Appendix A

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Report of the Director of Resources & Housing

Report to the Scrutiny Board (Strategy & Resources)

Date: 18th January 2018

Subject: Employee Health and Wellbeing: Sickness Absence and Positive Intervention

Are specific electoral Wards affected? If relevant, name(s) of Ward(s): n/a	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of Main Issues

Reducing sickness absence is important for any organisation. There is the obvious burden on financial resources and productivity, the impact on engagement and the duty to manage health and safety and provide good employment practices. It is even more important to a local authority who also have a wider duty to help improve public health and reduce worklessness.

To tackle this issue, four things need to be considered:

i. The data e.g. sickness absence statistics, Engagement Survey, Staff Network Surveys, Health and Safety and Occupational Health information.
ii. The employment framework to allow for attendance management.
iii. A strategy and interventions to improve employee health and wellbeing.
iv. Sustainable improvement through wider engagement and cultural change.

1. Purpose of this Report

1.1 This report aims to provide Strategy and Resources Scrutiny Board with information relating to sickness absence and includes: trends; context; main causes and the services most affected.

1.2 It will also provide an overview of the Employee Wellbeing Strategy and the interventions, both existing and planned, to support employees and bring about sustainable improvement.

2. Background Information

2.1 An estimated 137.3 million working days were lost due to sickness or injury in the UK in 2016. Since 2003, however, there has been a general decline in the number of days lost, particularly during the economic downturn.

2.2 The ONS report (2017) indicated a number of factors that influence a higher rate of sickness absence:

- ***Demographics and Geography*** – female and older workers have higher rates of absence and Yorkshire and Humber has the joint second largest absence rates in England;
- ***Health Conditions*** – smokers and those with long-term health conditions have higher absence rates;
- ***Type of Employment*** – a higher absence rate is found amongst those working: in the public sector, in larger organisations, part-time hours, in front-line services; and those working in care and leisure.

2.3 All of these factors are, of course, relevant to the public sector workforce – especially Leeds City Council which still delivers most of its services in-house. They can also help to explain the oft-cited differences between the higher rates of absence in the public sector and lower rates in private organisations. This was also confirmed in a survey by the Health and Safety Executive in 2010 which standardised sickness absence rates by age, gender and size of organisation. It revealed that differences between private and public sector absence rates were very modest, with public sector employees taking an average of 0.3 days a year more than their private sector counterparts.

3. Main Issues

3.1 Sickness Absence Trend in Leeds City Council

3.1.1 Figure 1 below illustrates the overall downward trend of sickness absence since 2009, although there has recently been a slight upward trend again since a 10 year low in 2016.

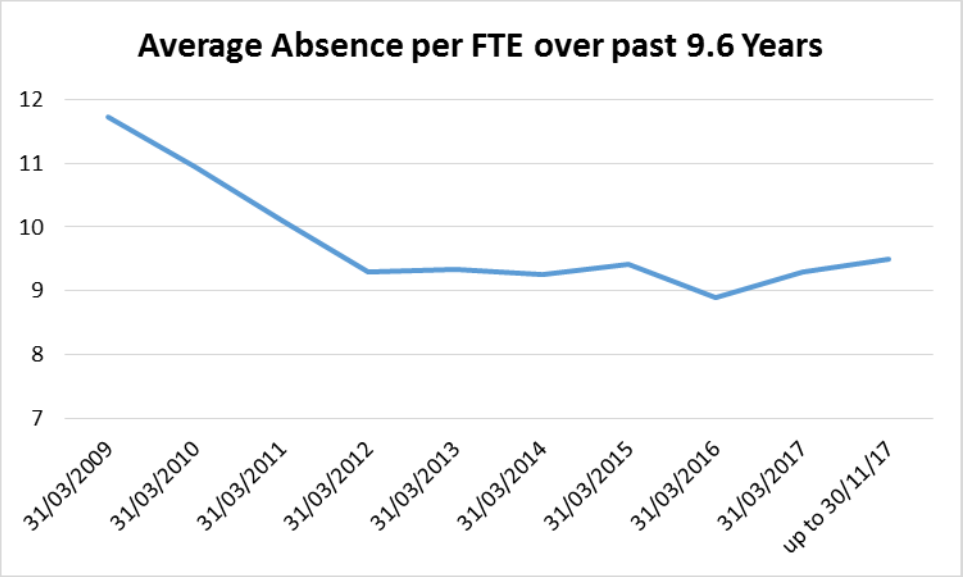

Fig 1

3.1.2 Figure 2 below illustrates the breakdown of sickness absence per directorate.

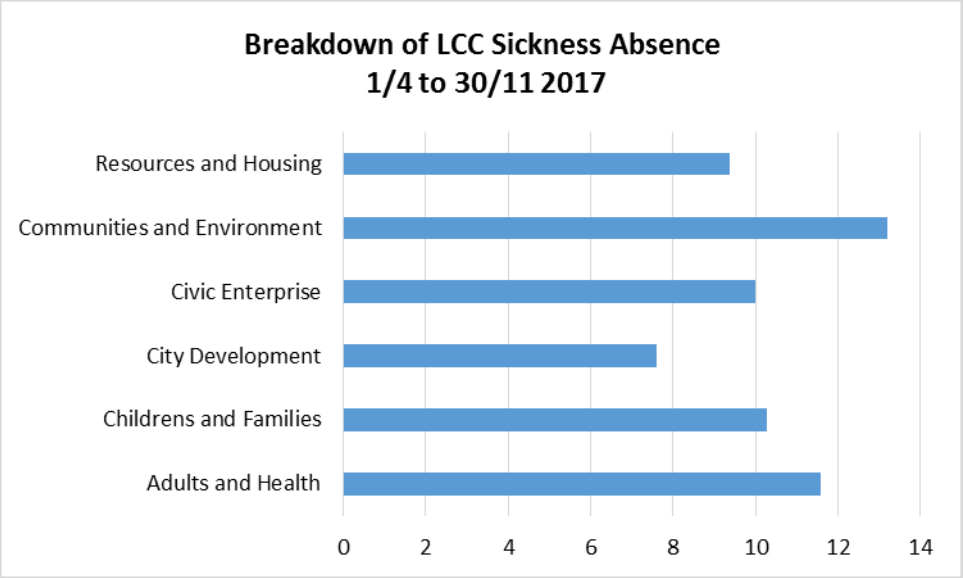

Fig 2

3.1.3 As each Directorate is made up of a variety of different services, it is perhaps more useful to consider those individual service areas with the highest levels of sickness absence, which can be seen in Figure 3 below. In line with the research discussed in Section 2, this information is not unexpected with these services being a combination of front-line, manual, caring roles and roles exposed to workplace hazards e.g. manual handling and violence and aggression.

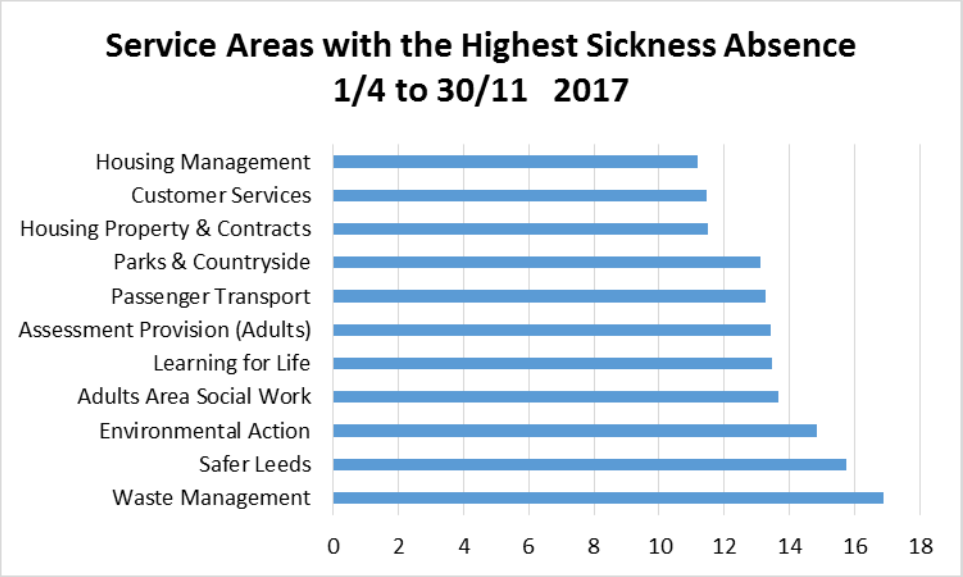

Fig 3

3.1.4 Long-term sickness (absence over 4 weeks) accounts for more than twice the number of overall days lost as short-term absence. Over the past year the number of employees on long term sick each month has remained largely static at approximately 400 employees.

3.1.5 Figure 4 below illustrates the main causes of sickness absence as a percentage of overall absence.

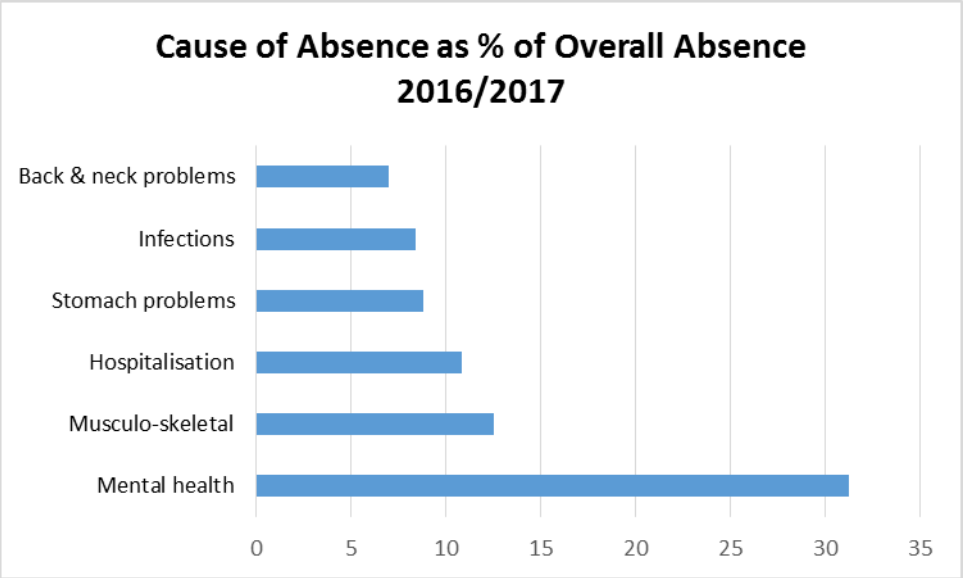

Fig 4

3.1.6 The highest cause of absence is mental health, which is made up of various categories including stress, anxiety, and depression. Stress is the largest recorded category under mental health at approximately 45%. As a percentage of overall absence, mental health is most significant in Children's and Families (43%) and Adults and Health (34%). Again this is in-line with the national picture where social work is cited as 'involving competing demands, uncertainty and complexity on a daily basis – all of which can increase pressure on people working in this field.'

3.1.7 The second highest cause are musculo-skeletal disorders, which is even more significant when you add the related 'back and neck problems' category.

3.1.8 In 2016/17 152 employees were referred to stage 3 hearings under the Managing/ Improving Attendance policy, this is 20% increase on the 2015/16 figure of 119 employees.

3.1.9 Leeds City Council, like most other local authorities, has had to reduce its workforce over the past few years, as the organisation continues to face significant financial challenges. Trade Union colleagues voiced a concern about the impact of a reducing workforce on those who remain and therefore sickness absence. FTE numbers in frontline services have, however, been largely maintained whilst the number of employees in support services have reduced. Support services traditionally have less sickness absence than frontline services, due to the factors already discussed.

3.2 Employee Health and Wellbeing Interventions

3.2.1 Workplace health involves promoting and influencing the health and wellbeing of staff and includes managing sickness absence and 'presenteeism' (a person physically at work, but unproductive). It also includes action to address health and safety risks. The latest LGA Survey (2017) cites research that demonstrates a return on investment of between £2 and £10, for every £1 spent on Employee Wellbeing Programmes.

3.2.2 **Managing Attendance:** there has been a lot of work over recent years to improve employment policies, guidance and training to provide a robust framework within which to manage attendance. This has included:

a) A new ***Improving Attendance Policy and Procedure*** was introduced in October 2016 and was supported by HR delivering a half day improving attendance briefing and a half day mock attendance meeting. The challenge for 2017/18 is to find a way to deliver "just in time" training for managers so they feel as confident as they do when they leave the training room in the real life situation 3 months later.

b) ***Mediation***: In Autumn 2016 a further 12 internal mediators (18 in total) were appointed and trained. They have successfully completed 35 mediations. Mediation has been shown to help resolve issues between staff members which could have resulted in a period of sickness absence (N.B. 'relationships' and 'support' are two of the stressors identified by the HSE).

c) There is an on-going review of ***Special Leave*** provisions, which will provide further clarity and help for carers.

d) ***Attendance Casework***: good quality, timely and effective casework is essential to enhancing employee and service performance. A range of employment policies (disciplinary, performance, attendance, grievance and probationary) have all now been reviewed and revised to make them more streamlined and

easy to use. All 'health and safety' policies are also being reviewed. The Casework and Attendance HR team are also working more closely with the BSC Attendance Monitoring Team in terms of the end to end process. This will bring efficiencies that will enable more resources to be redirected to preventative work.

3.2.3 **Employee Wellbeing:** an Employee Wellbeing Strategy was launched in 2016 to help all employees improve their health and wellbeing. It is intended that everyone will have: a choice of options to improve their health and wellbeing; an understanding of how to use the information and support provided; the awareness to take responsibility for their own health and wellbeing; and the confidence to talk honestly about health issues at work.

The current priorities are: mental wellbeing; physical health; healthy lifestyles; and improving the culture of wellbeing. This, coupled with the 8 key health and safety priorities agreed by CLT and Executive Board, aims to achieve a number of things:

- To address the main causes of sickness absence and help reduce presenteesim;
- To promote health and wellbeing among our workforce and contribute to our outward facing public health responsibilities through the workplace setting;
- To keep people well and in work, to contribute to our responsibilities to address worklessness in the city;
- To be an exemplar of good employment practice and an employer of choice for people with certain protected characteristics e.g. disability.

3.2.4 **Examples of Specific Interventions**

a)	***Mindful Employer*** – LCC signed the Charter for Employers who are Positive about Mental Health in 2011, which has led to specific improvements in the support provided for managers and staff.
b)	***Staff Networks*** – HR works closely with staff networks, particularly the Disabled Staff Network in relation to attendance issues. HR also founded the Healthy Minds Group, which is extremely active on mental health issues and is now led by a senior manager outside of HR.
c)	***Training*** – over 500 managers have been trained on mental health and stress through courses delivered by HR. A practical awareness session was also organised by Healthy Minds and HR for managers in the services most affected by mental health absence.
d)	***Employee Assistance Programme*** – this is currently delivered by HELP and in 2016/17 they took 1190 calls from LCC employees and, from these, 593 referrals for counselling were made. 49% of contacts described their issues as related to home, 21% related to work and 30 % to a combination of both.

	During 2016/17 employees were able to self-refer for face-to-face counselling. This has been widely welcomed and increased the uptake, especially for those employees who may not have felt confident to discuss their issues with a manager.
e)	***Direct Referrals into Physiotherapy*** – LCC works with Yorkshire Physiotherapy to provide access to physiotherapy treatment. This helps to keep people at work or reduce the length of potential sickness absence. The specialists also offer advice on improving ergonomics in work undertaken by services.
f)	***Changing the Workplace*** – thousands of LCC staff have either been through or are about to go through 'new ways of working', often moving to new workplaces. This has the potential to affect an individual's physical or mental health. The programme has now shifted emphasis to place people at the heart of it and delivering a joined up approach to health, safety, wellbeing and inclusion.
g)	***Occupational Health*** – the council continues to employ Occupational Health Practitioners who help managers to identify the impact of work on an employee's health or the impact their health has on their work. This is invaluable in ensuring the individual receives the correct support. They also undertake health surveillance for employees working in certain hazardous roles.
h)	***Health and Safety*** – this can impact on sickness absence directly through poor practices leading to chronic or acute health conditions or injuries, or indirectly as feeling safe at work impacts on how valued and engaged someone is. The Council's Health and Safety Policy is signed by both the Chief Executive and Leader of the Council, demonstrating the commitment of CLT and Executive Board.
i)	**Schools** – it is recognised that schools can sometimes be a challenging environment in which to work. Much support is provided e.g. assisting staff in managing pupils with challenging behaviour and a wellbeing programme for Heads and their Deputies.
j)	***Healthy Lifestyles*** – work is on-going with Public Health to promote campaigns such as 'get active' and 'One You'. We have also embarked on a 'Blood Pressure Project' within the council where there is scope and funding to test 7,600 staff.
k)	***Men's Health*** – it is proven that men do not talk about health concerns, especially mental health, and also visit their GP less frequently than women. This is especially true amongst manual workers. Over the past few years there has been a specific programme targeting men out on site at various times of the day – to give them information and practical advice. This has been well received and thousands of men have been seen.
l)	***Promotion*** – we have a network of over 100 Wellbeing Champions embedded in services who promote messages about health and wellbeing.
m)	***Cancer in the Workplace*** – a package for managers and staff has recently been launched to support people with cancer at work.
n)	***Flu Immunisation*** – it is recognised that some of our employees are

	exposed to certain infections like flu because of the nature of their work e.g. carers. LCC offers a free flu vaccination for these employees.

4. Future Developments and next steps

4.1 It is recognised that sustained improvement in health, wellbeing and attendance will only be achieved through winder engagement and culture change. Some of the plans to help influence this during 2017 – 2019 include:

Planned Actions for 2017 - 2019
1. Acting on areas from the recent Engagement Survey which may impact on health, wellbeing and attendance.
2. Working with Trade Union colleagues as part of a joint Wellbeing Group to look at strategies to reduce stress related absence.
3. Developing and implementing a 'Supporting Staff at Work Policy' which will require managers to hold a structured 'wellbeing conversation' with their members of staff at least twice as year linked to appraisals. The policy will provide a host of guidance and advice on both mental and physical health.
4. Improving awareness of managers and staff through a blended learning offer to cover all aspects of supporting staff at work and also in relation to the Social Model of Disability.
5. Continuing to trial the 'Wellbeing Conversation' pro-forma as part of changing the Workplace moves.
6. Procuring a new Employee Assistance Programme to meet current needs and exploring a different approach to increase awareness.
7. Building on the new Employee Benefits Package launched in December and explore opportunities for using this to engage with all staff about health and wellbeing.
8. Implementing a new policy for addressing violence, aggression and abuse faced by some LCC employees and procure a corporate approach to improving the protection of lone workers.
9. Working with the Disabled Staff Network to implement the proposed approach to 'Improving the Experience of Disabled Staff in LCC'. A draft action plan will be discussed and shaped with the Network in January 2018.
10. Considering the findings and recommendations of Leeds University who conducted research into how to improve employee resilience.

5. Consultation and Engagement

5.1 No work around this agenda, especially the desired culture change, can be successful without meaningful consultation and partnership working with a variety of stakeholders, within and external to LCC. Within LCC key stakeholders will be Trade Unions, service managers, Public Health, Elected Members and CLT.

6. Equality and Diversity / Cohesion and Integration

6.1 The link between sickness absence/ill health and certain protected characteristics has been discussed earlier in this report e.g. gender, age and disability. Any interventions and strategies will be designed to address specific needs and to try and ensure that there is no adverse impact on specific groups.

7. Council Policies and City Priorities

7.1 Most employment policies could have a direct or indirect impact on health, wellbeing and attendance and this report has illustrated those policies that have and are about to be revised/developed.

7.2 LCC is a major employer in the city and has an externally facing role in improving public health and wellbeing and addressing worklessness etc and using the council as a workplace setting for intervention is sensible. This is notwithstanding LCC's imperative to be an exemplar employer and the best city council.

8. Resources and Value for Money

8.1 Earlier in the report the return on investment of expenditure on health and wellbeing was highlighted. Sickness absence and presenteeism also costs a significant amount of money and loss of productivity.

9. Legal Implications, Access to Information and Call In

9.1 In managing attendance there is a legal duty to comply with employment law. Also relevant here is compliance with the Equality Act and Health and Safety legislation.

9.2 All employment information relating to sickness absence is managed in accordance with Data Protection legislation.

9.3 Nothing in the report would be subject to call-in.

10. Risk Management

10.1 Improving attendance and employee health and wellbeing is one of the key council risks. This is due to the costs of sickness absence, the impact of presenteeism, reputation and potential for legal challenge. This report is intended to explain how these risks are managed both now and in the future. Health and Safety is also on the Corporate Risk Register and as it's a standing risk an annual assurance report is usually prepared on it.

11.0 Conclusions

11.1 There is a national context of falling sickness absence over, at least, the past decade.

11.2 Despite a slight increase in LCC over the past couple of years, the overall trend over the decade has been downwards – but this needs to be watched carefully.

11.3 There are common factors that influence a high level of sickness absence in organisations and these are all present in most local authorities, especially LCC e.g. size, age, geography, demographics, type of work.

11.4 Mental health is the main cause of sickness absence in the council.

11.5 There is a well-established approach to both managing attendance and improving employee health and wellbeing in LCC and this is constantly evolving to meet current demands.

11.6 The key to sustained improvement is through wider engagement and cultural change and plans for 2017 – 2019 have been outlined in the report.

12.0 Recommendations

12.1 It is recommended that the Strategy and Resources Scrutiny Board note this report as an overview of sickness absence and employee wellbeing.

12.2 Comments regarding the content of this report are welcomed.

12.3 Strategy and Resources Scrutiny Board should also note that a Health and Safety Report will also be submitted in due course.

Follow-up Information for Scrutiny Board (Resources and Strategy)

1. Background

A report on 'Employee Health and Wellbeing: Sickness Absence and Positive Intervention' was presented to Scrutiny Board (Resources and Strategy) on 18th January 2018. The report prompted further questions from the Elected Members present that required further research. This information is set out below.

2. Further Information Requested

a) How LCC compares with other organisations in terms of sickness absence levels.

i. Comparison with regional local authorities:

Figure 1 below illustrates the days lost to sickness absence amongst responding Yorkshire and Humber local authorities in 2016/17.

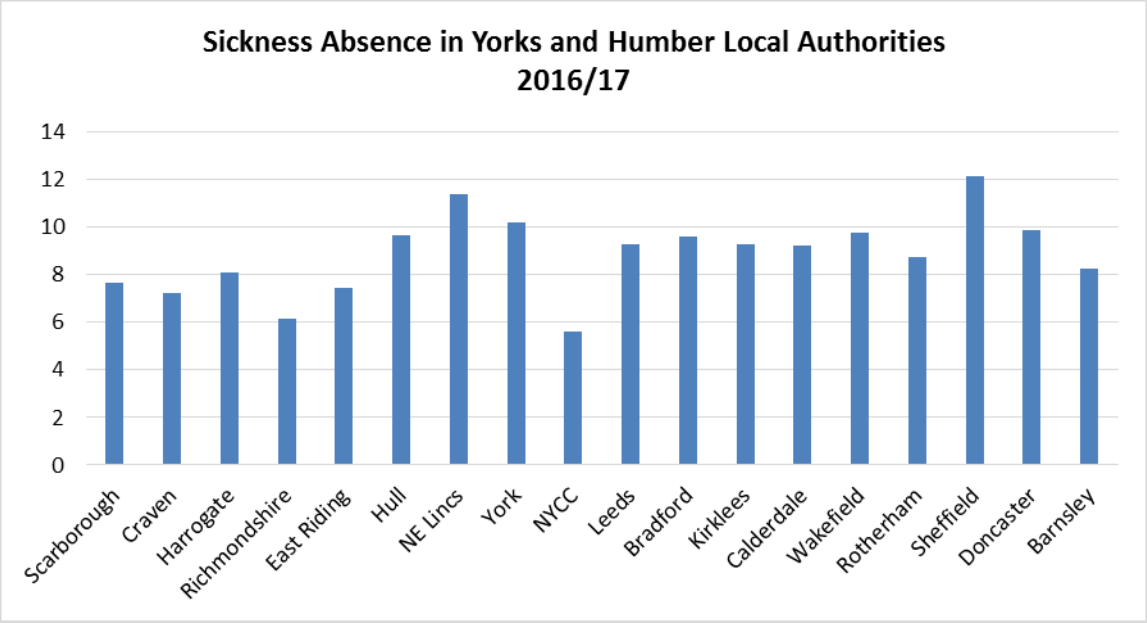

Figure 1

By comparison, local authorities in Greater Manchester reported an average sickness absence of 11.03 in 2015/16 with a range from 9.0 days up to 12.5. The average days lost to sickness in Yorkshire and Humber in 2016/17 was 8.9, with Leeds at 9.31.

ii. Comparison with core cities:

Figure 2 below illustrates sickness absence in Core City local authorities from 2015/16 – which is the last information currently held. N.B. data was not provided by Glasgow and Newcastle.

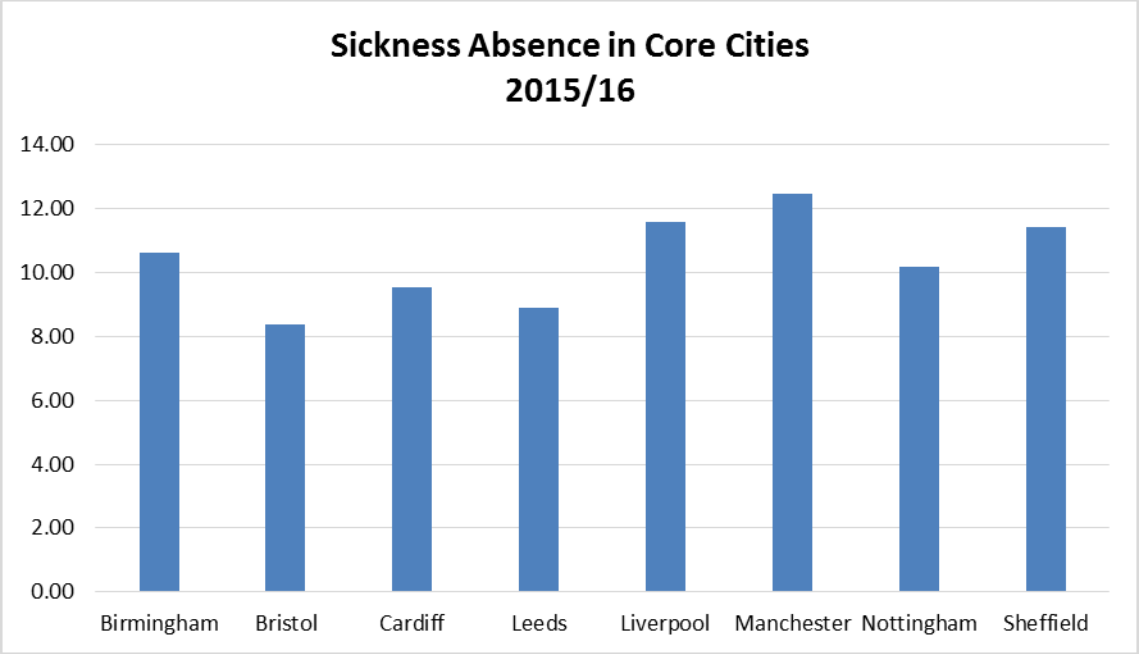

Figure 2

iii. Comparison with the private sector and other factors:

A survey in 2016 by the Chartered Institute of Personnel and Development found that the average number of days lost across all sectors was 6.3. The average in the private sector was 5.2, whilst it was 8.5 in the public sector.

This survey also evidenced some of the other factors referred to in the original Scrutiny Board Report i.e. manual workers in all sectors had 2.1 days more sickness absence on average a year and larger organisations saw more sickness absence – this ranged from 4.0 days in organisations with less than 50 employees to 9.4 in those with over 5,000 employees.

The original report cited a piece of research that showed public and private sector differences as 0.3 days, when standardised for these factors.

b) Numbers of employees leaving LCC or reviewed at the final stage of the Improving Attendance Policy due to ill health.

Table 1 below illustrates the outcomes of employees leaving LCC on health grounds or being reviewed at the final stage of the Improving Attendance Policy.

Outcome	No.
Dismissed on grounds of ill health capability	42
Dismissed on grounds of ill health retirement	44
De-escalated to Stage 2 of Policy after Stage 3 review	12
Re-deployed through medical re-deployment	7
Currently in review period at Stage 3	3
Total	**108**

Table 1

c) Calculation of figures presented in the original report

In the previous report some 'year to date' information was presented i.e. from 1/4/17 to 30/11 and this caused some confusion.

Normally average sickness absence is calculated based on the previous 12 months' absence within a team / service / directorate and equated to a full time equivalent employee within that area. The changes in directorates and structures from April 2017 meant however that, in most areas, it isn't possible to get a full 12 months absence data, therefore the absence was based on the period from 1/4/17 to date and pro-rata'd to make it up to 12 months. So, for example, in Waste, from 1/4/17 to 30/11/17 the actual average absence per full time equivalent for that period is 11.24. As this is for an 8 month period the figure is pro-rata'd to give a 12 month equivalent (11.24 / 8 (months) x 12=16.87).

d) Further analysis of Children's and Families

One Member asked why only one Children's and Families service (Learning for Life) featured in the top 11 services with the highest absence, when the Directorate as a whole had the third highest absence level.

The Directorate consists of three main areas and two of them break down into a number of services. The pro rata sickness absence, as of December 2017, in each area and service can be seen in Table 2 below. It can be seen that the service in the 'top 11' with the lowest absence had 11.0 days absence per FTE and the only service in Children's and Families higher than this was 'Learning for Life'.

Main service area	**Sickness Absence per FTE**
Partnerships	**10.05**
Active Schools	0.00
Childrens' Workforce Development	3.84
Commissioning and Market Management	8.01
Complex Needs	8.51
Partnership Development and Business Support	5.76
Traded Services	1.33
Safeguarding and Targeted Services	**10.91**
Childrens Social Work Services	10.33
Early Help Services	10.23
Integrated Safeguarding Unit	6.75
Learning for Life	13.18
Local Safeguarding Children Board	3.58
Complex Needs	0.00
Learning and Improvement	**5.83**

Table 2

e) Breakdown of the causes of sickness absence in Waste Services

As requested, Figure 3 below illustrates the breakdown of causes of sickness absence in Waste Services.

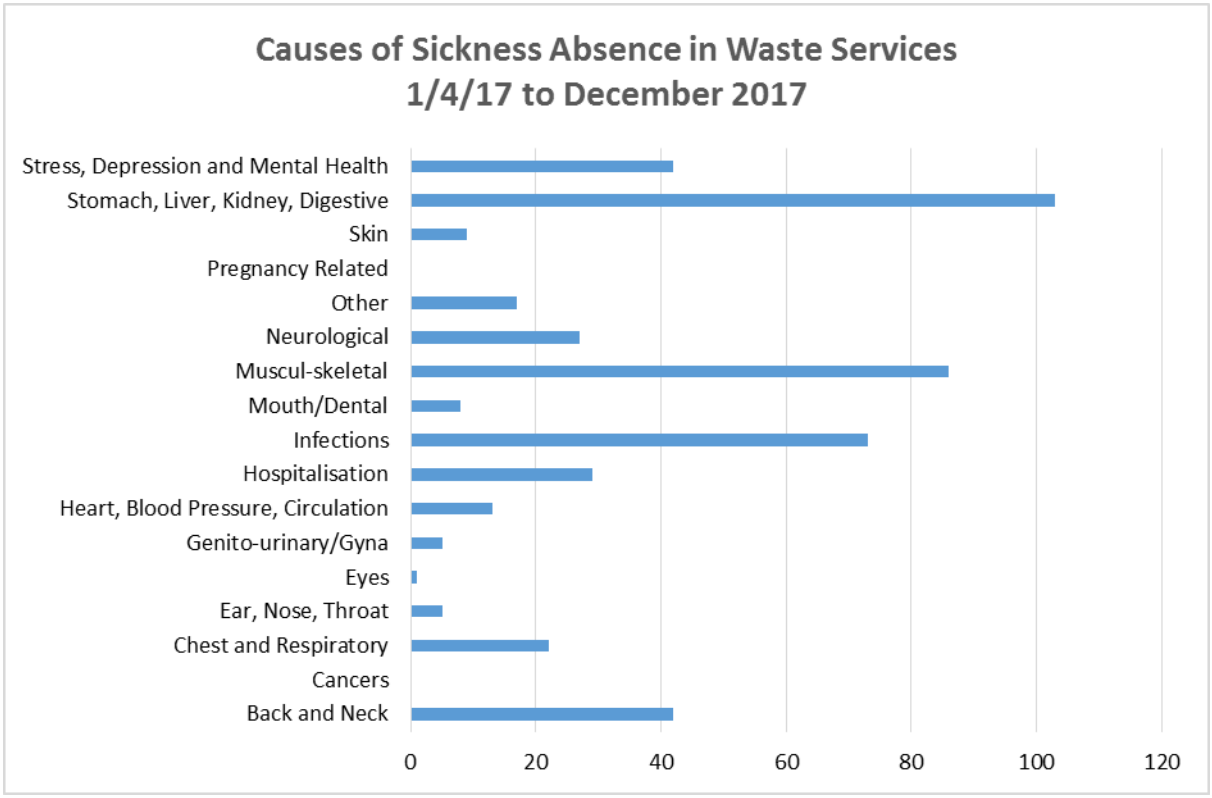

Figure 3

When 'back and neck' and 'musculo-skeletal' are considered together, this forms the largest cause of sickness absence, closely followed by 'stomach, kidney, liver and digestive'.

As mentioned during the meeting there have been a number of initiatives targeted at Waste including: bespoke manual handling training; Men's Health awareness sessions covering mental health, cancers, healthy lifestyle and hand hygiene. A grant funded blood pressure project will also shortly be taking place in Waste.

Further Comments

It is hoped that this paper answers the questions raised at Scrutiny Board (Resources and Strategy) which required further research. Please let me know if any further information is required or you have any comments.

Improving attendance and wellbeing remains a key priority and Human Resources will continue to work with key stakeholders to develop and deliver a range of strategies to address this issue.

Author: Chris Ingham, Head of Health and Safety, Human Resources,
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On behalf of: Neil Evans, Director of Resources and Housing
Date: 23rd January 2018.