Keep Britain Working

Additional evidence on preventing and managing further disability and ill health at work

Submission by Business Disability Forum  
May 2025

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# Introduction: About Business Disability Forum and this paper

## Who we are

Business Disability Forum (BDF) is a business membership organisation, representing over 600 businesses. We work with businesses, Government, and disabled people to improve the life experiences of disabled employees and consumers by removing barriers to inclusion. We are focussed on making policy as practical as possible to businesses so they can increase inclusion for disabled people in how they operate. Our policy and research team works with our member businesses, and the disabled people who work in and with them, to discuss and debate policy proposals, identify the challenges, and propose as practical solutions as possible that work for everyone.

## About this paper

During March and May 2025, our focus has been on disability, health and work inclusion, via responding to the government’s Equality (Race and Disability) Bill consultation, the equality law call for evidence, and the Access to Work part of the *Pathways to Work* consultation paper, partly as a way of contextualising the ‘background’ to the Keep Britain Working employer review. As a result, our Disability Data Monitoring Group, our Access to Work Forum, and our Work and Health Policy Forum have all had input into informing this paper.

We ran two discussion groups with our Work and Health Policy Forum on the Keep Britain Working review with a total of **71 employers**, and we ran three discussion groups with our Access to Work Forum with a total of **52 employers**. We also held a discussion group on workplace adjustments and support with **17 employees** who have disabilities or neurodiverse conditions. We have therefore spoken to **a** **total of 140 colleagues** from our membership to inform this paper for the Keep Britain Working review (‘the Review’ hereon).

We have also used findings from research we have conducted during the last few years, and we have referred to cases we have supported employers with via our advice and support services. We have referenced statistics and first person quotes where relevant.

## In this paper: A summary

In producing this paper for additional evidence for the Review, we want to show that many employers are doing a lot to support the work related health of their workforces, but that the boundary between what government should be doing and what is an employer’s responsibility can too often be unclear, and employers are increasingly subject to marketing and upselling from work and health providers for services and packages of support they believe they need to provide. This predominantly means high spend on workplace health and wellbeing, but with unclear measures of how well those interventions work, let alone how (and if) these high-cost packages and products are actually helping people to stay in and return to work.

We also want to show five key themes that repeatedly come up in our research, policy and advice work, and conversations with employers:

1. Employers need more support to be clear exactly what government wants them to do in balance with what the government should be doing themselves.
2. There is a lack of policy attention on ensuring employees get adjustments when they need them, and this therefore remains an unfulfilled right and an effective intervention for disabled workers which there has been little effort to enforce.
3. Employers feel there is little quality assurance and regulation of the workplace health and wellbeing sector which also consistently ‘markets’ and ‘upsells’ to them.
4. The NHS is not equipped to provide rehabilitation to the level of getting people back into work following a life changing illness, disability or injury, and the government needs to ensure that fit for purpose interventions are available to any employer and employee who would benefit.
5. Policy debate has shied away from looking into when work is *not* good for people, and where it could be work itself that is causing illness and absence, particularly for disabled workers.

## A note on the language of “prevention”

Our central premise for all of our work at BDF is that disability can happen to anyone at any time. It is unrealistic to “prevent” all ill-health and disability. This current narrative can too easily lend itself to ill-health happening to people who do not look after themselves to any referenceable standard, who have poor health vitals and statistics (such as weight), or due to their life choices (such as drinking and smoking). In reality, and practically, ill-health where these elements are factors account for a small subset of how someone becomes unwell or disabled.

“Preventing” disability is not a narrative we want to encourage in health and work policy in itself in recognition that disability is not wrong, is unpreventable for many, and the many people are born with conditions that will inevitably cause increased disability or ill health as they age. This is why we use the phrase “preventing *further* ill-health and disability”.

## Employers are only one part of the support needed

Employment and the support provided by employers cannot be looked at alone in isolation of all the other policy areas of someone’s life – particularly a disabled person’s life. We know that when a disabled person interacts with the labour market, as a candidate or as a worker, they are often supported ongoingly by the NHS and the social care system to varying extents. When health and social care services fall short of what someone needs, even for a morning – for example, therapy is cancelled or a carer does not turn up – it is not the government or local authority who gets the first call. It’s the employer.

This is why the merging topics of preventing sickness, preventing ill health, and what employers can do to support is not necessarily the right combination. Employers have a role, of course. But employers and their disabled employees are increasingly telling us that reduced health and social care, reduced Access to Work awards, little movement on making public transport accessible, poor availability of accessible housing, a struggling Disabled Facilities Grant system, and the increasing extra costs of being disabled increasing due to higher costs of living and the reduced amount of medication, aids and equipment available on the NHS, all matters for how work-ready a disabled individual is.

A key theme in our discussions with employers for this paper and for the Access to Work element of the *Pathways to Work* paper is whether the balance between what employers and government are doing to support disabled employees is rapidly becoming imbalanced with employers being asked to do more than ever. This caused an employer to ask us if, when we write this paper, we could flip the question they commonly hear from *“Are employers doing enough?”* to *“Are employers doing too much?”* [[1]](#footnote-1) This comes amid the cost-of-living crisis where it was not long ago these same employers were washing employees’ clothes in their workplace’s laundry rooms and having “charge your devices days” each week because so many employees were struggling with the increased cost of energy bills.

# Barriers to employers supporting employees

We asked employers what they felt the challenges and barriers to providing effective support to employees with disabilities and ill-health were. Their responses fell into five themes:

* How “in touch” to be during an employee’s absence.
* The interventions that cost a lot but feel high risk to remove, even though they do not have evidence that these interventions are actually effective.
* When providing too many support options is overwhelming for employees.
* A lack of clarity from government on what a ‘good’ employer should do and provide.
* Noticing that the benefits systems and being an employee are becoming ever closer when supporting employees.

## How ‘in touch’ to be during an employee’s absence

One area of most concern to employers managing an employee who is off sick and navigating how and when that individual can return to work is the anxiety of potential ‘harassment’ claims when an employee is signed off – that is, navigating the circumstances in which it is/not appropriate to keep in regular touch with an employee who is often sick and knowing the ‘line’ between ‘regular contact’ and ‘harassing the employee’.

A common question we receive is “If an employee is off sick due to work related stress, does that change how and when contact should be kept up during their absence?” Workplace policies and guidance rarely cover this, and HR professionals are constantly seeing in HR advice and news stories that can blur or conflict what they feel they are supposed to do: there appear to HR professionals to be as many employment tribunal reports on employers not keeping in touch with an employee enough as there are about employers contacting employees too much during their sickness absence. Yet there is little statutory guidance for employers to follow on this.

## High spend but low return interventions

Employers tell us their spend on interventions such as Employee Assistance Programmes (EAPs) and mindfulness is high but not solving the problems of improving absence levels and workplace health. However, employers tell us that while some costly interventions are not necessarily effective, they do serve as good ways to engage employees in considering their health or just simply enjoy being at work more or view their employer more positively (that is, “look at all the benefits our employer provides for us”). Mental health related training, courses, and events were cited as examples of this. There were also high-cost interventions that employers felt they needed to use, but that they did not feel were resolving their workplace health and absence issues. The most common example here was occupational health (when used at the wrong time and for the wrong situations).

One employer commented that *“We want employees’ time at work to feel good”* and they therefore offer time per week within someone’s job to do *“a wellbeing thing such as exercise or movement”*.[[2]](#footnote-2) Others said they offer lunchtime stretch and yoga classes. However, when we asked what uptake of these were like, employers told us that ‘one off’ wellbeing events – such as stretching or yoga – get higher take up than when they are more regular, and that EAP is not widely used, but counselling and coaching opportunities have a huge take up.

We generally found that employers are trying to ‘do the right thing’ by providing support for their workforce and alleviating pressure from primary health care (such as GPs) by providing EAPs, 24/7 private GP access, and/or private medical insurance. However, employers often commented that they do not know what to do for the best. Some employers gave the same example of when they had provided all of their employees with access to a specific EAP, and then some of those employers then saw those companies covered on investigative journalism documentaries. These documentaries had revealed the EAP providers’ ineffective and, at times, dangerous practices when supporting workers. Then employees get upset, because they too see these programmes, and this creates an internal employee relations ‘backlash’ for the employer to deal with. The ‘exasperation’ from many employers is “What is the best right thing to do?” and “What does good look like when purchasing health products and services from the private sector for thousands of people (employees)”?

## Too much support can be a stressful thing

Employees often say that their workload prevents them from taking up additional activities related to wellbeing or health during working hours because of their heavy workload. Disabled employees particularly commonly report to us that they often have to work longer or ‘make up the hours’ if they want to attend a health or social care appointment, have time for therapies to manage their condition, compress their hours, or take part in their organisations’ disability network. One employee commented that employers ask employees to do a lot at work which is actually not about their job – that is, they have to do their job, take part in team building or social events, they are encouraged to take up health and wellbeing activities (that usually are not accessible for disabled people[[3]](#footnote-3)), and they are also encouraged to join their disabled employee network as well. It caused one employee who has autism to explain that they really just wanted to say to their employer *“just let me work”.*

## Employers want clarity on what the government needs them to do

In our Access to Work Forum discussion groups which – at time of writing – are informing our response to the *Pathways to Work* consultation paper, the key term that has emerged is “clarity”. Employers want clarity on what their role is versus what the government provides. The same applies in wider workplace health and adjustments support. Employers were not clear what they should be providing in the following situations:

* How far employers should be managing the general health of their employees, as opposed to employees’ health as it affects their work. For example, members often tell us they are unsure how far they should be providing health checks and interventions to – for example – help employees lose weight, stop smoking, and reduce addiction, as their employer and outside of the employee’s medical team. Yet employers have heard from the government that they might be expected to perform health checks at work.[[4]](#footnote-4) Some employers do provide health checks for employees, but they said uptake of these are low, and they understood why. In one employer’s words, *“Employees don’t want to tell us about their health being poor”.*
* What types of adjustments employers should provide, and what is not their remit to provide. Employers commonly report making adjustments for someone’s job but, if the route to work from the individual’s home is inaccessible, they cannot get there. Many employers in the Access to Work Forum had this question and queried whether the government expects them to be paying for disabled employees to get to work as well as for their adjustments when they get there. Employers in this group explained situations where they have made all adjustments to the workplace, but the employee cannot get to work because the transport links between where they live and their place of work are not accessible. Some employers said, in these cases, they are also paying for taxis for multiple disabled employees who are in this situation to get them to work each day. They question, however, if they should be doing that, if the government expects them to do that, and whether they can stop doing this as the price of transport increases and travel support costs for employees are therefore mounting up. Further still, when an individual experiences disruption to their social care, employers have questioned if they are expected to pay for that care to continue so that the employee can keep coming to work.

## The work and benefits systems are closer than ever – even for employers

Employers described how the statutory sick pay and the benefits system is becoming more relevant to them, because these ‘peripheral’ policy settings are having an impact on their employees’ lives. For example:

* Some employers said they had helped their employee apply for Personal Independence Payments (PIP) as part of exiting someone from the business because, due to them no longer being able to do their job when their disability progressed, they had to leave the organisation.
* One employer referred to the statutory sick pay system not being flexible or enough to support an employee who has been off sick for two years. During this time, they have paid the employee’s full-time salary.

# Fit notes

We asked **23 employers** to describe a situation where a fit note from an employee had helped them make adjustments for an employee to return to work. Opinions were very diverse – from some saying fit notes have “never helped”, to others saying they have “multiple examples” of fit notes being effective and that they find them “really helpful”.

## When the fit note has not helped employees return to work

We asked employers to recall a specific example of when a fit note had helped them support an employer back to work. Many felt the fit note had not helped:

* *“It never has [helped]. We had to send them [the employee] for an occupational health review - which is fine, but, if the medical professional doesn't know what to suggest, then they should recommend that a suitable occupational health review is undertaken, if anything to remove the guess work”.*
* *“They haven't [helped] - we have to do individual risk assessments to determine what is required or / and send to occupational health to obtain recommendations.”*
* *“I can't think of one. The information on there is just too brief.”*
* *“Fit notes have rarely helped. It’s the additional OHS referral that has helped make adjustments for a return to work.”*
* *“Very occasionally GP's will write a detailed week 1, week 2, etc phased return plan that enables the employer to help the person back to work. This also applies when, on occasion, the GP provides examples of work the employee can do. Unfortunately, this is rare.”*

However, other employers could point to areas of the fit note that did work well:

* The dates are clear and helps manage the length of absence. In one employer’s words, *“It's functional in that we know exactly what date the employee is being reviewed again or needs to return to work*”.
* The reason for absence – this can help an employer start a conversation where the employee has told the GP but not the employer. It gives employers a “starting point” (employer’s words) when a conversation has not already happened.
* Indicating that someone can return to work.
* Allowing medical professionals other than the GP to issue fit notes.
* It is about fitness rather than unfitness: *“Diagnosis is now much clearer than it used to be, and the focus is on fitness and not illness”* and fit notes *“Focus on what someone is fit to do rather than unfit to do is more positive”* (employer’s words).
* Fit notes becoming electronic has been much better for employers.
* Fit notes can help “plan for an absence”.

## How often it helps

When we asked **37 employers** how often they feel a fit note has enabled employees in their organisations on sickness absence to return to work, responses told us the following:

* 4 employers said fit notes helped in **most** cases
* 17 employers said they helped in **some** cases
* 9 employers said they helped in **not many** cases
* 3 employers said they did not help in **any** cases
* 4 employers said they are **not sure**

However, there remain policy and practice problems with the fit note. The policy issue is that it places the responsibility on the first person to advise of fitness to keep working (or not) and to suggest possible adjustments with a GP or medical professional who has little or no knowledge of the employee’s job and/or how that job needs to be carried out, let alone the practical steps that could be put in place to remove any barriers the employee is experiencing or may experience. The practice issue is that there is no evidence that a nationwide labour market of line managers know what to do when they receive a fit note. Employers told us about the confidence levels of their managers with fit notes. When we asked how far employers (n=37) agreed that each manager in their organisations would know what to do if they received a fit note from an employee, they told us the following:

* 4 employers **strongly agreed**
* 7 employers **agreed**
* 9 employers **neither agreed nor disagreed**
* 15 employers **disagreed**
* 2 employers **strongly disagreed**

# Rehabilitation and managing health during long-term absence

## Returning employees to work after a period of long-term sickness absence

We asked **32 employers** what the single most helpful thing that could be done by their organisation or the government to help them support employees return to work after a period of long-term sickness absence would be.

The most common recommendation from employers for what government could do was to improve policy and support to allow better, more effective and more sustainable returns to work. Free text responses fell into the following themes in terms of what Government and policy could do:

The first was the government enabling better **phased returns**, including:

* *“Gradual phased returns, frequent engagement with the individual ensuring all the right support mechanisms are in place”[[5]](#footnote-5)*
* GP practices/Jobcentre Plus to assign work coaches to long-term sickness cases with the purpose of getting the individual back to work with a reasonable phased returned.
* Allowing a phased return alongside Statutory Sick Pay (SSP), and allowing that phased return to speed up or slow down to allow for a more manageable return rather than the current “all or nothing” policy which means that an employee must either be off sick or in work – there is no potential for a blended approach to allow an employee to come back part time as part of a phased return and to be “topped up” with SSP. Without that, a gradually increasing part-time return (which may be the only option that is doable for the employee) can often be unaffordable and thus the employee does not return at all or is financially disadvantaged if they try.
* Guidance which “understands both sides” (employee and employer) – that is, both have a role to play in the return. It is not just down to the manager/employer. Also understanding of what a realistic expectation is of what an employer can do to support someone who has been off sick and what is actually not reasonable.”[[6]](#footnote-6)

Additionally, employers wanted more support and practical advice with identifying **adjustments.** Employers reported getting different advice depending on where that advice came from so that they, in turn, could also apply consistent decision-making internally. Employers also had the following suggestions for what else would help them better support employees (all are direct quotes from employers):

* *“GP practices and Jobcentre Plus to assign work coaches to long-term sickness cases with the purpose of getting the individual back to work.”*
* *“[The government] supporting and improving mental health services to help prevent future absences and maintain good mental health”.*
* *“Access to Work applications fast tracked so that any workplace adjustments can be implemented before or as the employee returns to work.”*
* *“Make return to work interviews mandatory with a recommended framework of things to be considered/discussed”.*

In terms of what employers could do better, the key theme was clear: they needed better frameworks for communicating with employees during absence and when planning to return to work, and they needed their organisation to define a more consistent approach to arranging and providing workplace adjustments for individuals.

## What employers provide to help employees return to work following ill-health

We asked **37 employers** in our Work and Health Policy Forum what they provide to help their employees stay in or return to work:

* 33 employers use occupational health
* 32 employers provide an Employee Assistance Programme
* 31 employers use Access to Work
* 25 employers provide support buddies or mentoring
* 22 employers provide work coaching
* 22 employers provide counselling and psychological support
* 14 employers provide private medical insurance
* 12 employers offer returner programmes
* 10 employers use the support included in their Group Income Protection (GIP) product (although many said some aspects of their GIP is available only for their senior staff)
* 6 employers use work based occupational therapy
* 5 employers use physical rehabilitation therapies
* 4 employers use vocational rehabilitation

It is important to note that use of the above did not necessarily mean those interventions were effective. Those interventions were instead still used because internal policies and procedures had defined that these must be used in specific circumstances to fulfil internal employment procedures.

## Workplace health insurance and Group Income Protection

We generally see that employers are more confident to manage known disabilities and conditions and planned absences Many employers described policies, processes, and systems of support that are formed about predictable, known about, or planned situations. However, confidence often plummets when illness or disability has a sudden onset and where no one saw it coming – for example, accidents, injuries, cardiovascular situations (such as heart attacks) or neurological conditions (such as spinal or brain injuries or strokes). In these situations, employers could recall much less support that they offered, if any – even though we know many of those employers have a private medical insurance (PMI) or Group Income Protection (GIP) product that their organisations already pay for.

We asked **37 employers** how confident they are to describe what is covered by their organisation’s PMI and GIP services to an employee who might need to use them or to a manager who might need to explain this to a member of staff. Employers told us the following:

* 8 employers were **very confident**
* 6 employers were **somewhat confident**
* 6 employers were **not very confident**
* 5 employers were **not confident at all**
* 7 employers were **not sure**
* 5 employers said they did not know what PMI and/or GIP products are.

BDF is yet to look into and properly understand the effectiveness of various interventions that our members use. However, we are interested in an intervention that comes up in conversations regularly as a solution that has helped someone return to work following serious ill health or onset of disability: the combination of GIP to help the employer support the employee financially while they are recovering alongside the provision of tailored vocational rehabilitation (VR) to support the employee to regain the holistic biopsychosocial skills needed to return to work after long-term absence.

We repeatedly hear that while occupational health is an effective assessment and advice service that can recommend which interventions an employee undertakes, employers tell us that ‘traditional’ occupational health has rarely provided effective interventions for absence management and returning to work in itself. VR, however, is a multi-disciplinary, holistic approach incorporating interventions, case management, and practical support – that is, it can directly get tailored, individual support to employees in a timely way. We also often hear that the support an individual has received through VR was not an option discussed or offered during their NHS treatment. Increasingly, our members are using this model to get the advice, support, and provision ‘all in one’ where their internal procedures and set up allows. However, confidence and knowledge about VR was not consistent or particularly high among those who took part in our discussion groups.

We are increasingly seeing the success of GIP backed up by data. Recent figures from Group Risk in Development (GRID) show that **72 per cent** of employees who were potential GIP claimants who had a prolonged period of sick leave starting in 2024 had returned to work by the end of the year.[[7]](#footnote-7) In addition, an individual told us about their own situation. They were a senior manager working for a private bank when they had their stroke. Their employer’s GIP covered their pay while they were on long-term sickness absence focussing on their recovery. The GIP provided tailored neuro-physiotherapy and then vocational rehabilitation. This helped them regain the skills that currently fall between health and work settings – such as picking things up, walking on different surfaces, re-learning to sit and stand and manoeuvre around their working environment. They also got the mobility aids they needed that were not provided by the NHS. They could not stay in their original job, but the GIP covering the employee’s salary meant that the employer supported them to find another job elsewhere in their sector. We understand this individual is still in work today as a result of the holistic package of support that was enabled via their GIP.

## Promotion of benefits and services included in an organisation’s GIP

BDF hears from our members that managers and even HR business partners are not aware of the benefits that come with their workplace health insurance or GIP product. For example, when we speak to insurers, they tell us that they have a wide range of services included within their product, such as mental health support, financial health advice, health and fitness assessments, health checks, and workplace adjustments assessments, yet these are radically under-utilised by their client employers. Then we speak to employers who we know have purchased workplace health insurance products from those same providers, and they have no idea of the range of services to support employee health and wellbeing that has already been purchased from elsewhere within their organisation.

Employers tell us this could be because, usually, particularly in large organisations, the person purchasing the product for the organisation is not an employee caseload manager. This means someone senior in the business purchases insurance/GIP product, with all of its benefits and range of services, and then this does not get communicated effectively or filtered down to the people who are managing employees’ health, wellbeing, and absences. In addition, wellbeing teams often get their own (sizeable) budget and are so often purchasing the same products that the organisation already has access to via their workplace health or GIP provider. There is a lot of duplication, and this is both unnecessarily costly and causes confusion.

## Supporting entrepreneurs and self-employed people with GIP

As the government seeks to improve the number of people who get into work and to retain people in the job market who might need to change ‘how’ they work, we have been involved in discussions about increasing self-employment and entrepreneurship, particularly for people with disabilities and long-term conditions (such as via The Lilac Review). The Government has consulted on and considered access to occupational health subsidies or discounts for self-employed people, small businesses, and entrepreneurs. However, we think the intervention and offer could be better.

By the government and insurers working together to offer discounted or reimagined services for micro business and entrepreneurs from the point of start up, it potentially offers ‘cover’ for the key biggest concern which stops people starting their own business: pay during sickness or when having treatment for their disability, and/or if they have to have an extended amount of time off from work because of this. The right insurance product would give them access to workplace health assessment, income protection, wellbeing support, physical health support (health checks, physio for example) as well as workplace adjustments advice. Therefore, a workplace insurance approach would support start-ups much more comprehensively than an ‘occupational health only’ based model.

**Occupational health**

Occupational health (OH) has had a difficult history with disabled people. Pre-2010 UK Equality Act, many employees with disabilities and long-term conditions were prevented from securing an interview, let alone succeeding in getting a job. The key reason was that they were not getting through pre-employment health and disability questionnaires and assessments – and it was OH who were undertaking these. Therefore, there is a generation of disabled millennials in work who experienced this yet are now expected to see occupational health as the key service who helps them to stay in work.

**Little quality assurance and a lot of upselling**

Some employers said they are concerned that some condition-specific assessment providers and some occupational health providers are not medical professionals and do not have a significant amount of experience or qualifications on the workplace assessments they are undertaking. Some employers said, as a result, that they have started training people to do workplace needs assessments in house. They can do them more quickly, they know the roles, and there is no “upselling”. The practice of upselling caused employers to buy more and more ‘add ons’ that they were not sure they needed but were told could de-risk failing to provide adjustments and support but instead were seeing that spend on what should be comprehensive, quality-assured and regulated support was now costing too much with little evidence of effective results.

To resist the upselling, some had tried to do work internally to improve support processes and access to workplace adjustments. In doing so, many said the consultants and providers they had used had put together complex proposals and suggestions for internal work they could do when, in fact, the employer just had to formalise what managers were doing already.

**Disabled employees’ experiences of occupational health**

In *The Great Big Workplace Adjustments Survey* (2023), a total of **1,307 disabled employees** told us about their experience of using occupational health:

* Just **44 per cent** said the occupational health report was accessible and easy to understand.
* Just **33 per cent** said the format and location (including online platforms) of the appointment or assessment was accessible for them.
* **32 per cent** felt they had enough information about what would happen at the occupational health appointment or assessment.
* **31 per cent** said the occupational health process helped their employer put adjustments in place for them.
* **27 per cent** said occupational health helped their manager know how to support them.
* **22 per cent** said the occupational health process helped them understand or manage the impact of the disability or condition at work.

**Manager’s experiences of occupational health**

A total of **396 managers** told us the following about their experiences of occupational health

* Only **36 per cent** of managers agree a lot that the occupational health process helped them make adjustments for employees.
* Only **36 per cent** of managers agree a lot that they understand the role of occupational health, including what occupational health does and does not do.
* Only **36 per cent** of managers agree a lot that they are confident to tell employees what will happen during their occupational health assessment and next steps.
* Only **33 per cent** of managersagree a lot that they knew how occupational health fits in with their organisation’s workplace adjustments process.
* Only **27 per cent of managers** agree a lot that they knew what to do after they had received their employee’s occupational health report.
* Only **26 per cent of managers** agree a lot that the occupational health process was helpful.
* Only **25 per cent of managers** agree a lot that the occupational process helped them understand how to manage and support their employees.
* Only **14 per cent of managers** agree a lot that they were involved in their employee’s occupational health assessment and was able to speak to the occupational health adviser as the employee’s manager.

In addition to the above, we asked disabled employees to tell us their general views in free text responses. Out of the **577 disabled employees** who gave us additional information here, only **9 per cent** told us about positive experiences.

The most common free text response were employees saying they felt OH was a “tick box” part of the process that their manager ‘had’ to put them through, regardless of whether OH was the best fit for an individual’s situation; it was part of a process outlined in the employer’s policy and therefore ‘had’ to be done. In many situations, this left the employee feeling as though the OH assessor had merely repeated for the report what the employee said during the assessment, and it also made employees feel as though their employer did not trust the employee’s own experience of their own disability or condition:

* *“My manager wanted me to go to occupational health even though I told him this wasn’t necessary and I had identified the adjustment I needed already. He wanted to ‘cover his back’.”*
* *“I feel it [OH] is easily open to abuse. They [OH] literally take at face value what you say. My employer had already agreed and implemented the adjustment I require. I felt it was a bit of a ‘box ticking’ exercise.”*
* *“They repeated to my employer what I told them and so this was effectively an extra hoop to jump through – my employer could have just taken my word for it!”*
* *“I don’t feel any benefit from OH referrals. It felt like a tick box exercise. For my condition, they then to ask what I want/need and then put that in a report.” There was much evidence that, in these situations, OH causes employees much stress, unease, and to distrust both their employer and OH as a profession.*

This supported another key theme we saw in the free text responses: that occupational health was used, even when disabled employees already knew what was needed. Many employees said they were referred to OH even when they knew what they needed, purely because that was their employer’s process for getting adjustments:

* *“I accessed them [OH] to ask for a keyboard I already knew I needed.”*
* *“I had to use [occupational health] to get access to the disabled parking spaces.”*

We also heard that some candidates applying for jobs with organisations were referred to OH to get suggestions for adjustments. One employee said she requested an interpreter for her interview and was referred to occupational health for this to be confirmed.

With all of this said, we are clear that this is not a slur on the occupational health profession itself. While our members report poor providers and good providers (as with any service), the overall two-fold trend we continue to see is that:

* Employers and managers rarely have an accurate understand of what occupational health does; and
* Government and employers have over-relied on and overused occupational health for a whole range of policy solutions and interventions when OH may have not been the appropriate solution. This means OH has become a scapegoat for when employers’ knowledge about the range of solutions available for different situations is low and when the government have used OH as a ‘go to’ problem solver for the un/employment crisis, instead of seeing it as one part of a multi-disciplinary approach in managing workplace health.

## OH needs to be used appropriately and be reserved for its specialism

In one of our Work and Health Policy Group discussions, there was general agreement that OH was essential for assessing and managing the health and safety of individuals working in specific health and safety regulatory roles, but when an occupational health model is used to manage disability at work generally, ‘success’ is often low.

Employees said if there were good conversations between the manager and the employee about the employee’s situation, their job, and the current difficulties, the employee and manager can then decide together if OH is the best intervention needed at any one time. In many cases, employees said they did not feel an OH referral was necessary if they had a better conversation with their manager:

* *“My local support is so good and OH felt irrelevant.”*
* *“[OH] adds time, confusion, and bureaucracy to what could just be a conversation with a good manager. The key is to have a good manager!”*
* *“I find that if a person knows what they need to manage their conditions, then they should be trusted to advocate this for themselves without OH rubberstamping it. OH are a brilliant resource when you need a safe place to talk through what you’re going through but as they are generalists, they might not know what you need to cope at work.”*

# Work-related stress and illness

Work-related stress is not getting enough policy attention, despite growing evidence on the link between stress and ill-health. The Health and Safety Executive (HSE) is the only government agency that regularly identifies stress as a long-term health issue and that separates “stress” from “mental health”. HSE’s own figures[[8]](#footnote-8) show the following:

* **1.7 million** working people have a work-related illness.
* **776,000** workers experienced work-related stress, depression or anxiety.
* **33.7 million** working days were lost due to work-related illness and workplace injury.

Many professionals and employers are increasingly questioning whether work is indeed good for people.[[9]](#footnote-9) There is therefore little will to look into work-related stress and ill health as a policy problem. HSE speak about work-related stress and mental health well, in that they see them as separate problems and therefore separate topic. Employment and economic policy, however, often does not. HSE does not have the level of ministerial backing or ‘visibility’ that work and health policy does, so the narrative and focus does not get absorbed into DWP policy analysis and development. If we are to tackle non-employment and retaining people in employment, employment policy cannot ignore stress as a factor for people leaving work and decreasing economic activity – particularly in light of a growing body of literature and research which shows the causation between stress and ill-health.

This has perhaps not been helped by how Government and NHS data is structured and categorised. For example, fit note data puts stress and mental health into the same category of “mental and behavioural problems”, which then propels the policy narrative of mental health and stress being one and the same. This clouds and silences a significant area of policy that remains untouched: stress is causing many people to leave work, become unwell, become disabled, or, at best, have a poor time at work, which then in turn causes ill health, disability, and long-term absences once more. Even our research on disability workforce reporting showed that work-related stress is so common in organisations that when employers include this category as a type of disability in their workforce reporting, their disability workforce reporting figure soars. During our research on disability workforce reporting, one employer articulated this well:

*“What if it’s the workplace that’s making people ill? [My sector] is suffering from a mental health crisis, in part due to heavy workloads. So, I wouldn’t want [my sector] to quote high proportions of staff with mental health problems and it be seen as an indication of inclusiveness, when it might actually be the opposite.”* [[10]](#footnote-10)

## Additional stress of disabled employees at work

Many disabled employees we speak to are frustrated that there appears to be little understanding that stress at work is both “different and additional” for employees with a disability or long-term condition. Our research showed that **30 per cent** of disabled employees feel stressed at work most of the time, and **56 per cent** disabled employees feel stressed at work some of the time.[[11]](#footnote-11)

In addition, only **19 per cent** of disabled employees said they have enough time to manage their condition and do everything they need to do in their job. We asked employees in free text responses what causes them stress at work. The overwhelming response was “workload”. This was followed by “unreasonable deadlines”. “Pressure” was another commonly used phrase. Other common workplace stressors reported in free text response questions included:

* Poor communication from managers and senior leaders, including about changes to the organisation and to individual task deadlines, and general “indecisiveness”.
* Poor or “toxic” culture in teams, and “ableist” culture in the wider organisation.
* Lack of support or having adjustments in place. Responses on this topic included one employee saying they have been off work for 4 months while waiting for their adjustments, and another describing getting adjustments in place as *“attempting to climb a greasy pole.”*
* Overstimulation (including sight and sound) in office environments. “Overwhelm” was a commonly used term. One employee said, *“There is a noticeable spike in my heart rate and stress levels compared to days when I am at home.”*
* The demand created by lots of different types of communications. The number of emails was a common stressor.
* Experiencing bullying and harassment by colleagues and managers and feeling “unwelcome and unwanted.” **28 per cent** (n=1,480) of disabled employees said they want to or are considering leaving their current employer because they do not feel they have been treated well.[[12]](#footnote-12)
* The volume of meetings each day, including the amount of time employees are expected to spend in online meetings.
* Commuting to work was a huge stressor, and some said commuting was one of the main reasons they did not want to return to the office.
* Working at home when others work in the office *“means less communication with colleagues”* which results in *“[I] know less what the team are doing.”*
* Unstructured roles or not having clear direction on tasks and job “boundaries”.
* Dealing with difficult customers and clients with no additional support with the impact difficult interactions can have.
* Inaccessible IT software, including the incompatibility of assistive technology software with multiple internal systems.

Others pointed to the ongoing daily experience of their disability and how it adds to the pressure of work:

* *“It takes me longer to do things which puts me under pressure. I usually resort to working extra hours (unpaid) to ensure I achieve what I need to. I do my best to make sure my employer is not aware of this in case I am labelled as inefficient.”*
* *“I constantly worry about how I am performing; whether people are judging me for resting; worrying about needing sick leave; worrying about the variable, random nature of my illness and how unreliable that makes me; worried about people thinking I’m not ‘pulling my weight’. [I am] in pain 24/7, so pushing through to do my hours is stressful”.*
* *“I’m very stressed by my job, and it is impacting my mental health very negatively. My work/life balance is very poor, and little is being done by the organisation despite me flagging these issues. I am using all of my energy trying to keep going with work and have nothing left at the end of the day for myself or my family.”*

## Workload and burnout: Technology and communications as a stressor

In our post-pandemic research, *From ‘ping dread’ to burnout,*[[13]](#footnote-13) we had conversations with our members about the stress that comes from the combination of being remote from their staff, increased tech devices, and increased communications meaning that employees feel they always need to be “switched on” to one device or another most of the time.

The below are excerpts from some of our conversations with members about how they feel about wellbeing and attitudes to email and tech-based communications at work:

* Some people said they “dreaded” the Christmas and New Year break, because the sheer weight of their workloads had meant they could not finish everything they needed.
* Some said they “felt sick” and, again, “dreaded” coming back to work in January after the Christmas break because they knew “what is waiting” for them when they return (more work and more emails).
* Employees said they want “more humanity” from senior leaders, not a “productivity show”. One person said they would prefer to see their senior leaders *“taking a lunch break than replying to emails on their phone as they walk to the toilet”*. This would help prevent the employees feeling, in one person’s words, *“Is it just me who is overwhelmed?”*
* Some people said they felt “punished” for taking annual leave or going on holiday because of the number of emails and notifications that they must clear before they go and that are waiting for them when they return. No one we spoke to had their workload adjusted to take account of their annual leave.
* Someone referred to “ping dread” – the “anxiety” they feel when they are trying to work on something *“and another email pops up”.*
* People said they wanted more “kindness” in the expectations their managers and organisation have of them.

Research backs up what we heard in our conversations. At the time of writing this research, **up to 90 per cent** of fit notes from GPs at the end of 2021 were for stress related illnesses.[[14]](#footnote-14) In addition, **79 per cent** of workers regularly experience work related stress. Just **1 per cent** did not experience any work-related stress.[[15]](#footnote-15)

This ‘Ping Dread’ paper continues to be one of the most requested papers we have produced at BDF – perhaps because it still resonates with emerging research. For example, the HR trend “annual leave anxiety” has gained popularity since recent research showed that **78 per cent** of workers in the UK dread coming back to work following annual leave because of their workload.[[16]](#footnote-16) In addition, a 2024 study by Natwest showed that **45 per cent** of employees in the UK did not take all of their annual leave because of FOFB (“Fear of Falling Behind”)[[17]](#footnote-17)

Heavy, overwhelming and unreasonable workloads are becoming an increasingly common theme in our research discussion with both managers and disabled employees. Heavy workloads and pressure cause stress, absences, and long-term ill-health; yet work and health policy rarely looks at this – and, once again, the topic is almost entirely exclusive to the webpages of HSE. Stress, ill-health, and long-term absences will continue as long as workloads are overwhelming and unmanageable to the point that people see their work-life balance, sleep, rest, mood, and capacity for enjoyment outside of work affected by this.

# Other evidence

* Our research, *The Great Big Workplace Adjustments Survey*, comprehensively covers disabled employees’ employers of requesting and getting (or not getting) adjustments and managers experiences of receiving the request and implementing (or not implementing) those adjustments. The research is available here: <https://businessdisabilityforum.org.uk/policy-and-research/the-great-big-workplace-adjustments-survey-2023/gbwas-what-did-people-tell-us/>
* Our research on disability workplace and pay gap reporting “shines a light” on the views of disabled employees (as well as employers) on the introduction of mandatory workforce and pay gap reporting requirements. The research is available here: <https://businessdisabilityforum.org.uk/resource/towards-meaningful-disability-workforce-and-pay-gap-reporting/>
* A lot of work is being gathered by organisations at the moment on Access to Work to feed into the *Pathways to Work* consultation paper, which has closing date of 30 June 2025. We hope that the Keep Britain Working Review team will access the data findings from that consultation, because Access to Work is a pivotal scheme and intervention for how employers support disabled employees in work. The *Keep Britain Working* review deadline is a month earlier than the *Pathways to Work* deadline. Therefore, even if the dates on these integrally interlinked topics – retention, preventing further absence, and Access to Work – have not synced on their consultation dates, we are requesting that the *Keep Britain Working* review team works with DWP to find what the responses to the Access to Work section of the green paper have identified.

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1. Employers were referring to increasing mandatory reporting requirements, increasing national insurance contributions, greater Access to Work employer contributions, and navigating a raft of new upcoming employment legislation. In addition, the methodological caveat is that employers taking part in these discussions are already engaged in the workplace inclusion and wellbeing agenda and they are at manager level or above in roles related to these topics. [↑](#footnote-ref-1)
2. Direct quotes from employers. [↑](#footnote-ref-2)
3. Our research found that only **44 per cent** (n=1,480)of disabled employees who used their EAP felt it was accessible and inclusive to them, and just **15 per cent** of disabled employees said their employer had promoted health and wellbeing initiatives that were inaccessible to them because of their disability or condition (Business Disability Forum, 2023, *The Great Big Workplace Adjustments Survey*, page 96). [↑](#footnote-ref-3)
4. In an announcement on 30 August 2024, the NHS National Clinical Director for Stroke said that NHS health checks would be available in workplaces. Press release available here: <https://www.gov.uk/government/news/over-130000-people-to-benefit-from-life-saving-health-checks> However, most employers we spoke to have not heard anything more about this since. [↑](#footnote-ref-4)
5. Direct quote from employer. [↑](#footnote-ref-5)
6. Direct quote from employer. [↑](#footnote-ref-6)
7. Figures from GRID on 13 May 2025. Full figures and press release available here: <https://grouprisk.org.uk/2025/05/14/seventy-two-per-cent-of-new-absentees-under-group-income-protection-policies-returned-to-work-during-2024/> [↑](#footnote-ref-7)
8. Health and Safety Executive (2024)*.* [↑](#footnote-ref-8)
9. The Secretary of State for Work and Pensions used this in a speech in November 2024 and contuse to be used in policy development papers and speeches. The Health and Safety Executive reported 138 deaths in work-related accidents last year. Further still, we have seen an increase in calls from employers about deaths at work we have received. For example, in one case we supported, an employee was on an online call with their team, and they had a stroke while online in front of their colleagues; in another, an employee working in a manufacturing setting had a heart attack and died while working among others on the factory floor. [↑](#footnote-ref-9)
10. An employer’s own words. Sector details have been redacted in the quote. Source: Business Disability Forum (2025), *Towards meaningful disability workforce and pay gap reporting* (page 26-27). [↑](#footnote-ref-10)
11. Business Disability Forum (2023), *The Great Big Workplace Adjustments Survey*, page 88. [↑](#footnote-ref-11)
12. Business Disability Forum (2023) *The Great Big Workplace Adjustments Survey* (page 101). [↑](#footnote-ref-12)
13. Business Disability Forum (2022), “From ‘ping dread’ to burnout: Why we must manage technology instead of letting technology manage us”. Available from: <https://businessdisabilityforum.org.uk/resource/pingdread-burnout/> [↑](#footnote-ref-13)
14. Statistics from NHS England, 2022. [↑](#footnote-ref-14)
15. Research by Perkbox in 2022. [↑](#footnote-ref-15)
16. Robert Walters (2024) *Zombie Workforce*. Press release available at: <https://www.robertwalters.co.uk/insights/news/blog/zombie-workforce-uk-workers-are-struggling-to-switch-off-from-work.html> [↑](#footnote-ref-16)
17. Figures are from NatWest Group in 2024. Press release available here: <https://www.natwestgroup.com/news-and-insights/news-room/press-releases/financial-capability-and-learning/2024/sep/wfholiday-brits-work-on-average-25-days-during-a-7-day-break-and.html> [↑](#footnote-ref-17)