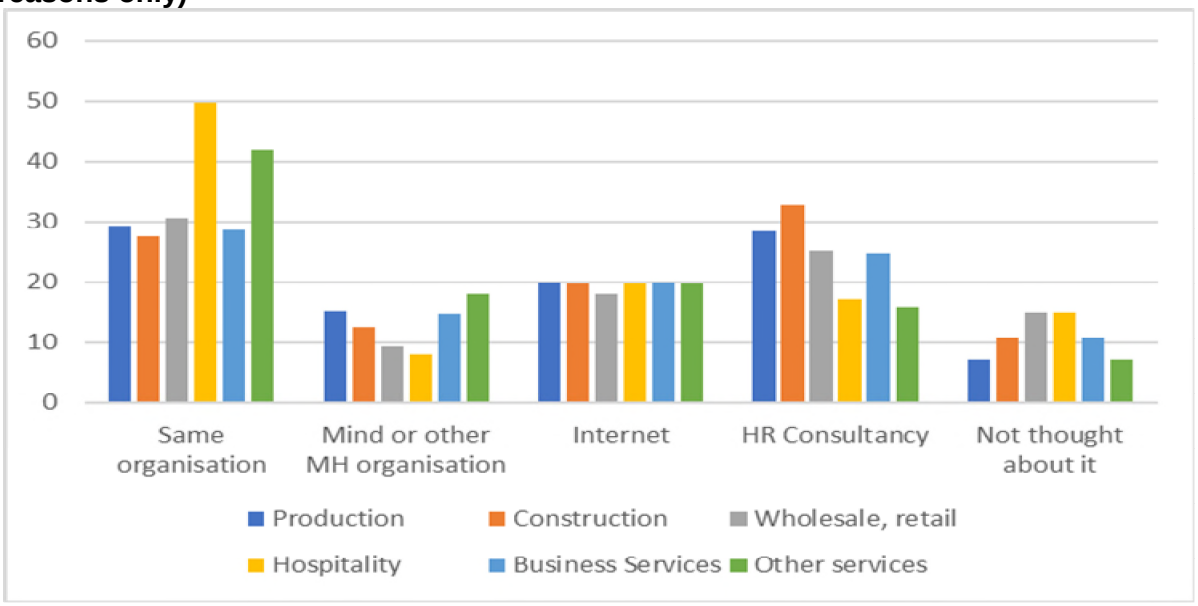


Base: All firms - 1899

Notes: i) Responses are weighted to provide representative results for each region.
ii) QH4: Multi code accepted. Not read out.

The patterns hold true when the data are explored by sector (Figure 9.3). The high proportion of establishments resorting to colleagues within the same organisation in Hospitality and Other Services may reflect a greater proportion of multi-site establishments in those sectors (as seen in Figure 3.4).

Figure 9.3 Where firms would look for advice on mental health issues: by sector (top 5 reasons only)

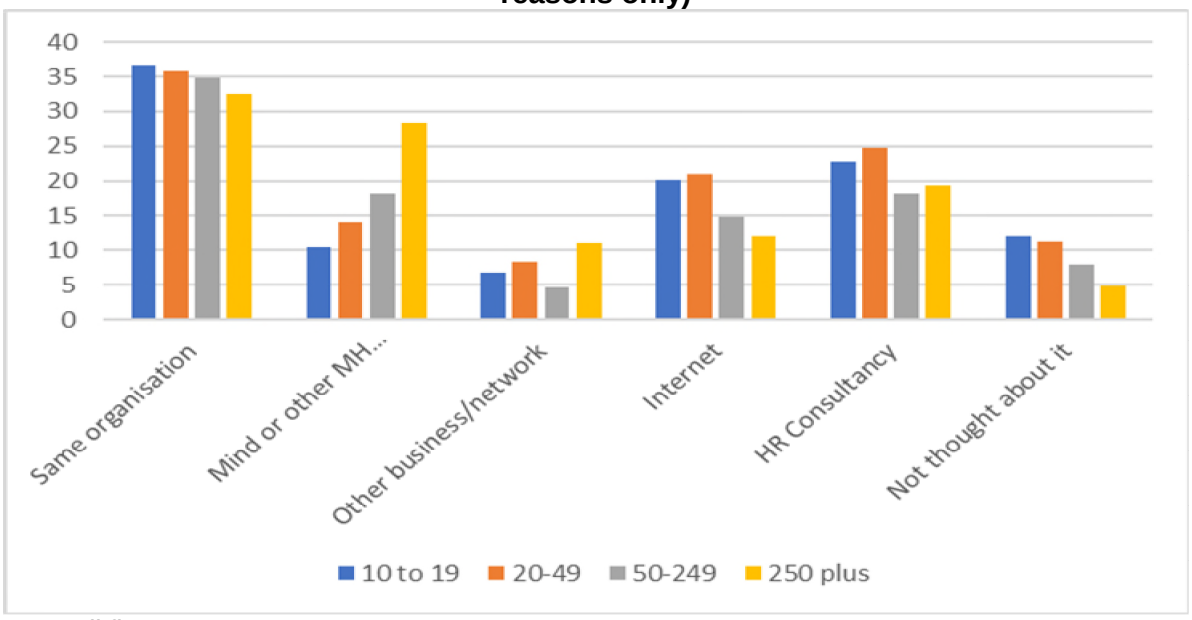


Base: All firms - 1899

Notes: i) Responses are weighted to provide representative results for each region.
ii) QH4: Multi code accepted. Not read out.

By size, larger firms are more likely to approach mental health charities and smaller firms are more likely to use the internet, which suggests that small firms are more likely to 'self-help' rather than resort to potentially 'paid-for' services (Figure 9.4)

Figure 9.4 Where firms would look for advice on mental health issues: by size (top 6 reasons only)



Base: All firms

Notes: i) Responses are weighted to provide representative results for each region.
ii) QH4: Multi code accepted. Not read out.

9.3 Awareness of mental health initiatives

The survey explored awareness and use of a selection of mental health initiatives, shown in Figure 9.5. These are described in Annex 6.

Firms are most familiar with the Mental Health First Aid initiative (MHFA), with four in ten either having used the initiative in the last 12 months (11%) or being aware of it but not having used it (31%). The remaining 57% had not heard of the initiative.

Larger firms were both more likely to have heard of the initiative and used it, with 37% having used MHFA in the last 12 months compared to 6% of the smallest firms. By sector, firms in the Other Services sector are likely to have heard of or used MHFA (36% and 17% respectively), though above average usage is also reported in the Construction (15%) and Business Services (12%) sectors.

Evidence from the qualitative research shows that people became aware of the initiative through channels such as annual health and safety courses and providers ranged from individual consultants to organisations like St John's Ambulance. But does it cover all the issues employers face (e.g. how to deal with unsympathetic colleagues and address stigma in the workplace)

The Health and Safety's Stress Management Standards (HSE) was next most likely to be used or heard of. 31% had heard of this but only 7% had used the Standards in the last 12 months, although this rises to 21% in the largest establishments.

The Time to Change Pledge, established in 2007, was next most likely to be heard of, by 18% of respondents, through only 3% had used this in the last 12 months. This was followed by a broader category of 'A workplace well-being commitment such as Thrive at Work', of which 15% of establishments were aware of but not used and 2% had used. While encompassing the West Midlands initiative, this might also include other initiatives, such as 'Mental Health at Work'. It is perhaps for this reason that awareness is no higher in West Midlands than East Midlands.

The lowest levels of awareness amongst businesses was of the Stevenson/Farmer thriving at Work report. Though this is not a specific toolkit, it has gained much attention amongst government and non-governmental organisations and led to the development or

redevelopment of toolkits, reported in Annex 6. Just 1% had used the report and 5% had heard of it.

9.4 Summary

Although the majority of firms report they would like additional support with mental health in the workplace, there is no single obvious channel through which they would seek advice. Current initiatives are not well-known and few have been used, with the exception of Mental Health First Aiders, for which funding has been available. Though this course was popular with participants in the qualitative research who attended it, and gave them more confidence and awareness of how to deal with mental health issues, it does not seem to cover supporting employers to talk to other colleagues and engender a more generally supportive working environment if it is not already the ethos of the organisation.

This poses challenges for the Mental Health and Productivity Pilot programme and other initiatives in terms of identifying which types of business to focus efforts on (those hard to reach and most likely to need help?) and the difficulty in reaching them.

These issues are discussed further in Chapter 10.

Figure 9.5: Awareness and use of mental health initiatives

	Stevenson/Farmer report		HSE Stress Management Standards		Time to Change Pledge		Mental Health First Aid		A workplace well-being commitment such as 'Thrive at Work'	
	Used in last 12 months	Heard of, not used	Used in last 12 months	Heard of, not used	Used in last 12 months	Heard of, not used	Used in last 12 months	Heard of, not used	Used in last 12 months	Heard of, not used
All Firms	1	5	7	31	3	18	11	31	2	15
East Midlands	1	4	7	29	3	17	11	30	2	14
West Midlands	1	5	6	32	2	18	12	32	2	15
Production	1	4	6	34	2	17	8	34	2	11
Construction	*	4	6	31	1	15	15	30	2	12
Retail	1	4	6	28	1	14	9	23	2	11
Hospitality	0	5	6	29	2	21	6	24	1	22
Business Services	2	5	7	27	3	19	12	36	3	15
Other services	1	6	7	35	5	20	17	36	4	17
10 to 19	*	4	5	26	2	15	6	26	1	13
20 to 49	1	4	7	29	2	20	11	33	2	13
50 – 249	1	8	8	45	5	22	24	39	5	22
250+	6	14	21	37	9	19	37	32	5	23

Base: All firms
Note: Responses are weighted to provide representative results for each region

CHAPTER 10: CONCLUSIONS AND IMPLICATIONS

10.1 Introduction

In this chapter we draw together the vast amount of data collected through the literature review; survey and qualitative research to reflect on the key messages. We also draw out implications for practice and for further research.

10.2 Businesses in the Midlands and the Mental Health and Productivity Logic Model

As a part of the research we developed a Mental Health and Productivity Logic Model and assessed the baseline position of firms against the logic model to inform on current practices and behaviour. The logic model is populated with survey data in Figure 10.1. This section explores each section of the logic model drawing on evidence from the survey and the qualitative research.

10.2.1 Inputs

A third of establishments (35%) have a **health and well-being lead** and a fifth (22%) have a mental health plan. There is low **engagement with existing mental health initiatives**, and very few establishments have a dedicated **budget for mental health and well-being activities** (12%). Although we cannot compare to other sources, this would appear to be quite low levels of demonstrable leadership, policies and allocation of resources, identified as important inputs in the Literature Review.

The qualitative research, which sampled establishments specifically based on whether they had reported mental health sickness absence and/or reported providing any mental health and well-being activities proactively, did tend to find that firms which implemented activities had strong leadership of the issue in the workplace, whether by the owner (s) or senior managers.

10.2.2 Activities

The activities explored included the assessment of need; policies and practices; line management; treatment and tackling stigma.

Assessment and identification of need

Five in six establishments (85%) regularly **measured or monitored sickness absence** and four fifths (80%) **recorded the reasons for sickness absence**. This suggests initially quite a high level of assessment of need, or at least monitoring of existing sickness absence. However, half of this proportion, 40%, **used data to monitor employee health and well-being**, raising questions concerning the efficacy of any activity in this area if firms are not fully aware of the extent and nature of the problem. This is further evidenced by the proportion of establishments which reported that they **did not know the broad reasons for mental health sickness absence** in their firm.

Participants in the qualitative research were most likely to report informal means of **identifying** mental health problems through the establishment of personal relationships through line managers or managers with responsibility for HR issues. Noting changes in behaviour seemed to be the main way of identifying need. There is a risk if line managers are not trained or able to identify or respond to this, noted particularly in larger establishments, that issues will not be identified. Remote working also makes the identification of need more difficult. One larger firm noted a need to act on well-being through an engagement survey, but this formal engagement mechanism did not seem to be commonly used in the establishments interviewed.

As in the quantitative research, the qualitative research revealed the importance of issues outside work, such as pre-existing conditions, and personal or family issues as causes of mental health sickness absence. Some employers reported greater prevalence of some issues in their sectors due to people being attracted to that sector for different reasons (e.g. PTSD of ex-army personnel in haulage; people on autistic spectrum in computer programming). Within the workplace issues included:

- Increasing customer expectations;
- Remote working;
- Insecure contracts.

Policies, practices and services

Almost all establishments reported ensuring staff have **good physical working conditions, opportunities for development and a healthy work-life balance**. One employer in the

qualitative research emphasised the importance of good physical working conditions by commenting:

> *We moved premises recently, a godsend mentally cos the old place was a cave. Now we're in bright, clean, warm and better premises which is helping attitude and well-being*
>
> Works Manager, Small manufacturer, East Midlands

At least three-quarters of establishments also reported that employees have **variety in their work, control over their work and access to flexible working**.

Almost half of firms had introduced **new technologies**, and of those firms which reported an impact of the new technology on staff health and well-being, the majority said this was positive, helping staff to do their jobs and reducing stress.

The minority (22%) of firms with a **mental health plan** appeared to be implementing good practice in carrying it out. The majority (68% of those with a mental health plan) reported that the plan was based on feedback from employee and 89% were **implementing and communicating** the plan. This suggests that the minority which are taking action are doing so in an engaged and considered way, as further evidenced through the qualitative research and the examples provided in Chapter 8.

Between a quarter and a half of firms provided activities associated with other aspects of well-being. 46% provided **healthy food and drinks**; three in ten (30%) provided **financial well-being advice**; a similar proportion provided support for **physical activities** and 26% offered **training aimed at building personal resilience**.

It is important to recall that some of the establishments might employ just 10 people, and all of these additional activities were less likely to be provided in small establishments. The qualitative research also suggests that some of these will be more difficult where staff are remote working, either through being on the road or because they are home-based.

Line managers have a critical role to play in supporting mental health and well-being in the workplace. They can spot early warning signs of increased absence, presenteeism or changed behaviour in the workplace. They have most opportunity to talk to colleagues who may be experiencing difficulties and represent the broader management's position on mental health and well-being – whether positive or negative – as shown in the qualitative research. The

survey informs us that of those which offered mental health activities, 80% ensured all staff have **regular conversations about mental health with their managers**. Fewer (48%) have **trained line managers** in aspects of mental health over the last 12 months. The qualitative research highlighted the challenges of having what might be difficult conversations and challenges even experienced managers had in supporting staff with mental health problems. Managers in the qualitative research were not, largely, seeking to avoid the issue but were concerned about how to handle it. This was an important benefit of the Mental Health First Aid courses many participants had been on – giving confidence to managers in what their role should be and where the boundaries are. However, these courses did not seem to support managers in tackling stigma associated with mental ill-health more broadly across the workplace.

Treatment

As a legal requirement, it is unsurprising that almost all establishments which offered mental health and well-being activities reported **making adjustments** to those who need them to support their mental health (93%) and 66% had **in-house mental health support services** or signposted to other services. The responses are illustrated in the qualitative research and include:

- Job-re-design/task reallocation
- Redeployment
- Seeking to implement advice from specialist websites (e.g. to support team cohesion)
- Line manager training.

There were a small number of examples of staff leaving the business where adjustments seemingly could not be made. In one particular example, this related to older workers having difficulty in adapting to the introduction of new technology.

Broadly, the qualitative research echoes the quantitative research in that managers are supportive and will seek to make adjustments to accommodate staff with mental health difficulties. They appear to be using their knowledge of the individual and the parameters of their own operations to make this work.

Tackling stigma

Finally, in this section on actions, we have seen that 65% of establishments which reported offering mental health and well-being activities had delivered **awareness raising training for staff** in the last 12 months. This would seem to be a relatively high proportion and reflects a number of comments in the qualitative research regarding the increasing prominence of mental health issues.

The importance of tackling stigma was vital in the qualitative research and something most participants seemed to find difficult, in terms of challenging the response of colleagues without breaching confidentiality. The impression that people were not really ill was, in some workplaces, difficult to challenge, as highlighted by one participant:

> *if you've never experienced or you don't understand and then you know the people are off but yet you're also aware that they are doing stuff out of work while they're off.*
> Practice manager, Medium Veterinary Practice, East Midlands

A third of establishments which offered mental health and well-being activities **had employee mental health champions**. These are thought to be important to raise the profile of mental health and promote openness. In a similar vein, 39% of establishments which offered mental health and well-being activities had **internal and external reporting of their approach to mental health** – another indicator of transparency.

More common though was **encouraging open conversations about mental health** and support available when colleagues are struggling, with 94% of establishments reporting taking this approach. This was more prevalent amongst the smaller establishments in the survey and reflects the qualitative research in which participants commented that it was easier to encourage openness amongst colleagues in smaller workplaces (and in offices, as opposed to remote working).

10.2.3 Outputs

Some of the outputs of the activities in the Mental Health and Productivity Logic Model cannot be addressed in a survey of employers: reporting of increased knowledge and trust in line manager relationships and increased understanding of the scale of mental health prevalence. However, where possible, some indicators have been used to provide an assessment of the output of these activities.

As an indicator of coherence of the well-being offer, most establishments which reported **mental health sickness absence believed they managed** it fairly or very effectively (88%) and in the majority of cases this is supported by the qualitative research which demonstrates the range of ways businesses have supported employees with mental health issues. However, does this amount to a coherent well-being offer?

Also, just 39% of those which offered mental health and well-being activities took steps to **evaluate the impact** of those activities. 60% of those which offered mental health and well-being activities reported at least some **improvements in mental health and stress management at wor**k and 51% reported **reduced work-related stress/mental health absence**. Of course, these are self-reported indicators and do not prove causality but do suggest some positive outputs of some activities. Overall though, the concern must be that given the scale of the association between productivity and mental health absence (Chapter 7 and below), are employers really doing enough to support people with mental health problems and to prevent them arising? And is what they are doing of sufficient quality, coherence and set within a broader approach to management that values employees?

10.2.4 Outcomes

Critical outcomes will be changes recorded to absenteeism and presenteeism and therefore reduced costs to employers. In this regard, the survey provides an essential baseline.

Figure 10.1 provides the data for headline outcomes within the Mental Health and Productivity Logic Model:

- 33% of establishments in the Midlands report **presenteeism**
- 41% report **long-term** general sickness absence
- 33% report **repeated** general sickness absence
- 31% report **mental health** sickness absence.
- An overall staff turnover rate of 10.4%

Do activities impact on the reporting of these issues, as suggested by the evidence? The regression analysis did not suggest that the implementation of mental health and well-being activities impacted on the likelihood to report long-term sickness absence or mental health sickness absence. Only the use of data to monitor mental health was associated with a greater likelihood to report mental health sickness absence, but this may be down to better data rather

than a greater likelihood to have mental health and well-being activities. Having a senior lead for mental health is slightly more likely to be associated with reporting long-term sickness absence.

This does not mean that the Model is invalid. We cannot measure the *quality* of the activities undertaken, we have not analysed how individual activities fit within the fuller range of activities or within a wider strategy. There are also other variables not included in the survey which might be important, such as the function of the organisation or remote working. These factors are all likely to play a part in determining the success of interventions. However, this provides a strong argument for further longitudinal study to assess changes in these trends over time.

Another means of assessing the outcome is through employers' own perceptions of the outcomes of mental health and well-being activities (some of which was reported within 'Outputs' above). Less than one in three (28%) report that the activities have helped with **staff recruitment**; 46% report **reduced staff turnover**; 47% report activities led **to improved customer service**; 50% report **improved business performance** and 57% **improved job satisfaction** levels. This latter is important as we noted in Chapter 5 that for many employers, a good, positive workplace with high morale was a definition of good mental health, and as we have seen in Chapter 2, this is a channel for improving productivity.

However, the qualitative research also revealed that few employers which had reported mental health sickness absence or offered mental health and well-being activities **formally recorded the impact on the firm** of mental health sickness absence. They were aware that there are increased costs associated with covering for absence and reduced efficiency or other burdens in terms of reallocating work across the team. They also noted the impact on the well-being of other employees.

The survey also informs us whether there are associations between mental health sickness absence and productivity and we have seen some stark impacts:

- Long-term sickness is associated with productivity which is lower by 27.2 per cent;
- Mental health sickness absence is associated with productivity which is lower by 18.3 per cent; and
- Firms reporting a situation in which mental health impacted their performance was associated with productivity which is lower by 24.5 per cent.

If firms do not formally record the impact of mental health sickness absence on their firms then they might well be under-estimating the impact. The qualitative research revealed that as well as providing modifications for employees experiencing difficulties, there was also a tendency to 'muddle through'. Perhaps the lack of information on how much poor health costs firms and impacts on productivity leads to sub-optimal responses to address reactively or proactively.

Larger firms and those with a higher proportion of people with disabilities are more likely to report that mental health issues affect performance, but the regression analysis largely showed that the likelihood of impact is not linked to the broad range of establishment characteristics, employee characteristics, employment practices or mental health and well-being activities. Thus, the productivity impacts can happen to any firm.

As with outputs, the data is a strong baseline from which to track change in outcomes.

10.3 Conclusions

Overall, the results of our research suggest there is much more than can be done to 'level up' establishments across the Midlands to reflect those which are more fully implementing the range of good practices associated with well managed workplaces from a mental health perspective. However, as a substantial minority are not currently offering any such activities, or intending to do so, this will likely take some time, as there is evidence that a coherent approach takes time and the right firm context (function, management, availability of resources) to develop.

The size of firm is also important. Smaller firms appear to have an advantage of being able to know staff better, spot warning signs and take action. Larger firms may be more distant, or rely on-line managers to act as conduits. If they are untrained or unaware, this could be a stumbling block. However, larger firms are more likely to have a budget allocated to these types of activity.

The research also tells us that sickness absence and mental health sickness absence has significant impacts on productivity, reducing productivity by 18% in the case of mental health sickness absence. But we have seen that firms are unlikely to record the additional costs or reduced efficiencies associated with mental health sickness absence so they may not be aware of how costly sickness absence can be.

Although the majority of employers reported that issues outside work were the main cause of mental health sickness absence, they did also acknowledge a responsibility for the mental health of their employees and the qualitative research identified a number of factors employers associated with poor mental health including remote working, insecure contracts and client demand.

Client demand was also a factor in the reporting of presenteeism and this raises questions about workplace cultures attuned to 'just in time' and cost-saving working practices.

These issues are all present for employers to address in supporting mental health and well-being, and we have seen many examples where with compassionate leadership, firms can do this, but for other it is more difficult.

Another challenge is tackling stigma and negative attitudes toward colleagues who are absent due to mental health issues. Employers need to strike a balance between alleviating frustrations felt by colleagues and respecting privacy of the employee affected.

However, providing this support may prove difficult as employers do not tend to use existing sources of mental health support and would be most likely to rely on their own organisation, an HR consultancy or an internet search for support. There would appear to be low awareness amongst employers that help and support is available and low awareness of the routes to access it.

What does all this mean for policy, practice and research? We turn to consider this in the final sections.

10.3.1 Implications for practice

The research suggests some important considerations for policy and practice.

Getting the message right

The **costs** of presenteeism and poor mental health in the workplace absence are enormous, as shown by Deloitte and this research also shows that **mental health sickness absence is associated with a reduction in productivity of a fifth**.

High staff turnover is also costly. But **putting in place the right structured and proactive activities and working practices** (dealing with mental health in the same way as physical health issues are dealt with) could reap rewards by reducing the impact of poor mental health in the workplace. This is especially the case for workplaces where risk factors are unavoidable (e.g. for those engaged in remote working).

Employers **seem to recognise their responsibility in this regard, but also appear not to be aware of the best sources of help and advice with putting the right activities into practice.** This provides a supportive and positive opportunity to approach the issue with businesses.

Using the right messengers

It is important to carefully consider the routes to reach employers. **Many employers do not currently usually consider mental health charities or government bodies when they look for support in these issues.**

We found some examples of firms **working with sector/professional bodies** on mental health issues. Working with such bodies could provide an effective means of targeting a significant number of employers with messages and solutions tailored to their circumstances and through trusted intermediaries. Overall, there is a need for **greater partnership working between employers, HR professionals, sector bodies and mental health charities.**

Employers are also likely to use internet searches, therefore it is important to ensure that relevant websites are accessible and readily found by employers.

What do employers want?

The Mental Health First Aider course is well-regarded but could be supplemented by **supporting employers to deal with stigma and addressing frustrations of colleagues** – which may in themselves lead to further mental health problems.

One size will not fit all. Small firms don't necessarily want more support – **they don't want to become *obliged*** to do activities that would not fit them but would fit larger firms. Being supportive without prescription will be an important factor.

The research suggests a need to build up to a coherent approach and this is unlikely to be achieved quickly from a standing start. **Supporting employers to acknowledge and overcome barriers at the outset** (stigma, resources) could be a useful stepping-stone into the many emerging sources of guidance.

Appointing a mental health lead within a firm, particularly in larger firms which experience more sickness absence due to mental health related reasons would also be an effective and practical way of taking action forward in a coherent and strategic way.

Remote working presents difficulties in terms of increased likelihood of mental health issues due to isolation or being away from home or away from access to workplace support. It also impacts on the ability of employers to identify mental health problems. Firms use a variety of ways to observe differences in the behaviour of remote workers, but the ability to support them was identified as more difficult and requiring bespoke solutions. Tailoring support for remote workers could be a useful 'hook' to engage employers.

Employers do tend to **record the reasons for sickness absence but not the impact**. Enabling greater recording and transparency may encourage a greater recognition of the issue and what firms can do to address it.

This research raises an important broader **cultural issue**. Increasing client expectations and the demands of customers are cited as causes of presenteeism and mental health sickness absence. How can an initiative recognise and tackle those complex and deep rooted cultural factors? Does the impact of Coronavirus provide an opportunity to think differently about workplaces **and client/supplier relationships**?

10.3.2 Implications for research

The research provides a wealth of data and an important baseline. A further future survey (for example in 2 years) will deliver longitudinal data to allow further analysis of what factors impact on mental health sickness absence and productivity.

However, in the shorter-term, there is an opportunity to use this research to identify detailed analysis of the differences made to mental health in the workplace and how employers respond to it brought about by the Covid-19 virus. This is particularly important given the

findings on remote working. Fieldwork for this research finished in the week before the UK introduced formal lockdown measures. This provides us with some potential opportunities:

- Return to the 20 firms interviewed in the qualitative research in the next few months to discuss the impact of the virus on their approaches to managing mental health and sickness absence;
- Use the survey to identify a sample of businesses employing 'key workers' to conduct qualitative research on their current experiences[10];
- Repeat the survey in 2 or 3 years to assess the changes brought about at a wider scale.

In all future research we would suggest more emphasis on **remote working** given the changes brought by Covid-19, and understanding the impact of this specifically on mental health and productivity.

Although this report is substantial, there is some further analysis which could be conducted, e.g. exploring whether there are different experiences for firms depending on whether they adopt a 'basket' of the high performance working measures included in the survey or **defining and measuring the adoption of a 'coherent well-being offer'**.

The findings on the introduction **of new technology** are interesting and do not support the hypothesis that this would negatively impact on well-being. Further research on the types of new technology introduced and how they were introduced would be valuable to understand this more in the context of apparent greater use of technology in the workplace (at least in facilitating more home-working, on-line education and so on) because of Covid-19.

Our research is based entirely on the perspective on employers, and in this regard, is unusual. It would, however, be useful to conduct **research with employees**, in the same firms, to explore their perspective and fill some of the evidence gap on the outputs of activities as reported by employees.

Previous research has demonstrated that mental health and well-being issues in the workplace are growing and are expected to continue to grow in the future. The issues

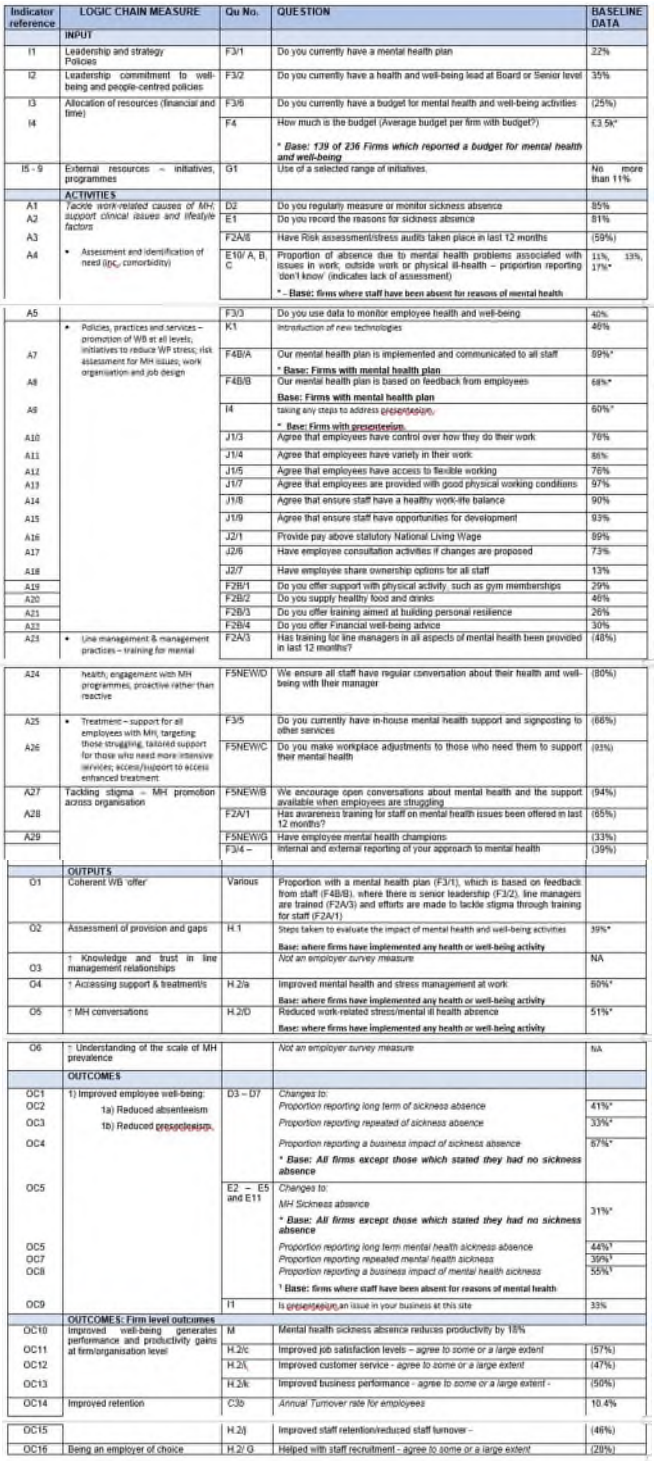
[10] The qualitative research focussed on priority sectors in the Midlands, which does not generally correspond with Coronavirus key worker sectors, so there is scope to conduct refocussed qualitative research drawing on the private sector, key worker establishments in the survey who agreed to be followed up.

have in fact become vastly more important in the few weeks since the fieldwork for this study concluded with the advent of Covid-19 which is having major impacts on working life in the UK. This research provides a powerful evidence base that can enable employers and policymakers to assess the mental health impacts of Covid-19 and to mitigate the longer-term impact on productivity and the economy.

Figure 10.1 Populated Mental Health and Productivity Logic Model

Notes:

1. Data in brackets denotes where asked of a sub-sample of the 40% of establishments which reported providing mental health activities, and is therefore not a proportion of all firms.
2. Where data is based on other sub-samples this is described in the 'Question' Column and indicated with a * or 1.



Indicator reference	LOGIC CHAIN MEASURE	Qu No.	QUESTION	BASELINE DATA
	INPUT			
I1	Leadership and strategy Policies	F3/1	Do you currently have a mental health plan	22%
I2	Leadership commitment to well-being and people-centred policies	F3/2	Do you currently have a health and well-being lead at Board or Senior level	35%
I3	Allocation of resources (financial and time)	F3/6	Do you currently have a budget for mental health and well-being activities	(25%)
I4		F4	How much is the budget (Average budget per firm with budget?) ***Base: 139 of 236 Firms which reported a budget for mental health and well-being***	£3.5k*
I5 - 9	External resources – initiatives, programmes	G1	Use of a selected range of initiatives.	No more than 11%
	ACTIVITIES			
A1	*Tackle work-related causes of MH; support clinical issues and lifestyle factors*	D2	Do you regularly measure or monitor sickness absence	85%
A2		E1	Do you record the reasons for sickness absence	81%
A3		F2A/8	Have Risk assessment/stress audits taken place in last 12 months	(59%)
A4	• Assessment and identification of need (inc. comorbidity)	E10/ A, B, C	Proportion of absence due to mental health problems associated with issues in work; outside work or physical ill-health – proportion reporting 'don't know' (indicates lack of assessment) *** - Base: firms where staff have been absent for reasons of mental health***	11%, 33%, 17%*
A5		F3/3	Do you use data to monitor employee health and well-being	40%
	• Policies, practices and services – promotion of WB at all levels; initiatives to reduce WP stress; risk assessment for MH issues; work organisation and job design	K1	*Introduction of new technologies*	46%
A7		F4B/A	Our mental health plan is implemented and communicated to all staff ***Base: Firms with mental health plan***	89%*
A8		F4B/B	Our mental health plan is based on feedback from employees **Base: Firms with mental health plan**	68%*
A9		I4	taking any steps to address presenteeism ***Base: Firms with presenteeism***	60%*
A10		J1/3	Agree that employees have control over how they do their work	76%
A11		J1/4	Agree that employees have variety in their work	86%
A12		J1/5	Agree that employees have access to flexible working	76%
A13		J1/7	Agree that employees are provided with good physical working conditions	97%
A14		J1/8	Agree that ensure staff have a healthy work-life balance	90%
A15		J1/9	Agree that ensure staff have opportunities for development	93%
A16		J2/1	Provide pay above statutory National Living Wage	89%
A17		J2/6	Have employee consultation activities if changes are proposed	73%
A18		J2/7	Have employee share ownership options for all staff	13%
A19		F2B/1	Do you offer support with physical activity, such as gym memberships	29%
A20		F2B/2	Do you supply healthy food and drinks	46%
A21		F2B/3	Do you offer training aimed at building personal resilience	26%
A22		F2B/4	Do you offer Financial well-being advice	30%
A23	• Line management & management practises – training for mental	F2A/3	Has training for line managers in all aspects of mental health been provided in last 12 months?	(48%)
A24	health; engagement with MH programmes; proactive rather than reactive	F5NEW/D	We ensure all staff have regular conversation about their health and well-being with their manager	(80%)
A25	• Treatment – support for all employees with MH, targeting those struggling, tailored support for those who need more intensive services; access/support to access enhanced treatment	F3/5	Do you currently have in-house mental health support and signposting to other services	(66%)
A26		F5NEW/C	Do you make workplace adjustments to those who need them to support their mental health	(93%)
A27	Tackling stigma – MH promotion across organisation	F5NEW/B	We encourage open conversations about mental health and the support available when employees are struggling	(94%)
A28		F2A/1	Has awareness training for staff on mental health issues been offered in last 12 months?	(65%)
A29		F5NEW/G	Have employee mental health champions	(33%)
		F3/4 –	Internal and external reporting of your approach to mental health	(39%)
	OUTPUTS			
O1	Coherent WB 'offer'	Various	Proportion with a mental health plan (F3/1), which is based on feedback from staff (F4B/B), where there is senior leadership (F3/2), line managers are trained (F2A/3) and efforts are made to tackle stigma through training for staff (F2A/1)	
O2	Assessment of provision and gaps	H.1	Steps taken to evaluate the impact of mental health and well-being activities **Base: where firms have implemented any health or well-being activity**	39%*
O3	↑ Knowledge and trust in line management relationships		*Not an employer survey measure*	NA
O4	↑ Accessing support & treatment/s	H.2/a	Improved mental health and stress management at work **Base: where firms have implemented any health or well-being activity**	60%*
O5	↑ MH conversations	H.2/D	Reduced work-related stress/mental ill health absence **Base: where firms have implemented any health or well-being activity**	51%*
O6	↑ Understanding of the scale of MH prevalence		*Not an employer survey measure*	NA
	OUTCOMES			
OC1	1) Improved employee well-being:	D3 – D7	*Changes to:*	
OC2	1a) Reduced absenteeism		*Proportion reporting long term of sickness absence*	41%*
OC3	1b) Reduced presenteeism		*Proportion reporting repeated of sickness absence*	33%*
OC4			*Proportion reporting a business impact of sickness absence* ***Base: All firms except those which stated they had no sickness absence***	87%*
OC5		E2 – E5 and E11	*Changes to:* *MH Sickness absence* ***Base: All firms except those which stated they had no sickness absence***	31%*
OC5			*Proportion reporting long term mental health sickness absence*	44%[1]
OC7			*Proportion reporting repeated mental health sickness*	35%[1]
OC8			*Proportion reporting a business impact of mental health sickness* [1] **Base: firms where staff have been absent for reasons of mental health**	55%[1]
OC9		I1	Is presenteeism an issue in your business at this site	33%
	OUTCOMES: Firm level outcomes			
OC10	Improved well-being generates performance and productivity gains at firm/organisation level	M	Mental health sickness absence reduces productivity by 18%	
OC11		H.2/c	Improved job satisfaction levels – *agree to some or a large extent*	(57%)
OC12		H.2/i	Improved customer service - *agree to some or a large extent*	(47%)
OC13		H.2/k	Improved business performance - *agree to some or a large extent* -	(50%)
OC14	Improved retention	C3b	*Annual Turnover rate for employees*	10.4%
OC15		H.2/j	Improved staff retention/reduced staff turnover -	(46%)
OC16	Being an employer of choice	H.2/ G	Helped with staff recruitment - *agree to some or a large extent*	(28%)

ANNEX 1: LOGIC MODEL DEVELOPMENT METHODOLOGY

The logic model is developed utilising the results of a rapid evidence review. To derive the logic model, evidence was needed about the linkages between mental health and productivity at the firm level. The evidence review was designed to source this evidence. This includes assessing the evidence for an overall relationship between the two concepts of interest – mental health and productivity, but also identifying the causal linkages between them as well as mediating factors in the relationship.

The evidence review uses the principles of a systematic review to develop an approach to source, screen, collate and assess the evidence (based on an adapted version of the EPPI-Centre [2002]), but sets additional parameters to account for the relative time and resource requirements of a full systematic review. The parameters of the search are set-out in the following Figures:

- Figure 1 lists the academic sources searched for relevant studies.
- Figure 2 provides the list of keywords used to search for literature. These keywords include mental health and well-being and productivity, as well as other terms which studies might use to measure firm performance.
- In addition to the academic search a small number of individual organisations were also searched; these are listed in Figure 3.

Throughout the searching inclusion has been limited to studies published between 2000-2019. In addition to the searches set-out in the Figures, some material has been incorporated based on ad hoc searches, citations from key papers, and material already known to the research team.

Papers were screened for relevance initially using the title; a subsequent additional screen was then carried-out on the abstracts of short-listed papers. After this sift, the papers were reviewed in full using a proforma designed to record relevant and consistent information – this includes, where available, information on the relationship between mental health and productivity, the mechanisms through which mental health is linked to productivity, evidence on the links between mental health and the work environment and mediating factors in the various relationships; evidence was also recorded on the methodologies.

The review was undertaken between September and November 2019; after the abstract screen 23 papers were taken forward to full review.

Figure A1: Academic sources searched

ASSIA (Applied Social Science Index & Abstracts)
Business source complete
s (in EBSCO)
Google Scholar
Scopus
Medline/PubMed
Public Health Database

Figure A2: Matrix of search terms for academic literature – abstract search

“Health” OR “Well-being”
AND
“Mental”
AND
“Productivity” OR “Performance” OR “Profit”
AND
“Firm” OR “Business” OR “Organisation” OR “Organization” OR “Company” OR “Companies” OR “Corporation”

Figure A3: List of repositories searched

Eurofound
European Trade Union Institute
ILO
OECD
RAND
The Work Foundation
Centre for Mental Health
Department for Work and Pensions
King’s Fund
What Works Centre – Well-being

ANNEX 2: SURVEY METHODOLOGY

Sample design

The Mental Health and Productivity survey aimed to provide baseline information on mental health and productivity in a representative sample of private business establishments across the East and West Midlands. The survey focussed on private for-profit firms, social enterprises and organisations in the charity and voluntary sectors. Local government and central government funded organisations were excluded. Establishments which had been operating for less than three years and those with less than 10 employees were also excluded.

The survey was based on establishments - defined as any business unit within the region. This was to ensure the responses were focussed on the Midlands region and avoided being re-directed to Headquarters of firms outside the region. To avoid interviewing multiple business units within the same firm (e.g. a number of Costa branches) no more than one branch per company group was included when making our sample selection.

Employees were defined as excluding owners and partners, agency staff and contractors but including other directors and temporary and casual staff.

The population of interest for this survey was non-government funded organisations with 10 or more employees based across the East and West Midlands. A randomised sample of relevant organisations was purchased from Dun & Bradstreet.

A disproportionate stratified sampling approach was adopted and targets were proposed in a 66-cell grid comprised of 11 grouped sectors[11] (ABDE, C, F, G, H, I, J, K, LMN, PQ, RS), region (East and West Midlands) and size (10-19, 20-49, 50+). Organisations with 10-19 employees were intentionally under-sampled as they accounted for the majority of the population universe. Larger organisations were therefore over-sampled to ensure they were adequately represented and to allow more robust sub-analysis.

[11] Using SIC 2007 definitions. See Table 1 for further definition of sectors.

The ratio of contacts to target interviews was 7:1. When unusable numbers were accounted for the actual ratio of contacts per interview was 6:1.

Questionnaire design and piloting

The intention of the questionnaire was to address the high-level questions of the research detailed in Chapter 1 and to provide data to populate the Logic Model on the mental health and well-being approaches and activities in firms and on firm outcome data.

The survey is intended to be replicated to track changes in these factors from this 2020 baseline, and therefore it was important to be fully confident of the reliability and validity of the questions. Thus, our initial approach was to trawl existing business surveys to examine and adopt or adapt existing questions.

Much of the available data on mental health issues and employment come from surveys of individuals (for example Mental Health at Work YouGov survey conducted for Business in the Community (BITC) and Mercer Marsh Benefits). The main survey of employers on health at work has been conducted by CIPD, and the latest iteration in association with Simplyhealth (CIPD, 2019). Our research revealed no survey of businesses which covered the issues of mental health *and* firm performance. However, in addition to the CIPD survey, there are a number of surveys which covered the business activities, outcomes and external factors identified in the Logic Model, such as:

- Longitudinal Small Business Survey (BEIS, 2017),
- *Management Practices and Productivity in British production and services industries – initial results from the Management and Expectations Survey* (ONS, 2018)
- and Employer Skills Survey 2017.

These sources were used to develop an initial long list of existing questions in the fields we were interested in.

This exposed some gaps specifically with regard to exploring approaches to management of mental health issues and engagement with mental health activities and initiatives. A number of sources were referenced to explore the types of activities undertaken by employers to explore in the questionnaire.

In particular, we focussed on the Standards in the Stevenson/Farmer report (2017) and the subsequent Mental Health at Work Commitment. To develop a metric for extent of engagement with these standards within the Midlands, we included questions which would provide at least a proxy indicator for adherence to the six standards within the Commitment, subject to the constraints of the complexity of the Actions within the Standard and of translating these to a valid telephone questionnaire.

Other sources used to inform this section include:

- Health and Safety Executive's Guidance on managing stress;
- CIPD and Simply Health, 2019, *Health and Well-being at Work*
- HSE *Management Standards on Workplace Stress*
- IES, 2019 *Mental health training for managers? A case of caveat emptor*
- King's Fund, 2019, *NHS sickness absence: let's talk about mental health*
- NICE *Workplace Health: management practices.* guideline 13
- Mind's Workplace Well-being Index

The literature review for the Logic Model and the sources cited above highlighted the complexity of factors which contributed to good mental health at work, beyond the provision of specified activities to issues such as management practices and job design (e.g. Bevan, 2019). There is a wide body of literature on the 'future workplace' and how the introduction of technology is displacing or disrupting jobs. This survey allowed us to explore, for the first time, whether firms had introduced new technology and the impact of this on employee mental health as well as questions on working practices from previous business surveys, notably the Employer Skills Survey.

Finally, to explore whether firms with different characteristics of employees were more or less likely to report mental health problems, we explored the age and gender profile of employees; how many had limiting long-term disability and how many were from a non-white background. We also explored qualification level which, together with the sector, would give us a proxy for types of roles and skill levels of employees.

The questionnaire was piloted with 21 firms on 11th and 12th December 2019 by the survey company OMB Research. The pilot interviews exceeded the target time of 20 minutes by some distance, with the mean interview length at 30 minutes and the shortest interview 21 minutes. This required a careful review of the breadth and depth of coverage of the

questionnaire. Some questions previously asked of all employers were filtered, specifically those concerned with take-up of activities to reduce the length and improve the interview experience for respondents. Other questions were shortened from a five-scale Agree/Disagree response to a Yes/No response and the number of initiatives asked about in Section G was reduced due to low response.

Consent for future contacts and data use

In addition to providing baseline information on mental health and productivity across the region another objective of the survey was to identify a cohort of firms which might be willing to participate in other subsequent elements of the Mental Health and Productivity Pilot project. Seeking this consent required a number of additional questions to be included. This was the focus of questions N1 to N6C in the telephone questionnaire (see Annex 3).

Explicit consent for re-contact and future data use was in three parts. First, respondents were asked whether they would be willing to be re-contacted as part of future research. Specifically, question NI asked:

> *'The research team will be conducting some more detailed research on the issues we have covered here in the coming weeks. This might include telephone interviews and/or discussions in small groups. Would it be OK if one of our colleagues from the research team at either the University of Warwick or the Midlands Engine contacted you by telephone or email initially to see if this is something you could help with?*

Where this question received a positive response telephone and/or email details were taken from the respondent. Note that the form of words adopted here allow the respondent to decline any future research participation. Around 70.0 per cent of respondents gave a positive response to this question (68.8 per cent East Midlands, 71.0 per cent West Midlands).

A second question on data use relates to data matching, i.e. the potential to link MH&P survey data to other public data sources such as longitudinal data on business performance. This was asked as follows (question N5):

> *'It is sometimes possible to link the data we have collected with other government surveys or datasets to enable further statistical analysis. Would you be happy for this to be done?'*

Around 76.8 per cent of respondents gave a positive response to this data matching question (76.3 per cent East Midlands, 77.2 per cent West Midlands).

Finally, respondents were asked whether they would be interested in participating in further aspects of the Mental Health and Productivity pilot project (question N6A):

> *'Finally, the team at Midlands Engine would like to contact survey participants with information on how the Mental Health and Productivity Pilot programme can support them to improve the mental health of their employees. Would you be willing for us to pass on your contact details to the team at the Midlands Engine so that they could contact you in future with this information?'*

Around 54.5 per cent of respondents gave a positive response to this data matching question (52.4 per cent East Midlands, 56.2 per cent West Midlands).

Fieldwork

The survey was conducted using Computer Assisted Telephone Interviewing (CATI). This is proven to be the best means of reaching the appropriate personnel within a business, typically with much better response rates than administering an online survey. Within each organisation, the most senior person with responsibility for the health and well-being of workers was sought to be interviewed.

The survey was conducted between 6th January 2020 and continued until the 20th March. The final week of interviewing coincided with the first week of restrictions on movement due to the Coronavirus outbreak. In total, 1,899 CATI interviews were completed. This represents about 1:40 firms in the target population. The mean interview length on completion of fieldwork was 21 minutes.

The profile of achieved interviews, broken down by region, size and sector are detailed in Figure A2.1 below.

Table A2.1. Profile of achieved interviews

	Total	East Midlands			West Midlands		
		10-19	20-49	50+	10-19	20-49	50+
ABDE – Primary and utilities	72	21	4	11	14	11	11
	3.8%	*1.1%*	*0.2%*	*0.6%*	*0.7%*	*0.6%*	*0.6%*
C - Manufacturing	292	51	50	33	62	64	32
	15.4%	*2.7%*	*2.6%*	*1.7%*	*3.3%*	*3.4%*	*1.7%*
F - Construction	139	26	19	21	28	21	24
	7.3%	*1.4%*	*1.0%*	*1.1%*	*1.5%*	*1.1%*	*1.3%*
G – Wholesale, Retail	320	66	52	22	108	49	23
	16.9%	*3.5%*	*2.7%*	*1.2%*	*5.7%*	*2.6%*	*1.2%*
H – Transport and Storage	82	14	6	20	18	8	16
	4.3%	*0.7%*	*0.3%*	*1.1%*	*0.9%*	*0.4%*	*0.8%*
I – Accommodation and food	204	54	27	20	46	37	20
	10.7%	*2.8%*	*1.4%*	*1.1%*	*2.4%*	*1.9%*	*1.1%*
J – Information and communication	71	15	8	10	10	12	16
	3.7%	*0.8%*	*0.4%*	*0.5%*	*0.5%*	*0.6%*	*0.8%*
K – Financial and insurance	73	11	8	15	11	12	15
	3.8%	*0.6%*	*0.4%*	*0.8%*	*0.6%*	*0.6%*	*0.8%*
LMN – Business services	324	61	45	28	104	58	28
	17.1%	*3.2%*	*2.4%*	*1.5%*	*5.5%*	*3.1%*	*1.5%*
PQ – Public services	236	51	39	20	65	40	21
	12.4%	*2.7%*	*2.1%*	*1.1%*	*3.4%*	*2.1%*	*1.1%*
RS – Arts and other services	86	10	10	17	26	7	16
	4.5%	*0.5%*	*0.5%*	*0.9%*	*1.4%*	*0.4%*	*0.8%*
Total	1,899	380	268	217	492	319	222
	100%	*20.0%*	*14.1%*	*11.4%*	*25.9%*	*16.8%*	*11.7%*

Response rate

The outcomes of attempted calls can be divided into four broad categories:

- Completed interviews;
- Refusals (direct refusals by target respondent; terminated interviews; and where the 'gatekeeper' – a receptionist, PA or colleague – refuses to put the call through);
- 'Unusable' numbers. These indicate both 'screen outs', e.g. organisations falling outside of the scope of the survey, as well as dead phone lines, wrong numbers, etc.;
- Contacts still live at the end of fieldwork (appointments made with target respondent; answer phones; no reply; etc.).

Table A2.2 Response rate

	Total	East Midlands	West Midlands
Total number of records	13,938	6,417	7,521
Unusable	2,509	1,116	1,393
% Unusable	18%	17%	19%
Total usable records	11,429	5,301	6,128
Completed Interviews	1,899	866	1,033
Response Rate	17%	16%	17%
Refusals	3,028	1,501	1,527
Refusal Rate	26%	28%	25%
Live	6,502	2,934	3,568

Weighting

The survey oversampled larger firms to ensure adequate cell sizes across sectors. This means weighting is necessary to account for this structured sampling and also any differential response between cells. A relatively simple region x sector x sizeband structure was adopted with the population drawn from the Office of National Statistics data on the Activity of UK businesses 2019, Figure 18 - Number of VAT and/or PAYE based local units within region by Standard Industrial Classification (SIC) division and employment sizebands. Survey responses are given in Figure A2.3 and the derived frequency weights are included in Figure A2.4

Table A2.3: Number of survey responses

	Employment sizeband				
	10-19	20-49	50-249	250+	Total
A. East Midlands					
ABDE - Primary + Utilities	20	4	9	3	36
C - Manufacturing	51	50	27	6	134
F - Construction	25	19	19	3	66
G - Wholesale and Retail	64	52	19	5	140
H - Transportation and Storage	14	6	18	2	40
I - Accommodation and Food	54	27	20	0	101
J - Information and Communication	15	8	7	3	33
K - Financial and Insurance Activities	11	8	12	4	35
LMN - Business Services	61	43	25	5	134
PQ - Public Services	51	38	19	2	110
RS - Arts + Other Services	10	10	14	3	37
Total	376	265	189	36	866
B. West Midlands					
ABDE - Primary + Utilities	14	10	8	4	36
C - Manufacturing	62	64	27	5	158
F - Construction	28	21	19	5	73
G - Wholesale and Retail	106	48	21	5	180
H - Transportation and Storage	18	8	13	3	42
I - Accommodation and Food	45	36	18	4	103
J - Information and Communication	10	12	9	7	38
K - Financial and Insurance Activities	11	12	10	5	38
LMN - Business Services	104	57	24	5	190
PQ - Public Services	65	40	19	2	126
RS - Arts + Other Services	26	7	10	6	49
Total	489	315	178	51	1,033

Table A2.4: Frequency weights

	Employment sizeband				
	10-19	20-49	50-249	250+	Total
A. East Midlands					
ABDE - Primary + Utilities	20.3	70.0	16.1	8.3	23.8
C - Manufacturing	28.3	23.9	32.0	25.8	27.3
F - Construction	38.2	23.2	11.3	5.0	24.6
G - Wholesale and Retail	61.0	43.6	43.4	24.0	50.8
H - Transportation and Storage	39.6	75.0	19.2	45.0	36.0
I - Accommodation and Food	39.4	51.9	14.3	59.0	37.9
J - Information and Communication	23.7	31.3	16.4	6.7	22.4
K - Financial and Insurance Activities	29.1	18.8	4.6	3.8	15.4
LMN - Business Services	39.3	31.0	34.0	32.0	35.4
PQ - Public Services	51.6	73.0	91.8	60.0	66.1
RS - Arts + Other Services	92.0	47.0	18.2	10.0	45.3
Total	42.6	41.5	30.2	21.3	38.7
B. West Midlands					
ABDE - Primary + Utilities	30.0	24.0	18.8	10.0	23.6
C - Manufacturing	28.0	22.9	35.6	30.0	27.3
F - Construction	37.1	22.6	11.3	5.0	24.0
G - Wholesale and Retail	45.2	57.4	49.0	31.0	48.5
H - Transportation and Storage	35.3	58.8	31.2	31.7	38.2
I - Accommodation and Food	52.1	46.0	22.2	6.3	43.0
J - Information and Communication	47.0	25.4	17.8	4.3	25.4
K - Financial and Insurance Activities	38.2	17.9	9.0	10.0	20.4
LMN - Business Services	31.4	28.4	42.1	47.0	32.3
PQ - Public Services	47.7	76.6	114.7	87.5	67.6
RS - Arts + Other Services	40.2	77.1	27.5	5.0	38.6
Total	39.4	40.7	38.6	19.8	38.7

ANNEX 3: TELEPHONE SURVEY QUESTIONNAIRE

Midlands Engine Mental Health Productivity Pilot

Employer Baseline Questionnaire

OMB Research / Enterprise Research Centre

INTRODUCTION

Good morning/afternoon. My name is xxxx and I'm calling from OMB Research, an independent market research agency.

We've been commissioned by the University of Warwick to conduct a survey about well-being in the workplace with employers in the Midlands. The survey focuses on health and well-being of your workers and how Government policy might be improved to help you with this.

Please could I speak to the most senior person at this organisation with responsibility for these sorts of issues (e.g. Human Resources Manager, Company Director, Partner or similar)?

The survey will take around 20 minutes, depending on your answers. Is it convenient to speak to you now or would you prefer to make an appointment for another time?

ADD IF NECESSARY:

Participation in this survey is voluntary, although your cooperation will ensure that the views expressed are representative of all employers in your industry in the region.

The Government is funding this research through the Midlands Engine, a coalition of Councils, Combined Authorities, Local Enterprise Partnerships, Universities and businesses.

The Midlands Engine is actively working with Government to improve skills, transport and innovation across the region, to make the Midlands a more attractive to place to live, work, study and visit.

If you would like, we will also email you a summary report of our findings as a thank you for taking part once the research has been completed

Your organisation was selected at random from a list purchased from a commercial sample provider.

If you would like to speak to someone about the survey please contact Stephanie Harris (Research Executive, OMB Research) on 01732 220582. Alternatively, if you wish to talk to someone at University of Warwick / Midlands Engine about the research please call Professor Steve Roper on 024 7652 2501 or Dr Vicki Belt on 07469 020687 or vicki.belt@wbs.ac.uk

The research is being conducted under the Code of Conduct of the Market Research Society. If you would like to confirm that OMB Research is a bona fide market research agency, you can contact the Market Research Society on 0800 975 9596.

GDPR CONSENT

The information you provide will be used for research purposes only and will be treated in the strictest confidence. OMB Research will not disclose to University of Warwick who has taken part in the research or divulge specific details about your organisation unless you agree to this at the end of the survey.

You can find out more information about our surveys and what we do with the information we collect in our Privacy Notice, which is on our website (IF NECESSARY: www.ombresearch.co.uk/privacy).

All calls are recorded for training and quality purposes.

ASK ALL

Z1. Before I continue, can I just confirm that you are happy to participate in the survey on this basis? SINGLE CODE.

Yes, agreed to participate in survey	1	CONTINUE
Requested more information	2	SEND INFO EMAIL
No, declined to participate	3	CLOSE

A. FIRM SIZE AND SECTOR SCREENING

ASK ALL

I'd like to start by asking some questions about the structure of your organisation.

ASK ALL

A1 So firstly, is this organisation...?

READ OUT. SINGLE CODE.

A business mainly seeking to make a profit	1	
A charity or voluntary sector organisation or a social enterprise	2	
A local government financed body (e.g. such as a service provided or funded by the council such as leisure centres, social care, waste or environmental health services)	3	CLOSE
A central government financed body (e.g. such as the Civil Service, any part of the NHS, a college or university, the Armed Services, an Executive Agency or other non-departmental public bodies)	4	CLOSE
DO NOT READ OUT: Another type of public sector organisation	5	CLOSE
DO NOT READ OUT: None of the above	6	CLOSE

ASK ALL

A3 And is this specific site…?

READ OUT. SINGLE CODE.

The only site in the organisation, or	1	
One of a number of sites within a larger organisation	2	

ASK ALL

A2 For how many years has the <IF A3=2 **part of the**> **business** <IF A3=2 **based at this site**> **been operating?**

READ OUT. SINGLE CODE.

AS NECESSARY: **This includes under all ownerships and all legal statuses**

Less than 3 years	1	CLOSE
3 to 5 years	2	
More than 5, up to 10 years	3	
More than 10, up to 20 years	4	
More than 20 years	5	
DO NOT READ OUT: Don't know	6	

A3 MOVED BEFORE A2

A4A, A4B, A5 AND A6 - DELETED

ASK ALL

A7A How many people are currently on the payroll as employees < *A3=2* at this specific site >
RECORD NUMBER.
AS NECESSARY: **Please…**
Include full and part time staff
Include temporaries/casuals
Exclude agency staff
Exclude self-employed, contractors
Exclude owners/partners, but count other directors as employees

Write in number	1	IF <10 CLOSE
DO NOT READ OUT: Don't know/refused	2	

IF DK/REF NUMBER OF EMPLOYEES (A7A=2)

A7B Do you know the approximate number of employees < *A3=2* at this specific site >, is it…?

READ OUT. SINGLE CODE.

Under 10	1	CLOSE
10-19	2	
20-49	3	
50-99	4	
100-249	5	
250-499	6	
500 - 999	7	
1,000+	8	
DO NOT READ OUT: Don't know	9	
DO NOT READ OUT: Refused	10	

ASK ALL

A8 Has the number of employees < *A3=2* at this site > increased, decreased or stayed the same over the last 12 months?

PROMPT AS NECESSARY. SINGLE CODE.

Increased	1	
Decreased	2	
Stayed the same	3	
DO NOT READ OUT: Don't know	4	
DO NOT READ OUT: Refused	5	

B. FIRM ACTIVITIES AND OWNERSHIP

ASK ALL

B1. And please can I take a note of your job title?

PROBE AS PER PRECODES – SINGLE CODE.

Owner/Proprietor	1	
Partner/Director	2	
Managing Director	3	
Human Resources Manager/Director	4	
Finance Manager / Director	8	
General Manager	9	
Other (PLEASE SPECIFY)	5	
DO NOT READ OUT: Don't know	6	
DO NOT READ OUT: Refused	7	

C. BUSINESS CHARACTERISTICS

CATI TO ONLY ASK C1 TO 1 IN 10 RESPONDENTS (RANDOMLY SELECTED)

C1 Can you tell me in your own words what you understand by 'good mental health and well-being in the workplace'?

RECORD VERBATIM.

C2 - DELETED

ASK ALL

C3A Do you regularly measure or monitor staff retention or staff turnover < *A3=2* **at this site >?**

SINGLE CODE.

Yes	1	
No	2	
DO NOT READ OUT: Don't know	3	
DO NOT READ OUT: Refused	4	

ASK ALL

C3B Do you know the annual turnover rate for employees < *A3=2* **at this site > in the last 12 months?**

By this we mean the number of employees who left the company in the year, divided by the average number of employees over that time, multiplied by 100.

SINGLE CODE.

Yes: Write in percentage (0-100)	1	
No	2	
DO NOT READ OUT: Don't know	3	
DO NOT READ OUT: Refused	4	

ASK ALL

C4 Would you say that staff turnover < *A3=2* **at this site > is…?**

READ OUT. SINGLE CODE.

Above average for your sector	1	
About average for your sector	2	
Below average for your sector	3	
DO NOT READ OUT: Don't know	4	
DO NOT READ OUT: Refused	5	

D. GENERAL SICKNESS ABSENCE MEASUREMENT AND PRACTICES

ASK ALL

And now thinking about how you manage sickness absence in your establishment…

ASK ALL

D1A Do you offer sick pay for your staff above the level of Statutory Sick Pay?

READ OUT. SINGLE CODE.

Yes – for all staff	1	
Yes – for some staff only	2	
No	3	
DO NOT READ OUT: Don't know	4	
DO NOT READ OUT: Refused	5	

ASK IF OFFER SICK PAY FOR SOME STAFF D1A=2

D1B For which staff or which circumstances do you offer sick pay above the level of Statutory Sick Pay?

AS NECESSARY: **Is it for certain levels of staff, lengths of service etc.**

WRITE IN	1	
DO NOT READ OUT: Don't know	2	
DO NOT READ OUT: Refused	3	

ASK ALL

D2 Do you regularly measure or monitor sickness absence < *A3=2* **at this site >?**

SINGLE CODE.

Yes	1	
No	2	
DO NOT READ OUT: Don't know	3	
DO NOT READ OUT: Refused	4	

ASK ALL

D3 Do you know the average number of sickness absence days <u>per employee</u> < *A3=2* **at this site > in the last 12 months?**

SINGLE CODE.

AS NECESSARY: **If you don't know the exact figure we just need your best estimate**

Yes (Write in number – allow one decimal place, allow zero)	1	
No	2	
DO NOT READ OUT: Don't know	3	

DO NOT READ OUT: Refused	4	

ASK ALL

D4 Would you say that levels of sickness absence < *A3=2* at this site > are…?

READ OUT. SINGLE CODE.

Above average for your sector	1	
About average for your sector	2	
Below average for your sector	3	
DO NOT READ OUT: Don't know	4	
DO NOT READ OUT: Refused	5	

ASK ALL UNLESS D3=ZERO

D5A Over the last 12 months, have any of your staff < *A3=2* at this site > been on long term sickness absence, by which I mean a single absence lasting 4 weeks or more?

Yes	1	
No	2	
DO NOT READ OUT: Don't know	3	
DO NOT READ OUT: Refused	4	

D5B DELETED

ASK ALL UNLESS D3=ZERO

D6 In the last 12 months, have you had any instances of staff taking repeated sickness absence < *A3=2* at this site >? By which I mean individuals taking multiple occasions of sickness absence, whether on a short or long-term basis?

SINGLE CODE.

Yes	1	
No	2	
DO NOT READ OUT: Don't know	3	
DO NOT READ OUT: Refused	4	

ASK ALL

D8 Does sickness absence impact on the operation or performance of your business in any way?

SINGLE CODE.

Yes	1	
No	2	

DO NOT READ OUT: Don't know	3	
DO NOT READ OUT: Refused	4	

ASK IF SICKNESS ABSENCE IMPACTS OPERATION/PERFORMANCE (D8=1) BUT ONLY ASK TO 1 IN 5 WHO QUALIFY (RANDOMLY SELECTED)

D9 What sort of problems does it present?

PROBE AS NECESSARY: **This could be the cost of replacement staff, impact on customer service, delivery of business objectives or staff morale?**

E. REACTIVE/TARGETED RESPONSES TO MENTAL HEALTH PROBLEMS

ASK ALL

E1 Do you record the reasons for any sickness absence < *A3=2* at this site or elsewhere in the organisation>?

READ OUT. SINGLE CODE.

Yes <SHOW IF A3=2 at this site>	1	
SHOW IF MULTISITE A3=2 Yes – elsewhere in the organisation	2	
No	3	
DO NOT READ OUT: Don't know	4	
DO NOT READ OUT: Refused	5	

ASK ALL UNLESS D3=ZERO

E2 In the last 12 months, have any staff been off sick, for any length of time, due to mental health problems, including illnesses such as bipolar disorder, depression, anxiety or stress?

READ OUT. SINGLE CODE.

Yes	1	
No	2	
DO NOT READ OUT: Don't know	3	
DO NOT READ OUT: Refused	4	

ASK IF STAFF HAVE BEEN OFF SICK FOR MENTAL ILL HEALTH (E2 = 1)

E3A What proportion of sickness absence over the last 12 months was accounted for by mental health problems?

RECORD PERCENTAGE.

AS NECESSARY: **By this we mean the number of sickness absence days taken for mental health problems divided by the total number of sickness absence days, multiplied by 100.**

Record percentage (0-100)	1	
DO NOT READ OUT: Don't know/refused	2	

ASK IF DON'T KNOW PROPORTION OF ABSENCE (E3A = 2)

E3B Approximately what proportion of sickness absence was accounted for by mental health problems?

READ OUT. SINGLE CODE.

Less than 25%	1	
26% to 49%	2	
50%	3	

51% to 94%	4	
95% to 100%	5	
DO NOT READ OUT: None	6	
DO NOT READ OUT: Don't know	7	
DO NOT READ OUT: Refused	8	

ASK IF STAFF HAVE BEEN OFF SICK FOR MENTAL ILL HEALTH (E2 = 1)

E4A What proportion of sickness absence due to mental health problems over the last 12 months has been long term, by which I mean a single absence lasting 4 weeks or more?

RECORD PERCENTAGE.

AS NECESSARY: **By this we mean the number of sickness absence days taken for mental health that were long term divided by the total number of mental health sickness absence days, multiplied by 100.**

Record percentage (0-100)	1	
DO NOT READ OUT: Don't know/refused	2	

E4B DELETED

ASK IF STAFF HAVE BEEN OFF SICK FOR MENTAL ILL HEALTH (E2 = 1)

E5 In the last 12 months, have you had instances where staff took repeated sickness absence because of mental health problems?

By this I mean individuals taking multiple occasions of sickness absence, whether on a short or long term basis?

SINGLE CODE.

Yes	1	
No	2	
DO NOT READ OUT: Don't know	3	
DO NOT READ OUT: Refused	4	

E7, E8 AND E9 DELETED

ASK IF STAFF HAVE BEEN OFF SICK FOR MENTAL ILL HEALTH (E2 =1)

E10 What proportion of absence due to mental health problems over the last 12 months was associated with….?

READ OUT STATEMENTS A-C - SINGLE CODE.

		None (0%)	Less than 50%	50%	More than 50%	(Don't know)
A	Issues in work					
B	Issues outside of work					

C	Issues to do with physical ill health					

ASK IF STAFF HAVE BEEN OFF SICK FOR MENTAL ILL HEALTH (E2 =1)

E11 Has the performance or operation of your business been impacted by sickness absence due to mental health problems?

SINGLE CODE.

Yes	1	
No	2	
DO NOT READ OUT: Don't know	3	
DO NOT READ OUT: Refused	4	

IF PERFORMANCE HAS BEEN AFFECTED BY MENTAL ILL HEALTH ABSENCE (E11 = 1)

E12 What sort of problems does sickness due to mental health problems present?

RECORD VERBATIM. PROBE AS NECESSARY: **This could be the cost of replacement staff, impact on customer service, delivery of business objectives or staff morale?**

E13, E14, E16, E17, E15 DELETED

ASK IF STAFF HAVE BEEN OFF SICK FOR MENTAL ILL HEALTH (E2 =1)

E22 In your opinion, how effectively is sickness absence for reasons of mental ill health managed at this establishment?

READ OUT. CODE ONE ONLY

Very effectively	1	
Fairly effectively	2	
Neither	3	
Fairly ineffectively	4	
Very ineffectively	5	
DO NOT READ OUT: Don't know	6	

F. MENTAL HEALTH INITIATIVES

ASK ALL

F1 Do you offer any sort of activities or initiatives to promote good mental health at this workplace?

SINGLE CODE.

Yes – currently offer	1	
No – would offer if needed / plan to offer in future	2	
No – do not currently offer and have no plans to	4	
DO NOT READ OUT: Don't know	3	

ASK ALL

F3 <F1=2-4 Although you do not currently offer any activities to support good mental health, can I check,> Does your business < *A3=2* at this site > **do or have any of the following?**

READ OUT. RANDOMISE ORDER. CODE ALL THAT APPLY.

A mental health plan	1	
A health and well-being lead at Board or Senior level	2	
Use data to monitor employee health and well-being	3	
SHOW IF F1=1: Internal and external reporting of your approach to mental health	4	
SHOW IF F1=1: In-house mental health support and signposting to other services.	5	
SHOW IF F1=1: A budget for mental health and well-being activities	6	
DO NOT READ OUT: None of the above	7	
DO NOT READ OUT Don't know	8	

ASK IF HAVE A BUDGET (F3=6)

F4 Can you tell me how much the total budget for mental health and well-being activities < *A3=2* at this site > **was over the last 12 months?**

RECORD NUMBER.

ADD AS NECESSARY: Please just provide your best estimate

RECORD AMOUNT WHOLE £	1	
DO NOT READ OUT: Don't know/refused	2	

ASK ALL WITH A MENTAL HEALTH PLAN (F3_1=1) - NEW QUESTION

F4B Thinking specifically about your mental health plan, is it….?

READ OUT STATEMENTS. RANDOMISE ORDER. SINGLE CODE PER ROW.

		Yes	No	(Don't know)
A	Implemented and communicated to all staff	1	2	3
B	Based on feedback from employees	1	2	3

ASK IF F1=1

F2A Have any of the following activities taken place at this site in the last 12 months? Please answer yes or no for each.

READ OUT. RANDOMISE ORDER CODES 1-8. CODE ALL THAT APPLY.

Awareness raising for staff on mental health issues	1	
DELETED	2	
Training for line managers in managing mental health	3	
DELETED	4	
DELETED	5	
DELETED	6	
DELETED	7	
Risk assessment/stress audits	8	
DELETED	9	
DELETED	10	
DO NOT READ OUT: None of the above	11	
DO NOT READ OUT Don't know	12	

ASK IF F1=1

F5NEW And thinking about your organisation's approach to mental health and well-being in the workplace, do you do any of the following? So firstly do you….?

READ OUT STATEMENTS. RANDOMISE ORDER. SINGLE CODE PER ROW.

		Yes	No	(Don't know)
A	DELETED	1	2	3
B	Encourage open conversations about mental health the workplace	1	2	3
C	Make appropriate workplace adjustments to those who need them to support their mental health	1	2	3
D	Ensure all staff have a regular conversation about their health and well-being with their manager	1	2	3
E	ASK ONLY IF A7A>500 OR A7B = 7 OR 8	1	2	3

	Have disclosure processes that encourage openness regarding mental health and well-being and provision of a good response			
F	DELETED	1	2	3
G	Have employee mental health champions	1	2	3

ASK ALL – NEW QUESTION

F5B To what extent do you agree or disagree that 'mental health is a personal issue and not one which should be addressed at work'?

SINGLE CODE

Agree strongly	1	
Agree slightly	2	
Neither	3	
Disagree slightly	4	
Disagree strongly	5	
DO NOT READ OUT: Don't know	6	

ASK ALL

F2B Have any of the following been offered or made available to staff at this site in the last 12 months? Please answer yes or no for each.

READ OUT. RANDOMISE ORDER CODES 1-4. CODE ALL THAT APPLY.

Support with physical activity such as gym memberships, cycle to work schemes	1	
Supplying healthy food and drinks	2	
Training aimed at building personal resilience	3	
Financial well-being advice	4	
Any other activities to promote health and well-being? (PLEASE SPECIFY)	5	
DO NOT READ OUT: None of the above	6	
DO NOT READ OUT Don't know	7	

G. AWARENESS AND ENGAGEMENT WITH HWB INITIATIVES

ASK ALL

G1 There are a number of initiatives available intended to help businesses which want to support staff mental health and well-being at work.

In the last 12 months have you used or heard of any of the following services or initiatives?

READ OUT. RANDOMISE ORDER. SINGLE CODE PER ROW.

		Used in the last 12 months	Heard of but not used	Not heard of this initiative	(Don't know)
A	The Stevenson/Farmer report 'Thriving at Work'	1	2	3	4
B	Health and Safety Executive Stress Management Standards	1	2	3	4
C	DELETED	1	2	3	4
D	DELETED	1	2	3	4
E	DELETED	1	2	3	4
F	DELETED	1	2	3	4
G	Time to Change Pledge	1	2	3	4
H	Mental Health First Aid	1	2	3	4
I	A workplace well-being commitment such as 'Thrive at Work'	1	2	3	4

G2 AND G3 DELETED

ASK ALL

G4 Would your organisation like to provide more mental health and well-being support to employees?

SINGLE CODE.

Yes	1	
No	2	
DO NOT READ OUT: Don't know	3	

H. OUTPUTS/OUTCOMES

ASK OF ANYONE WHO HAS DONE ANY KIND OF ACTIVITY IN SECTIONS F OR G (ASK IF G1 A-I=1 OR F1=1 OR F3=1-6)

H1 Does your organisation take any steps to evaluate the impact of its mental health and well-being activities?

SINGLE CODE.

Yes	1	
No	2	
DO NOT READ OUT: Don't know	3	

ASK OF ANYONE WHO HAS DONE ANY KIND OF ACTIVITY IN SECTIONS F OR G (ASK IF G1 A-I=1 OR F1=1 OR F3=1-6)

H2 Have the activities undertaken to improve mental health and well-being for your staff at this establishment achieved any of the following in the last 12 months?

READ OUT. RANDOMISE ORDER. CODE ALL THAT APPLY.

AS NECESSARY IF YES: Is that to a large extent or to some extent?

		To a large extent	To some extent	No	(Don't know)
A	Improved mental health and stress management at work	1	2	3	4
B	DELETED	1	2	3	4
C	Improved job satisfaction levels	1	2	3	4
D	Reduced work related stress/mental ill health absence	1	2	3	4
E	DELETED	1	2	3	4
F	DELETED	1	2	3	4
G	Helped with staff recruitment	1	2	3	4
H	DELETED	1	2	3	4
I	Improved customer service	1	2	3	4
J	Improved staff retention/reduced staff turnover	1	2	3	4
K	Improved business performance	1	2	3	4

H2B AND H3 - DELETED

ASK ALL

H4 Where would your business go for help and advice on how to deal with mental health and well-being issues in the workplace?

DO NOT READ OUT. CODE ALL THAT APPLY.

SHOW IF A3 = 2: Elsewhere in the organisation (including HR or personnel department)	1	
MIND or other mental health organisation	2	
Mental Health at Work website	3	

DELETED	4	
HR consultancy	11	
Other business or other business network (local or sectoral)	5	
Look up on internet	6	
Training provider/college	7	
Other (SPECIFY)	8	
Don’t know where we would go – Not thought about it	9	
Don’t know where we would go – Help/advice not required	10	

H5 - DELETED

I. PRESENTEEISM

ASK ALL

We'd like to now ask some questions about presenteeism, by which I mean staff working when they are unwell and shouldn't be at work, or when staff regularly work over and above their contracted hours.

ASK ALL

I1 Have you had any instances of presenteeism in your business <A3=2 at this site>?

SINGLE CODE.

Yes	1	
No	2	
DO NOT READ OUT: Don't know	3	

IF PRESENTEEISM INSTANCES (I1 = 1)

I2 Is that because staff are working when unwell, or working beyond contracted hours, or is it something else?

CODE ALL THAT APPLY.

Working when unwell	1	
Working beyond contracted hours	2	
Other (SPECIFY)	3	
DO NOT READ OUT: Don't know	4	

IF PRESENTEEISM INSTANCES (I1 = 1)

I3 What are the reasons for these presenteeism instances in your business?

DO NOT READ OUT. PROMPT IF NECESSARY. **CODE ALL THAT APPLY.**

Peer pressure from other colleagues	1	
Pressure from managers	2	
Need to meet deadlines/client demand	3	
Short staffed	4	
Always worked like that here – part of our culture	5	
Job insecurity – might lose their job	6	
They want or need extra hours/money	9	
Other (SPECIFY)	7	
Don't know	8	

PRESENTEEISM INSTANCES (I1 = 1)

I4 Are you taking any steps to address presenteeism?

SINGLE CODE.

Yes	1	
No	2	
DO NOT READ OUT: Don't know	3	

IF TAKING STEPS TO ADDRESS PRESENTEEISM (I4 = 1)

I5 What steps are you taking to address this issue?

DO NOT READ OUT. PROMPT IF NECESSARY. CODE ALL THAT APPLY.

Managers sending people home who are unwell	1	
Training /guidance for line manages to spot warning signs	2	
Leaders role modelling by not working when ill	3	
Investigating its potential causes, e.g. workload	4	
Other (SPECIFY)	5	
(Don't know)	6	

IF NOT TAKING STEPS TO ADDRESS PRESENTEEISM (I4 = 2)

I6 Why are you not taking any steps?

DO NOT READ OUT. PROMPT IF NECESSARY. CODE ALL THAT APPLY.

Essential to meet customer expectations	1	
Not a serious problem/rare	2	
No senior management commitment to address it	3	
It's their choice	6	
Other (SPECIFY)	4	
Don't know	5	

J. HIGH PERFORMANCE WORKING

ASK ALL

J1 Moving on to think about the systems and processes you have in place for your staff more generally, can you tell me to what extent do you agree or disagree with the following statements? So firstly…?

READ OUT. RANDOMISE ORDER. SINGLE CODE PER ROW.

		Agree strongly	Agree slightly	Neither	Disagree slightly	Disagree strongly	(Don't Know)
1	DELETED	1	2	3	4	5	6
2	DELETED	1	2	3	4	5	6
3	Employees have control over how they do their work	1	2	3	4	5	6
4	Employees have variety in their work	1	2	3	4	5	6
5	Employees have access to flexible working	1	2	3	4	5	6
6	DELETED	1	2	3	4	5	6
7	We provide employees with good physical working conditions	1	2	3	4	5	6
8	We ensure staff have a healthy work life balance	1	2	3	4	5	6
9	We ensure staff have opportunities for development	1	2	3	4	5	6

ASK ALL

J2 Does your establishment have any of the following?

READ OUT. RANDOMISE ORDER. CODE ALL THAT APPLY.

Pay rates above the statutory National Living/ Minimum Wage	1	
DELETED	2	
DELETED	3	
DELETED	4	
DELETED	5	
Employee consultation activities if any changes are proposed	6	
Employee share ownership options for all staff	7	
DO NOT READ OUT None of the above	8	
DO NOT READ OUT Don't know	9	

K. TECHNOLOGY

ASK ALL

K1 Has your organisation recently introduced any new technologies to aid business performance?

SINGLE CODE.

ADD IF NECESSARY: New technologies could include internal communications & data sharing tools, new HR systems, Computer Aided Design Software, or networks to enable real-time data sharing with suppliers or customers

Yes	1	
No	2	
DO NOT READ OUT: Don't know	3	

IF INTRODUCED NEW TECHNOLOGIES (K1=1)

K2 Has the introduction of any of these technologies had any notable or reported impact, either positively or negatively, on staff health and well-being?

SINGLE CODE.

Yes	1	
No	2	
DO NOT READ OUT: Don't know	3	

IF NEW TECHNOLOGIES HAD IMPACT ON WELL-BEING (K2=1)

K3 What impact have these new technologies had on staff health and well-being?

RECORD VERBATIM.

INTERVIEWER TO PROBE Which technology? What impact? Has the impact been on any particular staff?).

L. EMPLOYEE CHARACTERISTICS

ASK ALL

I'd now like to move on to ask you a little more about the characteristics of your business.

ASK ALL

L1 Are any of your staff < *A3=2* at this site > on zero hours or temporary contracts?

READ OUT. MULTICODE OPTIONS 1+2, CODES 3-5 EXCLUSIVE.

On zero hours contracts	1	
On temporary contracts	2	
Or, neither	3	
DO NOT READ OUT: Don't know	4	
DO NOT READ OUT: Refused	5	

L2A, L2B, L3A AND L3B DELETED

ASK ALL

L4A Thinking now about your current staff < *A3=2* at this site >, roughly what percentage of them are qualified to Level 4 or above - by Level 4 I mean a degree level qualification or higher, or an HND, HNC or Foundation degree?

RECORD PERCENTAGE.

Write in percentage (0-100)	1	
DO NOT READ OUT: Don't know/refused	2	

ASK IF DK % WITH LEVEL 4 (L4A=2)

L4B Approximately what proportion of your staff < *A3=2* at this site > are qualified to Level 4 or above - by Level 4 I mean a degree level qualification or higher, or an HND, HNC or Foundation degree?

READ OUT AS NECESSARY. SINGLE CODE.

Less than 25%	1	
26% to 49%	2	
50%	3	
51% to 94%	4	
95% to 100%	5	
DO NOT READ OUT: None	6	
DO NOT READ OUT: Don't know	7	
DO NOT READ OUT: Refused	8	

ASK UNLESS 100% AT L4A

L5A And roughly how many have no post-16 qualifications i.e. they only have GCSEs or lower level qualifications?

RECORD PERCENTAGE.

Write in percentage (0-100)	1	
DO NOT READ OUT: Don't know/refused	2	

ASK IF DK % WITH NO POST-16 QUALIFICATIONS (L5A=2)

L5B Approximately what proportion of your staff < *A3=2* at this site > have no post-16 qualifications i.e. they only have GCSEs or lower level qualifications

READ OUT AS NECESSARY. SINGLE CODE.

Less than 25%	1	
26% to 49%	2	
50%	3	
51% to 94%	4	
95% to 100%	5	
DO NOT READ OUT: None	6	
DO NOT READ OUT: Don't know	7	
DO NOT READ OUT: Refused	8	

ASK ALL

L6A What proportion of staff < *A3=2* at this site > are aged…

READ OUT. RECORD PERCENTAGE.

Under 25	1	%
25 to 49	2	%
50 +	3	%
DO NOT READ OUT: Don't know/refused	4	

ASK IF DK AGES (L6A=4)

L6B Approximately what proportion of your staff < *A3=2* at this site > are aged….?

READ OUT. PROMPT WITH BANDS AS NECESSARY. SINGLE CODE PER ROW.

		None	Less than 25%	26% - 49%	50%	51 -94%	95-100%	(Don't know)
A	Under 25	1	2	3	4	5	6	7
B	25- 49	1	2	3	4	5	6	7
C	50+	1	2	3	4	5	6	7

ASK ALL

L7A What proportion of staff < *A3=2* at this site > are from a non-white ethnic group?

RECORD PERCENTAGE.

Write in percentage (0-100)	1	
DO NOT READ OUT: Don't know/refused	2	

ASK IF DK % NON_WHITE ETHNIC GROUP (L7A=2)

L7B Approximately what proportion of your staff < *A3=2* at this site > are from a non-white ethnic group?

READ OUT AS NECESSARY. SINGLE CODE.

Less than 25%	1	
26% to 49%	2	
50%	3	
51% to 94%	4	
95% to 100%	5	
DO NOT READ OUT: None	6	
DO NOT READ OUT: Don't know	7	
DO NOT READ OUT: Refused	8	

ASK ALL

L8A What proportion of staff < *A3=2* at this site > are female?

RECORD PERCENTAGE.

Write in percentage (0-100)	1	
DO NOT READ OUT: Don't know/refused	2	

ASK IF DK % OF FEMALE STAFF (L8A=2)

L8B Approximately what proportion of your staff < *A3=2* at this site > are female?

READ OUT AS NECESSARY. SINGLE CODE.

Less than 25%	1	
26% to 49%	2	
50%	3	
51% to 94%	4	
95% to 100%	5	
DO NOT READ OUT: None	6	
DO NOT READ OUT: Don't know	7	
DO NOT READ OUT: Refused	8	

ASK ALL

L9A What proportion of staff < *A3=2* at this site > have a long-term disability that affects the amount or type of work they can do?

RECORD PERCENTAGE.

AS NECESSARY: **A 'long-term disability' is an illness, health problem or disability that can be expected to last for more than one year**

Write in percentage (0-100)	1	
DO NOT READ OUT: Don't know/refused	2	

ASK IF DK % WITH LONG TERM DISABILITY (L9A=2)

L9B Approximately what proportion of your staff < *A3=2* at this site > have a long-term disability that affects the amount or type of work they can do?

READ OUT AS NECESSARY. SINGLE CODE.

Less than 25%	1	
26% to 49%	2	
50%	3	
51% to 94%	4	
95% to 100%	5	
DO NOT READ OUT: None	6	
DO NOT READ OUT: Don't know	7	
DO NOT READ OUT: Refused	8	

M. TURNOVER

ASK ALL

M1 Can you please tell me the turnover of your business in the past 12 months <A3 at this site>?

RECORD NUMBER.

Write in number (£)	1	
DO NOT READ OUT: Don't know/refused	2	

IF DK/REF TURNOVER (M1=2)

M2 Do you know the approximate turnover of your business in the last 12 months. Is it…?

READ OUT UNTIL ANSWER GIVEN. SINGLE CODE.

Less than £85,000	1	
£85,000 - £99,999	2	
£100,000 - £249,999	3	
£250,000 - £499,999	4	
£500,000 - £999,999	5	
£1m – £1.99m	6	
£2m - £2.8m	7	
£2.81m - £4.99m	8	
£5m - £9.99m	9	
£10m - £14.99m	10	
£15m - £24.99m	11	
£25m or more	12	
DO NOT READ OUT: Don't know	13	
DO NOT READ OUT: Refused	14	

ASK ALL

M3 Compared with the previous 12 months, has your turnover < A3=2 at this site > increased, decreased or stayed roughly the same?

SINGLE CODE.

Increased	1	
Decreased	2	
Stayed the same	3	
DO NOT READ OUT: Don't know	4	
DO NOT READ OUT: Refused	5	

M4. M5, M6. M7, M8 DELETED

ASK IF PRIVATE SECTOR (A1=1)

M9a Is this business family owned?

SINGLE CODE.

AS NECESSARY: **By family owned we mean one which is majority owned by members of the same family.**

Yes	1	
No	2	
DO NOT READ OUT: Don't know	3	
DO NOT READ OUT: Refused	4	

IF FAMILY OWNED (M9A = 1)

M9b And is the business…

READ OUT. SINGLE CODE.

Managed by the founder(s) of the business	1	
Managed by someone else who is a family member	2	
Or, managed by someone who is not a family member	3	
DO NOT READ OUT: Don't know	4	

ASK IF PRIVATE SECTOR (A1=1)

M10a Are your products or services primarily sold…?

READ OUT. SINGLE CODE.

Locally – within 30 miles of your site	1	
Regionally – within the Midlands only (East or West)	2	
Within the UK	3	
Internationally	4	

DO NOT READ OUT: Don't know	5	
DO NOT READ OUT: Not applicable	6	

ASK IF THIRD SECTOR (A1=2)

M10b Does your establishment primarily serve the population…?

READ OUT. SINGLE CODE.

Locally – within 30 miles of your site	1	
Regionally – within the Midlands only (East or West)	2	
Within the UK	3	
Internationally	4	
DO NOT READ OUT: Don't know	5	
DO NOT READ OUT: Not applicable	6	

ASK IF PRIVATE SECTOR & IF PRIMARY MARKET IS NOT INTERNATIONAL (M10A =1-3 OR 5)

M11 Can I just check, do you sell any of your products and services outside the UK?

SINGLE CODE.

Yes	1	
No	2	
DO NOT READ OUT: Don't know	3	

N. CLOSING

READ OUT TO ALL

That's the end of the interview, thank you very much for your time. I just need to run through a few questions to ask your permission for how we use your data.

ASK ALL

N1 The research team will be conducting some more detailed research on the issues we have covered here in the coming weeks. This might include telephone interviews and/or discussions in small groups. Would it be OK if one of our colleagues from the research team at either the University of Warwick or the Midlands Engine contacted you by telephone or email initially to see if this is something you could help with?

AS NECESSARY **The Government is funding this research through the Midlands Engine, a coalition of Councils, Combined Authorities, Local Enterprise Partnerships, Universities and businesses.**

SINGLE CODE

Yes	1	
No	2	

ASK ALL AGREEING TO FURTHER CONTACT (N1=1)

N2 And can I just confirm the best number to contact you on is [SHOW TELEPHONE NUMBER**]?**

SINGLE CODE.

Yes	1	
No - write in number	2	

ASK ALL AGREEING TO FURTHER CONTACT (N1=1)

N2B And can I take a note of your email address please?

SINGLE CODE.EMAIL

Yes – WRITE IN EMAIL	1	
No	2	

ASK ALL

N3 <IF N1=2 For quality control purposes, > Can I just confirm your name?

SINGLE CODE.

Yes - Write in name	1	
No – refused	2	

ASK ALL

N4 If you would like, we can also email you a summary report of our findings as a thank you for taking part once the research has been completed. Would you like us to email you the report?

SINGLE CODE.

IF N2B=YES: Yes	1	
IF N1=NO OR N2B=NO Yes - Write in email	2	
No	3	

ASK ALL

N5 It is sometimes possible to link the data we have collected with other government surveys or datasets to enable further statistical analysis. Would you be happy for this to be done?

SINGLE CODE.

ADD IF NECESSARY: **Your confidentiality will be maintained, and linked data will be anonymised and only used for statistical purposes.**

Yes	1	
No	2	

ASK ALL

N6A Finally, the team at Midlands Engine would like to contact survey participants with information on how the Mental Health and Productivity Pilot programme can support them to improve the mental health of their employees. Would you be willing for us to pass on your contact details to the team at the Midlands Engine so that they could contact you in future with this information?

The data controller would be Coventry University

Your contact information would be held until August 2022

The data will only be accessible to members of the Midlands Engine coalition (AS NECESSARY The Midlands Engine is a coalition of Councils, Combined Authorities, Local Enterprise Partnerships, Universities and businesses).

Contact details will include your name, organisation name, organisation address, telephone number and email address

SINGLE CODE.

Yes	1	
No	2	

IF AGREE TO CONTACT (N6A=1)

N6B And would you be willing for your survey responses to be passed to the Midlands Engine along with your contact details so they can provide you with the most relevant information?

Yes – happy for my survey responses to be passed on to Midlands Engine alongside my contact details	1	
No – I do not want my survey responses to be passed on	2	

IF AGREE TO CONTACT (N6A=1) AND NOT ALREADY CAPTURED EMAIL (N4=3)

N6C And can I take a note of your email address please?

SINGLE CODE.EMAIL

Yes – WRITE IN EMAIL	1	
No	2	

READ OUT TO ALL

Finally, I would just like to confirm that this survey has been carried out by OMB Research and within the rules of the MRS Code of Conduct.

ANNEX 4: QUALITATIVE RESEARCH

To supplement the survey and extract fuller insight on some of the issues identified, 20 qualitative interviews were conducted with employers who agreed to be re-contacted for follow up research.

Sampling strategy and achieved sample

The sample of 20 was split evenly across the East and West Midlands. The 10 employers in each region were then selected on the basis of:

- Whether they had reported some mental ill health absence (question E2)
- Whether they provided any activities to support mental health in the workplace (question F1).

In addition, we attempted to incorporate as many firms within the Midlands Engine 'priority sectors' as possible. This was defined in keeping with the SIC definitions used for the Midlands Engine Science and Innovation Audit (SQW 2016):

<u>Healthcare, Life Sciences and Translational Medicine (NB: our survey only includes private sector firms)</u>

21 - Manufacture of basic pharmaceutical products and pharmaceutical preparations

86 - Human health activities

<u>Creative, Digital and Design Sector</u>

58.2 –Software publishing

59 – Motion picture, video and television programme production, sound recording and music publishing activities

61 – Telecommunications

62 – Computer programming, consultancy and related activities

63 – Information service activities (not 63.9)

74 - Other professional, scientific and technical activities (not 74.2 photography or 74.3 translation)

<u>Energy and Low Carbon Technologies</u>

05 - Mining of coal and lignite

06 - Extraction of crude petroleum and natural gas

09 - Mining support service activities

19 - Manufacture of coke and refined petroleum products

35 - Electricity, gas, steam and air conditioning supply

36 - Water collection, treatment and supply

37 - Sewerage

38 - Waste collection, treatment and disposal activities; materials recovery

39 - Remediation activities and other waste management services

71 - Architectural and engineering activities; technical testing and analysis (shared with creative)

Transport Technologies

29 – Manufacture of motor vehicles, trailers and semi-trailers

30 – Manufacture of other transport equipment

33 – Repair and installation of machinery and equipment **(transport only)**

Advanced Manufacturing and Engineering

20 – Manufacture of chemicals and chemical products

22 – Manufacture of rubber and plastic products

25 – Manufacture of fabricated metal products, except machinery and equipment

26 – Manufacture of computer, electronic and optical products

27 - Manufacture of electrical equipment

29 – Manufacture of motor vehicles, trailers and semi-trailers

42 - Civil engineering

72.1 – Scientific research and development

Agri-food and drink manufacturing and production

10 - Manufacture of food products

11 – Manufacture of beverages

Fieldwork and respondents

Fieldwork was conducted between 10th February and 17th March. The respondent responded to the survey and consented to follow up research. A total of 20 interviews were achieved, 10 in East Midlands and 10 in West Midlands. The distribution across size is shown in the Figure below, and whether or not the respondent was in a priority sector.

	East Midlands	West Midlands	Total
10-19 (small)	4	2	6
20-49 (medium)	3	4	7
50+ (large)	3	4	7
Priority sector	4	4	8
Non-priority sector	6	6	12
Total	10	10	20

Topic areas

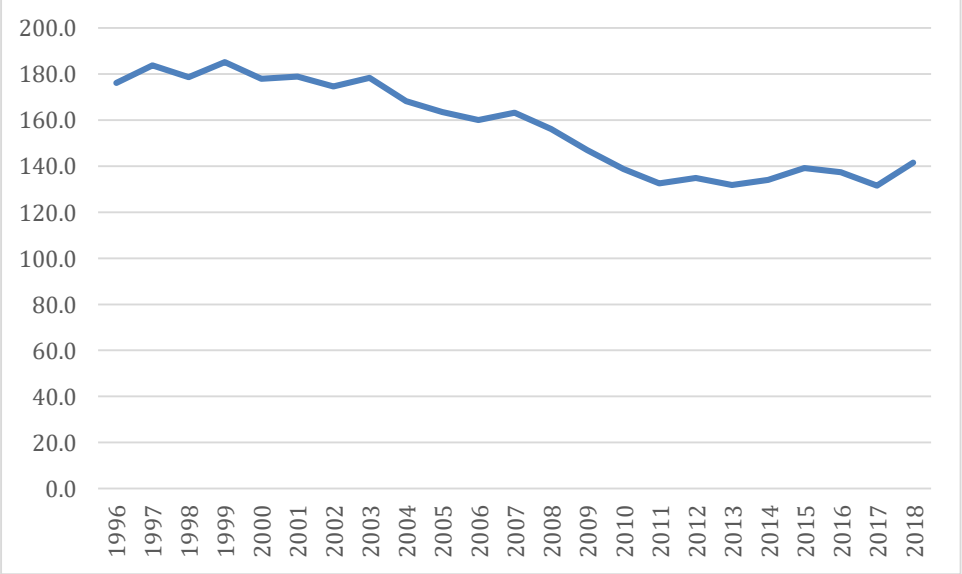
The topic areas covered were

- **Attitudes**: How do employers characterise mental health issues in the workplace? What attitudes do managers/leaders express towards mental health issues?
- **Impacts**: What do they see as the impacts of mental health issues in their workplace? How, if at all, do they measure or track these impacts? How have these impacts, or the measurement of them, changed over time?
- **Policies and practices**: Where do employers go for information and input about mental health issues and mental health policies in the workplace? How do employers characterise their firm's policies and practices related to mental health? How if at all has this changed in recent years? What do they see as the purpose of the policies and practices? How do they monitor and evaluate these policies and practices? Who is responsible for the development, implementation and monitoring of the policies? How does the process work and what resources do they draw on to manage it?
- **Sectoral variation:** How, if at all, do attitudes, impacts and policies/practices vary among sectors?

ANNEX 5: ADDITIONAL SURVEY EVIDENCE

There are two key sources of data on sickness absence. The Office for National Statistics (ONS) draws on the Labour Force Survey. In November 2019, ONS reported the latest UK Sickness absence rates and reported an estimated 141.4 million working days were lost because of sickness or injury in the UK in 2018, the equivalent to 4.4 days per worker and 2% of all working hours. This is a slight increase on the lowest level recorded in 2017, but still shows relatively flat levels since 2010, as shown in Figure A5.1.

Figure A5.1 Total number of days lost through sickness absence 1996 - 2018



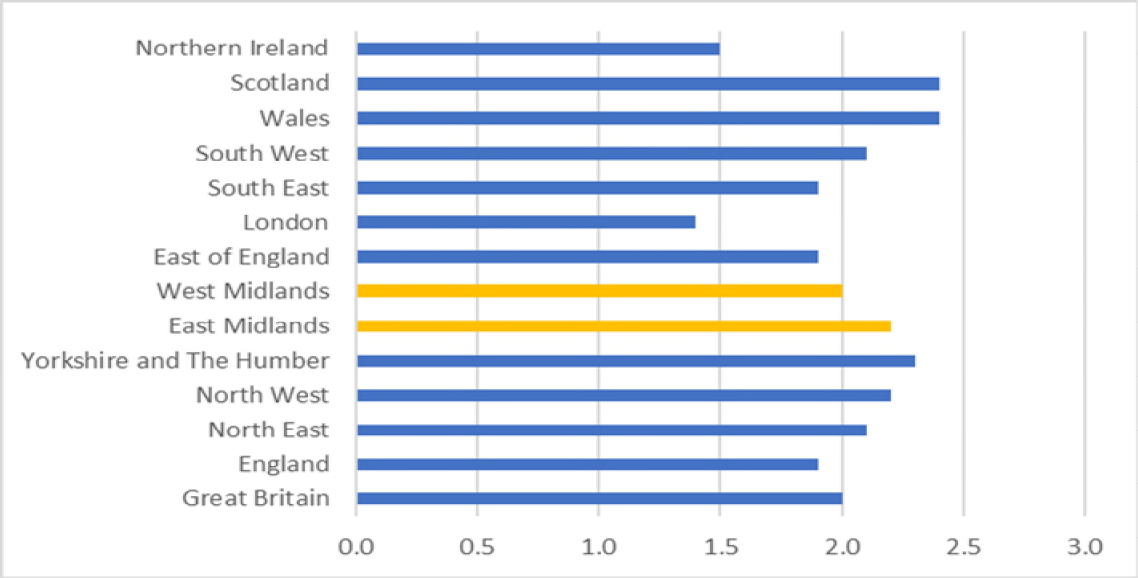
Source: Office for National Statistics Labour Force Survey 2019

The groups with the highest rates of sickness absence in 2018 were women, older workers, those with long-term health conditions, people working part-time, and those working in organisations with 500 or more employees. Sickness absence levels have been relatively stable since 2010. But the long-running survey also reports that since 1997, workers with long-term health conditions, workers aged 50 to 64 years, and those in the public sector have seen the greatest reduction in sickness absence rates.

Minor illnesses (including coughs and colds), musculoskeletal problems (including back pain and neck and upper limb problems), “other” conditions (including accidents, poisonings and diabetes), and mental health conditions (including stress, depression and anxiety) are the four most common reasons for sickness absence in 2018.

By region, London had the lowest sickness absence rates and Wales the highest. West Midlands was on par with the UK average (2%) while the rate was higher in the East Midlands at 2.2%

Figure A5.2: Sickness Absence rates across the UK



Source: Office for National Statistics Labour Force Survey 2019

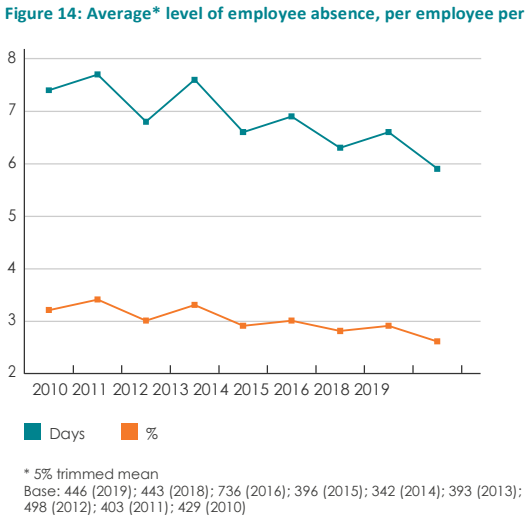
ONS also reports on the likelihood of groups reporting sickness absence using Logistic regression. This technique allows an examination of how each independent variable impacts on the likelihood of sickness absence given that all other factors remain equal. 'From January 2018 to December 2018, the likelihood of reporting sickness absence (when controlling for different factors that may influence sickness) for different groups were:

- by sex, 39% higher for women relative to men
- by age, 41% lower for workers aged 16 to 24 years, 24% lower for workers aged 25 to 34 years and 21% lower for workers aged 35 to 49 years, all relative to those aged 50 years to State Pension age
- by sector, 8% higher for workers in the public sector relative to workers in the private sector
- by size of organisation, 40% higher for workers in organisations with 500 and over employees relative to workers in organisations with fewer than 25 employees

- by occupation group, 12% lower for managers and senior officials relative to those working in professional roles, but 52% higher for workers in the caring, leisure and other service occupations sector'.[12]

The Labour Force Survey is a survey of individuals. CIPD have long undertaken a survey of businesses to produce estimates of the levels of sickness absence. The latest survey, published in 2019, shows that absence levels were at the lowest levels ever recorded by the survey, at 5.9 days, as shown in Figure A5.3.

Figure A5.3 Sickness absence rates



Source: CIPD, 2019

Larger firms and public sector firms typically have higher levels of sickness absence.

The most common cause of sickness absence is minor illness, with 92% of respondents citing this within the top 3 reasons for short-term absence, 53% reported musculoskeletal injuries within the top 3, followed by 47% citing stress and 33% Mental health. However, mental health reasons are the most common reason for long-term sickness absence, as shown in the following Figure.

12 https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/articles/sicknessabsenceinthelabourmarket/latest

Figure A5.5: Top three most common causes of long-term absence

Mental ill health (for example clinical depression and anxiety)	59
Stress	54
Musculoskeletal injuries (for example neck strains and repetitive strain injury, including back pain)	54
Acute medical conditions (for example stroke, heart attack and cancer)	45
Work-/non-work-related injuries/accidents	19
Minor illness (for example colds/flu, stomach upsets, headaches and migraines)	17
Recurring medical conditions (for example asthma, angina and allergies)	16
Caring responsibilities for children	4
Other caring responsibilities (for example for elderly/ill relative)	2
Absence due to non-genuine ill health (unexplained)	2

Source: CIPD, 2019

Both CIPD and ONS point to the same trends, but suggest different scales. One is a survey of individuals representative of all the working population, one a survey of employers electing to complete the survey.

The CIPD survey explores the steps taken by businesses to address stress. In the 2019 survey report, 71% of firms were taking steps to identify and reduce stress at work; but only 46% of those believed those efforts are effective.

With regard to managing mental health, 9% had a standalone mental health policy and 33% reported that mental health was part of another policy. The Figure below shows that phased return to work and reasonable adjustments (61%) are the most common type of action to manage employee mental health, closely followed by a more proactive response of increasing awareness of mental health issues across the workforce (60%). Fewer train managers to support staff with mental ill health (40%) and 31% offer Mental Health First Aid training.

Bevan (2019) has cautioned that the evidence on Mental Health First Aid training is, to date, confined to immediate post-training responses of participants rather than on any impact on the workplace. The Government is investing £15m to get people trained to MHFA and therefore it warrants attention on its effectiveness. IES suggest that awareness raising

is necessary but not sufficient to improve mental health at work and it ‘places too little emphasis on preventative measures such as risk assessment and job design’

ANNEX 6: EXISTING ADVICE AND GUIDANCE FOR EMPLOYERS

Our literature review highlighted a number of existing guidance and frameworks to support employer intervention in the workplace on mental health and/or well-being. There is a less explicit focus on productivity and more of a general focus on a business case and doing the best for employees and wider society. This Annex summarises some of the key frameworks available.

Stevenson/Farmer report: Thriving at Work: The Independent Review of Mental Health and Employers: This extensive review focused on the role of business in supporting people with mental health problems to stay in, and thrive, at work. The report recognised the need for wider societal change in attitude to mental health, through an approach that started with employers. The vision articulated in the report is that in ten years' time the following changes will have happened:

- Employees in all types of employment have good work, which contributes positively to their mental health, our society and our economy.
- Every one of us will have the knowledge, tools and confidence, to understand and look after our own mental health and the mental health of those around us.
- All organisations, whatever their size, will be: equipped with the awareness and tools to not only address but prevent mental ill health caused or worsened by work; equipped to support individuals with a mental health condition to thrive from recruitment, and throughout the organisation; aware of how to get access to timely help to reduce sickness absence caused by mental ill health.

They set out six "mental health core standards", based on the available evidence (though they articulate that more evidence is needed) which they believed all organisations can achieve quickly:

- Produce, implement and communicate a mental health at work plan;
- Develop mental health awareness among employees;
- Encourage open conversations about mental health and the support available when employees are struggling;
- Provide employees with good working conditions and ensure they have a healthy work life balance and opportunities for development;
- Promote effective people management through line managers and supervisors;
- Routinely monitor employee mental health and well-being.

They also set out more ambitious standards for employers who can lead the way:

- Increase transparency and accountability through internal and external reporting
- Demonstrate accountability
- Improve the disclosure process
- Ensure provision of tailored in-house mental health support and signposting to clinical help

The **Time to Change Employer Pledge**[13]**,** led by mental health charities, is a commitment to change 'the way we all think and act about mental health in the workplace' and was launched in 2007. The commitment is supported by a 12-month Employer Action Plan[14] which was reshaped following the Stevenson-Farmer report and aligns to the six core standards above.

In a similar vein, in October 2019, the **Mental Health At Work Commitment** was launched by UK businesses, mental health charities and non-governmental organisations. The intention is to get businesses to sign up to the commitment and promote staff well-being. This also built on a variety of sources, including the Thriving At Work review, and comprises six, different, standards:

- Prioritise mental health in the workplace by developing and delivering a systematic programme of activity
- Proactively ensure work design and organisational culture drive positive mental health outcomes
- Promote an open culture around mental health
- Increase organisational confidence and capability
- Provide mental health tools and support
- Increase transparency and accountability through internal and external reporting

[13] ttps://www.time-to-change.org.uk/get-involved/get-your-workplace-involved/employer-pledge
[14] https://www.time-to-change.org.uk/get-involved/get-your-workplace-involved/employer-pledge/develop-your-action-plan

Also in 2019, the Health and Safety Executive published its **Management Standards on Workplace Stress**. HSE's Management Standards 'cover six key areas of work design that, if not properly managed, are associated with poor health, lower productivity and increased accident and sickness absence rates'. The Management Standards are:

- Demand – this includes issues such as workload, work patterns and the work environment
- Control – how much say the person has in the way they do their work
- Support – this includes the encouragement, sponsorship and resources provided by the organisation, line management and colleagues
- Relationships – this includes promoting positive working to avoid conflict and dealing with unacceptable behaviour
- Role – whether people understand their role within the organisation and whether the organisation ensures that they do not have conflicting roles
- Change – how organisational change (large or small) is managed and communicated in the organisation[15]

Guidance on implementing the Standards is based on HSE's 'five steps to risk assessment' approach, encompassing:

1. Identify the Stress Risk factors - using the Management Standards;
2. Decide who might be harmed and how – gather data
3. Evaluate the risks – explore problems and solutions;
4. Record findings – develop and implement action plans;
5. Monitor and review – assess effectiveness

In the West Midlands**, Thrive at Work** is a free health and well-being accreditation programme for workplaces, created by the West Midlands Combined Authority. This looks beyond just mental health and also encompasses physical health, musculoskeletal issues, and organisational issues such as health and safety and manager training. Businesses can be accredited at three levels:

- Bronze, focusing on providing accurate and appropriate information to help employees to make healthier choices
- Silver, focusing on understanding employees' health needs and taking direct action to prevent poor health

[15] http://www.hse.gov.uk/stress/standards/

- Gold, about becoming an expert in understanding employee needs and developing strategies to improve employee health and well-being in an active, monitored and sustainable way.

Businesses which sign up receive a toolkit which guides to local and national resources, policies and services that can help put the commitment into practice. Accredited businesses receive the Thrive at Work Well-being Award, celebrated at an awards ceremony.

In February 2020, during fieldwork for this project, the IES introduced their **Workplace Well-being Audit**, focusing on supporting businesses to audit an organisation's approach to workforce well-being and ensure it is delivering well implemented and 'paying off'. This emphasised basing activity on a clear understanding of what is happening within the company and on horizon scanning outside the company, and ensuring data informs assessments of what is working and not working to inform action planning.

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