Manchester City Council
Report for Resolution

Report to: Human Resources Subgroup – 7 March 2013

Subject: Attendance Monitoring

Report of: Sharon Kemp, Assistant Chief Executive (People)

Purpose of the report

Following on from discussions at the Finance Scrutiny Committee meeting on 24 May 2012 and the Overview and Scrutiny Human Resources Sub-group meeting on 31 July 2012, this report seeks to provide the sub-group with a progress update on corporate and directorate absence trends and the actions undertaken to increase attendance.

Recommendation

The Committee is asked to note the update on attendance, including:

- The feasibility study on the introduction of a staff flu-vaccination programme
- An action plan related to stress related medium and long-term absence in the Directorate for Adults, Health and Wellbeing
- Further information on the incidence of stress related absence in Children's Services and the effectiveness of actions being undertaken to address this.

Wards Affected: All

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents

are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

- Finance Scrutiny Committee meeting of 24 May 2012 – Attendance Monitoring report and minutes of the meeting.
- Overview and Scrutiny Human Resources Sub-group meeting of 31 July 2012 – Attendance Monitoring report and minutes of the meeting

EXECUTIVE SUMMARY

In the period following the Finance Scrutiny Committee (24 May 2012) and the HR Sub-Group meeting (31 July 2012), the average days lost due to sickness have reduced from 10.23 days in May 2012 to 10.07 in December 2012, a 1.6% decrease over the 8 months. Given the absence reporting system it will be several months before the full impact of actions taken will be evident.

An analysis of those hitting absence management triggers in November 2012 shows that 130 (23%) of those who hit triggers in the month did so in relation to short-term absence, 173 (32%) in relation to medium-term absence and 243 (45%) in relation to long-term absence.

Long-term sickness absence is declining with a 2% reduction in the period April – November 2012. Medium-term absence has reduced by 0.1% whilst short-term absence is more volatile and has increased by 3%. Improvements to the approaches to managing stress/depression and musculoskeletal issues is reflected in a reduction in days lost due for these reasons.

Whilst progress is demonstrated with the reductions in the number of *live* medium and long-term absences cases, these reductions will not be fully reflected until a full 12 month reporting cycle has been completed, e.g. August 2012 to July 2013.

Increasing attendance has continued to be prioritised and an overview of the range of actions implemented since July is set out below.

INTRODUCTION

On 24 May 2012, the Finance Scrutiny Committee considered a report on attendance. This report provided information on the corporate approach to the management of attendance, including progress on managing absence and recent performance trends in this area. A further report was presented to the Committee's HR Sub Group with a particular focus on:

- The financial cost of long and short term sickness
- The impact of covering for absences
- Comparison with other relevant authorities and the private sector
- The role of the ***m people*** approach in reducing sickness levels
- Detail on sickness levels in individual services

Following the meeting on 31 July 2012, the Overview and Scrutiny Human Resources Sub-Group requested that a further update be provided including:

- The feasibility study on the introduction of a staff flu-vaccination programme
- Action plan related to stress related medium and long-term absence in the Directorate of Adults, Health and Wellbeing
- Further information on the incidence of stress related absence in Children's Services and the effectiveness of actions being undertaken to address this.

This report provides the specific information requested by the HR Sub-Group along with an update on attendance levels across the authority achieved in the interim period.

SECTION 1 - CORPORATE OVERVIEW

Absence Trends

Since the report to Finance Committee on 24 May 2012 a strong focus has continued to be placed on activity to improve attendance levels. The corporate measure of attendance 'average days lost per person per year' has shown a general declining trend over this period the average days lost due to sickness have reduced from 10.23 days in May 2012 to 10.07 in December 2012, a 1.6% decrease over the 8 months.

Table 1 - Average Days Lost Per Employee. Corporate Sickness Absence Indicator

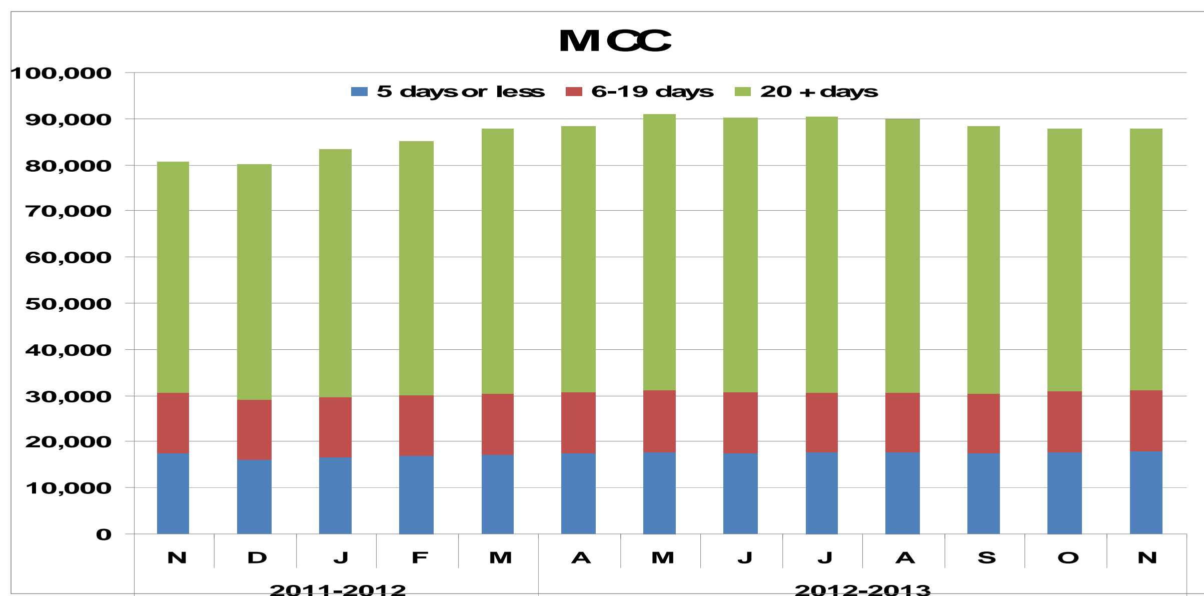
	20010/11	2011/12	2012/13
Average Days Sickness Per Person			
April		9.15	9.97
May	11.45	8.65	10.23
June	11.26	8.7	10.16
July	11.14	8.6	10.26
August	10.97	8.96	10.23
Sept	10.92	9.00	10.05
Oct	10.59	9.10	9.99
Nov	10.48	9.08	10.02
Dec	10.54	9.06	10.07
Jan	10.33	9.36	
Feb	10.26	9.60	
Mar	9.61	9.88	

An analysis of those hitting absence management triggers in November 2012 shows that 130 (23%) of those who reached the triggers did so in relation to short-term absence, 173 (32%) in relation to medium-term absence and 243 (45%) in relation to long-term absence.

Since the previous report, long-term sickness absence, in terms of days lost is showing a declining trend with a 1.6% reduction in the period May –December 2012. Medium-term absence has also reduced by 0.1% whilst short-term absence is proving more volatile and has increased by 3%. (Detailed data attached in Appendix 1).

Improvements in the approach to dealing with stress/depression and musculoskeletal issues is reflected in a reduction in days lost due to these reasons.

Figure 1 – Days lost - short term/medium term and long term absence breakdown

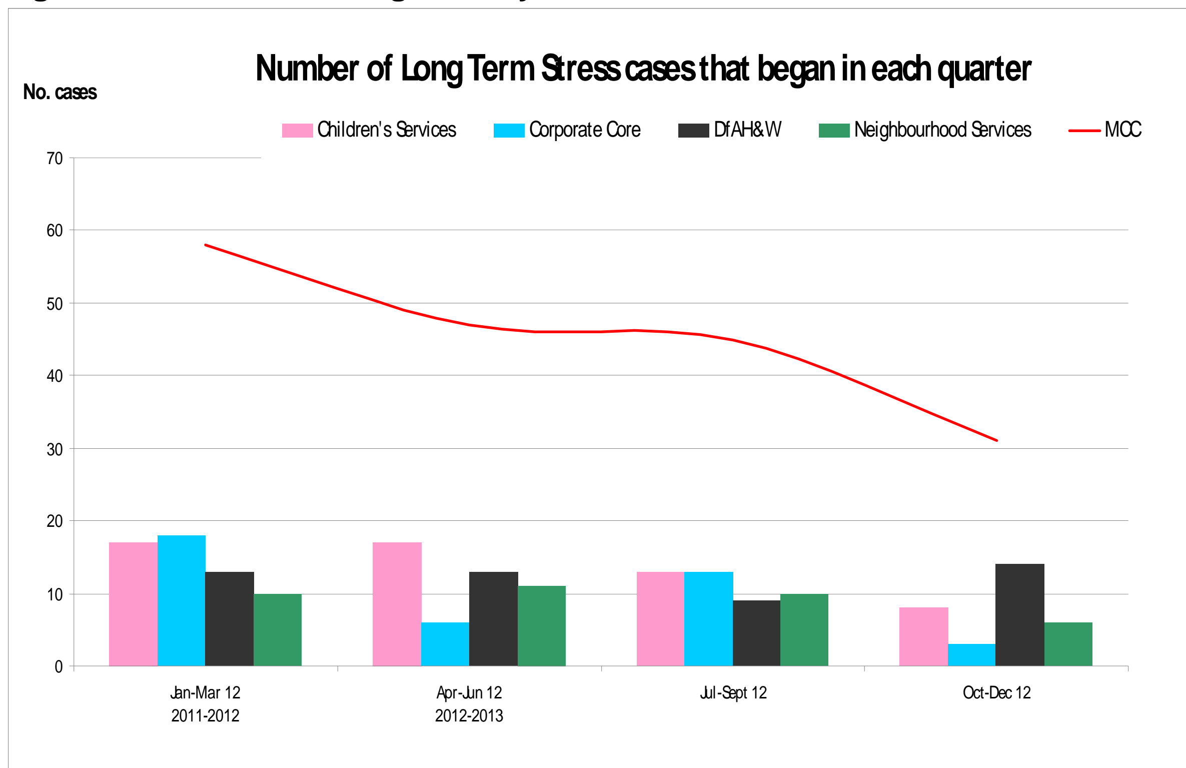


Appendix 2 provides details of changes in terms of the reasons for absence. From this data it is evident that both stress and anxiety have been reducing month on month between August - December 2012. Days lost to stress have reduced by 20% and those lost due to Anxiety by 18% in this period. This trend is encouraging given that stress and anxiety are towards the 'acute' end of the mental health spectrum. Depression/reactive illness is a more chronic condition requiring longer-term and potentially clinical interventions and this has increased by 10% over the same period.

Shoulder injury and back strain/trouble are the two main types of musculoskeletal reasons for absence. In the period August - December 2012 both have declined – shoulder injury by almost 11% and back strain/trouble by more than 10%.

The graph below illustrates the number of stress cases originating in each period specified and shows the declining trend in the number of long-term stress cases over the period. The substantial reduction in Corporate Core stress cases can be linked to the number of counselling referrals made to the Occupation Health provider within the same period.

Figure 2 – Absence lasting 20+ days, due to stress



SECTION 2 – MEASURES TO IMPROVE ATTENDANCE LEVELS

Corporate Strategies for Improving Attendance

The effective management of attendance is a key corporate priority and an indicator within the Corporate Dashboard which is reviewed quarterly by the Strategic Management Team. This section outlines some of the measures in place and being developed to support attendance in general with a specific focus on the most significant contributors to high absence levels as set out above.

I) Specific initiatives undertaken to improve attendance based on key themes identified through the management of attendance process:

- Early support and action to prevent short and medium absence escalating into long-term absence (especially in stress related cases) and bringing resolution to long-term absence cases
- Prioritising dealing with stress related absence as it is one of the most common reasons for absence with 51of the current 156 long-term cases are off due to stress (33%)
- Dealing with Musculoskeletal Disorders (MSD) which accounts for 24 of the current 156 long-term cases (15%).

- **Supporting Managers**
  The HROD Help desk have undertaken focused work to support Managers in their management of absence particularly where staff are reaching absence management triggers. This has resulted in clear improvements as set out in Table 2 below.

Table 2 - Comparison of May 2012 and November 2012 Triggers.

CASES (no of staff hitting absence triggers)	May 2012	Nov 2012
Short term (less than 5 days)	129	130
Medium term (5 – 16 days)	198	173
Long term (20+ days)	374	243

The Directorate breakdown of short, medium and long term absence for November 2012 was:

	Adults	Children's	Corporate Core	NS	Total
No of Short Term	19	20	53	38	130
No of Medium Term	48	43	39	43	173
No of Long Term	54	57	51	81	243

Significant progress has been in reducing the number of *live* long-term absence cases which have reduced by 131 between May and November 2012. The progress made on reducing medium and long-term sickness absence will take time to fully emerge as sickness absence is reported based on a rolling 12 month period.

When an employee hits an absence trigger the HR/OD Helpdesk staff talk to managers at an early stage and advise on a range of early interventions (particularly on stress and MSD's). The HR/OD Helpdesk also offers a "Drop In" facility which gives Managers the opportunity to meet with a HR Service Delivery Officer to discuss more complex absence cases and develop suitable strategies.

Data collated via the HROD Helpdesk shows improvement in management practice since the previous HR Scrutiny Sub Group meeting. Between July 2012 and November 2012:

- the number of cases where Attendance Management Reviews (AMR) had been completed at the time the manager was contacted by Helpline staff improved from 47% to 79%.
- the number of staff placed on absence monitoring as a result of AMR's increased from 57 in July to 188 in November.
- managers' awareness of equality-related absence issues has increased. The number of cases identified by the manager as covered by the Equality Act (up from 72 to 133)
- the number of attendance management warnings issued has increased from 13 to 19.

The reasons for long term absence, the application of the management of attendance policy and evidence based good practice has been reviewed particularly in relation to degenerative diseases and specifically cancer. This review, together with analysis of our own cases has shown that the current approach employed is fit for purpose. The management of absence in relation to musculoskeletal disorders (MSD's) and stress has also been reviewed:

- **Musculoskeletal Disorders (MSDs)**
  An analysis of absences relating to MSDs has been undertaken, this involved research and interventions to reduce MSD related absence, identification of hotspots within directorates and work with our Occupational Health provider to trial targeted interventions. Best practice from private and public sector organisations has also been reviewed with support from the University of Lancaster which included mapping the cases against the interventions available from our Occupational Health provider. This work has identified improvements such as increased pre-emptive health awareness to prevent MSDs and also increased opportunities to adopt reasonable adjustments in the workplace to enable a swifter return to work.

- As detailed in the Employee Health and Wellbeing Strategy agreed in October 2012, targeted interventions on health promotion, initially promoting the Council's Healthy Lifestyles service to employees, and a review of safety training such as lifting and handling has started to be rolled out and is now in place in Neighbourhood Services.

- The analysis of long-term absence cases shows a decline in the number of days lost attributable to musculoskeletal reasons. The learning from the work undertaken on the management of absence related to MSD's has been captured into a 'Top Tips for managers' guide which is being developed as an intranet guide and will also form the basis of a short workshop/ briefing which will be rolled out from Neighbourhood Services.

- **Stress**
  Analysis absence cases related to stress has helped to improve our understanding of the issues involved in managing stress, explore preventative actions and consider the most effective management strategies to deal with stress. New practices have been implemented with the Occupational Health provider adding a new data stream to measure the impact of counselling and the achievement of timely returns to work. As above information and workshops will be made available to managers to embed the high quality management of stress and mental health cases across the Council.

- **Occupational Health interventions in Stress and MSD cases**
  The new Occupational Health Service provides access to a full range of support for staff such as counselling/cognitive behavioural therapy (for support with to stress/anxiety and depression) and physiotherapy (to support those with musculoskeletal disorders).

Crucially from an absence/capability perspective these are provided in much quicker timescales than would be available on the NHS, for example the average waiting time for physiotherapy on the NHS is 71 working days but City Council employees, on average, have their first physiotherapy session 7 days after a need is identified. More in depth evaluation of the use of both physiotherapy and counselling has shown that treatment does have a positive and measurable impact on both the health/wellbeing of the employee and also has a positive impact on keeping the employee in work or helping them to attain full capacity at work.

Table 4 - Source of referrals by Directorate (Sept – Nov 2012)

Directorate	Physiotherapy	Counselling
Children's	3	17
Adults	7	18
Neighbourhoods	7	16
Corporate Core	5	24
	22	**75**

Feedback from the service provider shows that on average, following counselling the employees resilience / ability to cope score increased by 20% at the end of the treatment. 53% of employees in receipt of counselling were able to remain in work – a core objective of the management of attendance policy.
For physiotherapy referrals, on average, employees assessed before and after treatment perceived pain score had more than halved at the end of the treatment.

II) Managing People Training

Following the adoption of the ***m people*** framework in 2010, a clear need was identified by managers and trade unions to develop leadership and management capacity which would reduce the need for and reliance on formal dispute resolution processes. The expectation underpinning ***m people*** is of employee flexibility, adaptability, willingness to change and continuous improvement through positive performance management.

The key focus of the recently revised people management policies is on supporting managers to achieve effective performance management through day-to-day engagement and communication with their employees. Where issues arise they should be resolved early with the employee being given the opportunity to improve and redress performance issues prior to formal processes being invoked. The Managing People training focussed on developing the essential skills and behaviours needed by managers and promoting the benefits of early intervention in pre-empting conflict. To increase the impact of the Managing People Workshops, priority service areas were identified through the HROD Service Delivery Teams. Approximately 1,150 managers in Grades 7 – 12 were identified for the training and as of end January 2013 almost 900 managers have attended the training.

The feedback from the sessions indicates that managers have received the course positively and would value more skills based training, particularly on

dealing with equality issues which is seen as a key area of need. This is consistent with the feedback emerging from the IIP Assessment. Better people management skills and behavioural change will enhance the workplace environment thereby having a positive impact on attendance levels.

III) Health and Wellbeing Strategy

The Employee Health and Wellbeing (EHWB) Strategy agreed at Personnel Committee in October 2012 provides a framework for the Council to take a proactive and engaging approach to enhancing the health and wellbeing of its employees. The driving force of the Strategy is the aspiration that through the development of a happy, healthy and motivated workforce we will improve productivity, morale and outcomes. Through creating a better place for our people to work we will deliver better results for the City.

The objectives of the Employee Health and Wellbeing Strategy are to:

- Support the maintenance of a safe and healthy working environment
- Improve the physical and mental wellbeing of our workforce
- Encourage and support our employees to develop and maintain a healthy lifestyle
- Support employees with health issues to maintain access to or remain at work
- Remove barriers that prevent employees with health issues or impairments achieve their potential and optimising their well-being
- Improve staff satisfaction and morale.

Following endorsement by the Personnel Committee an Employee Health and Wellbeing Steering Group has been established including officers from across the authority, public health partners and representatives of key staff groups. The steering group is driving the delivery of the Strategy through a detailed action plan and performance framework.

SECTION 3 - FLU VACCINATION – A FEASIBILITY STUDY

Influenza or 'flu' is a respiratory illness associated with infection by influenza virus. Symptoms frequently include headache, fever, cough, sore throat, aching muscles and joints. Symptoms are at their worst about 2 days into the illness but most generally healthy people will recover completely within seven days although for some a cough may linger on for another week or two after the other symptoms are gone.

As the symptoms of influenza are non-specific it often misdiagnosed by individuals when in fact they have an infection of another type. This common trend to self-misdiagnose is crucial when assessing effectiveness of flu vaccination as the flu vaccine will have no affect whatsoever on “flu like” viruses. “Flu like” illnesses are very common, and except during a flu epidemic they will be more prevalent than influenza. Influenza occurs most often in winter and usually peaks between December and March in the northern hemisphere.

For most people influenza infection is just a very unpleasant experience, but for some it can lead to more serious illnesses. The most common complications of influenza are bronchitis and secondary bacterial pneumonia and these complications can be particularly serious in the elderly, asthmatics and those with serious medical conditions. This is why the influenza vaccine (or flu jab as it is commonly known) is offered free through the GP for high risk groups.

As it is not offered to the general population there is no evidence on public health grounds that it should be offered to all staff. The medical view is that the benefits of flu vaccination outweigh any risks of having the vaccination for healthy individuals. Hence if we choose offer it to staff the medical view would be the flu vaccination can be offered safely to staff.

A key cause of short term absence are flu symptoms, colds and upset stomachs etc. In the period May to October 2012 13% of short-term absence was related to flu.

Table 5 – Absence related to Influenza

Year	Workforce at March of year	Total Number of Days Lost to Influenza	(as a percentage of total days lost Oct-Mar)	Number of instances (all durations)	Number of days lost to influenza (sickness of duration 4 - 19 days).	Number of instances (sickness of duration 4 - 19 days).
2009 - 2010	11889	1950	3.13%	653	1108	204
2010 - 2011	10377	2574	5.08%	826	1348	254
2011 - 2012	8891	1122	2.19%	398	602	109

These figures show that sickness reported as Influenza is a very small percentage of the total days lost in the winter periods of the 3 years reported. As these figures are self-reported by employees then many of these cases may not be due to true influenza but to other ‘flu-like illnesses’, for which no vaccination is available. Hence these figures are likely to be an over-estimate. The figures do show a correlation with the national figures (i.e. in that 2010/11 was a severe flu year for the UK and flu sickness is 5.08% of the total whereas 2011/12 was a mild flu year and is 2.19% of the total).

The vast majority (89%) of sickness reported by City Council employees as flu was for absences lasting 5 working days or less. The medical view is that true influenza generally lasts around 7 days but symptoms often remain for a couple of weeks. This would confirm that much of the sickness which is being reported as influenza is actually flu-like inflections e.g. heavy colds, upon which the vaccine would have no effect at all.

It is therefore assumed in the calculations in this report that only sickness which is of duration of between 4 working days up to (and including) 19 working days lost should be included when quantifying number of days lost to influenza.

No obvious pattern emerges from flu instances at Directorate level, for example it does not seem that front line staff are worse effected than back office staff or that there are lower levels of flu related absence in Directorate of Adults and Wellbeing due to the free vaccination that they are offered.

The feasibility of running flu vaccination programmes has been examined and consultation in this respect has taken place with managers, occupational health and public health professionals. Details of the feasibility study are attached at Appendix 3.

SECTION 4 – DIRECTORATE OVERVIEW

Trends in terms of sickness duration and reasons continue to be largely consistent across the authority. However, it is important to highlight particular trends within specific directorates.

Figure 3 “Average Number of Days Lost Per Employee” shows the trends in absence levels by directorate and compares this to the authority wide trend from May 2010 to December 2012.

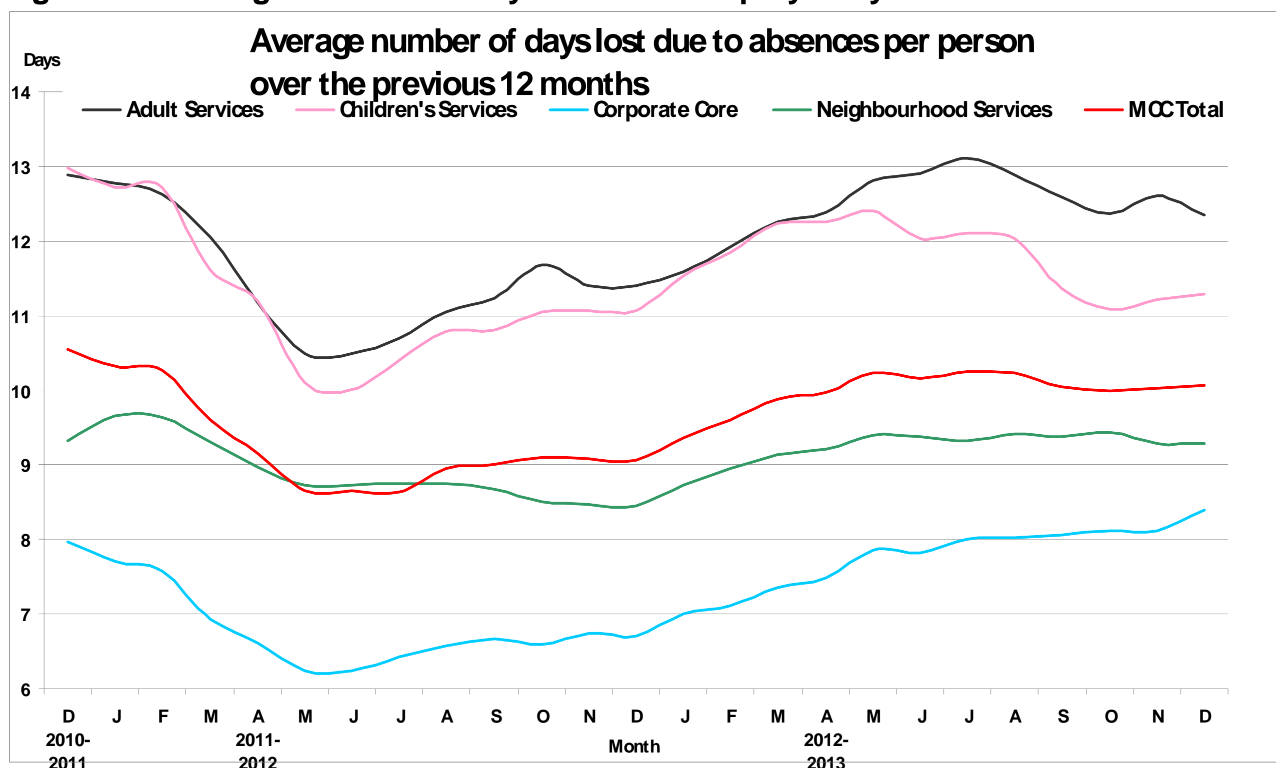
Table 6 - Average Days Lost by Directorate – May to December 2012

2012	May	June	July	Aug	Sept	Oct	Nov	Dec
MCC Total	**10.23**	**10.16**	**10.26**	**10.23**	**10.05**	**9.99**	**10.02**	**10.07**
Adult Services	12.82	12.91	13.12	12.90	12.60	12.37	12.60	12.34
Children's Services	12.39	12.03	12.11	12.04	11.37	11.08	11.22	11.29
Corporate Core	7.85	7.81	8.00	8.02	8.05	8.12	8.11	8.39
Neighbourhood Services	9.39	9.38	9.33	9.41	9.37	9.44	9.28	9.29

Within each directorate management of attendance and reducing absence due to sickness remains a key priority.

The total agency spend incurred in covering for sickness in the period May – November 2012 for Council amounted to £599,364.51. Directorate break downs of this figure are provided in the relevant Directorate section.

Figure 3 – Average Number of Days Lost Per Employee by Directorate



Children's Services

68% of all absence within Children's Services is long term absence This is a 2% reduction in comparison with April 2012 as a proportion of total absence.

Analysis of those hitting absence management triggers within the Directorate in November 2012 shows that 20 (17%) of those who hit triggers in the month did so in relation to short-term absence, 43 (36%) in relation to medium-term absence and 57(48%) in relation to long-term absence.

The nature of work undertaken together with statutory minimum cover requirements have meant that agency costs incurred for covering sickness within the Directorate in the period May – November 2012 were £478,815.42.

Long term absence continues to be the highest contributor to absence within the directorate. However, the level of long term absence has reduced in the main due to the resolution of a number of historical cases through more robust management activity. The two service areas identified in the last report to Scrutiny on absence as having the highest absence rates are residential services and social work. There has been a specific focus within these two service areas on activity to improve attendance levels.

Absence levels within Residential services have decreased. Long-terms cases have reduced from 8 to 2. The activity to reduce absence in this area has had three key strands:

- Increased management focus and overview which has resulted in more robust management of absence.

- A number of Residential Services managers have been trained as Health Champions through an accredited programme by the Royal Society of Public Health. This programme has assisted managers in having conversations in supervision with staff on stress related issues and absenteeism and signposting individuals to universal health services.
- Training for six people to deliver a “train the trainer” model in strategies and responses of dealing with challenging behaviours of residents in order to reduce the number of assaults on staff and prevent resulting stress-related absence.

Absence levels within social work have also reduced. A range of strategies have been put in place to address both the management of current absence but also, strategies to improve morale, clarify expectations and improve support to social workers in order to prevent future stress-related absence. In November there were 7 Social Workers who were absent due to stress. This has reduced to 5 in January 2013.

The activity to reduce absence in the social work service has had three key strands:
- Increased management focus and overview which has resulted in more robust management of absence
- Activity as part of a broader social work improvement plan that has included the introduction of a case management tool, focused recruitment activity to recruit to social work vacancies, improved support to newly qualified social workers, assessment backlogs have been cleared and a requirement for a quarterly review of all open cases to ensure historical cases are appropriately closed down as both of these impact on perceptions of high caseloads and the introduction of quality forums to support social work practice improvement.
- Communication and engagement – managers now begin all supervisions with a more general overview of employee welfare and how they are coping before moving onto focus on caseloads. There has been some positive staff engagement and communication as part of a “myth-busting” exercise which has focused on the significant investment into the service which has resulted in an increase in the number of social workers, the positive recruitment to vacancies and the resulting reduction in caseloads.

The recent Peer Review of Manchester’s safeguarding services reported that Manchester social workers were found to be positive, motivated and proud to work in Manchester.

Neighbourhood Services

63% of all absence within Neighbourhood Services is long term absence. This is a 1% reduction in comparison with April 2012 as a proportion of total absence. In the period January-December 2012,

Analysis of those hitting absence management triggers within the Directorate in November 2012 shows that 38 (23%) of those who hit triggers in the month did so in relation to short-term absence, 43 (27%) in relation to medium-term absence and 81 (50%) in relation to long-term absence.

Agency costs for covering sickness within the directorate were primarily within Hospitality and Community Transport in the period May – November 2012 totalled £19,824.08.

In common with other Directorates, the main reason for sickness absence in Neighbourhood Services is stress/ anxiety/ depression. This has overtaken musculoskeletal disorders as the top reason for overall absence within this Directorate.

The Directorate's Management of Attendance Steering Group is meeting on a regular basis to address the key trends arising in Neighbourhood Services. The group consists of representatives from the main services together with HR and Health and Safety. The group have been looking at how management information around absence can be improved and identifying hotspots for targeted support in areas with particular issues relating to stress and musculoskeletal issues.

Targeted interventions on health promotion, initially promoting the Council's Healthy Lifestyles service to employees, and a review of safety training such as lifting and handling, have now started in Neighbourhood Services. These actions have been emphasised in the Employee Health and Wellbeing Strategy agreed in October 2012 and will be monitored as part of the on-going review of the strategy.

To support tackling absence, a series of briefings for management teams in hot spots areas (Catering, NDT depots and Business Support) within Neighbourhood Services has been concluded, focusing on early interventions to address stress and MSDs in the workforce. These will now be evaluated and results fed back to the Neighbourhood Services Management Of Attendance Steering Group. These sessions have confirmed that barriers include the remoteness of some staff in services such as Catering and Cleaning. It has been recognised through earlier briefings in Cleaning Services that there are also literacy issues among some supervisors that make completing the paperwork for Attendance Management Reviews and Return to Work interviews difficult. These issues are being taken up by the MOA Steering Group and further details of the numbers affected are being taken so that the Union Learning Representatives can be approached to support in this area.

The senior management team receive regular updates on managing attendance performance and issues and this remains a key priority for the directorate at all levels.

Adults, Health and Wellbeing

The Directorate Management Team have agreed a reinvigorated approach to management of attendance, and developed an agreed set of actions;

- Identify hotspot areas within the Directorate
- Improve understanding of reasons for stress including identification of causes / early interventions
- Sickness clinics in place with DMT members leading and strong focus from the Strategic Director

- Develop a Wellbeing strategy for DfAHW (this has been superseded by the development of a Corporate Employee Health and Wellbeing Strategy)
- Develop and deliver Well being workshops
- Review of Healthworks interventions for stress i.e. CBT (link to corporate review)
- Set up a Management of Attendance Strategy Group to monitor progress and share good practice

68% of all absence within Adults in is long term absence. This is a 1% increase in comparison with April 2012 as a proportion of total absence.

Analysis of those hitting absence management triggers within the Directorate in November 2012 shows that 19 (16%) of those who hit triggers in the month did so in relation to short-term absence, 48 (40%) in relation to medium-term absence and 54 (45%) in relation to long-term absence.

Stress, depression and anxiety accounts for over 27% of all long term sickness for the 12 months to November 2012. This is a significant decrease from 60% in March 2012. In response to the high levels of stress identified in March 2012, a concentrated piece of work was undertaken within the Directorate to understand the reasons for the absences that were attributed to stress / anxiety and depression. It was noted that in most cases individuals absence were usually attributed to an event either at work i.e. a grievance or concern in the workplace or a life event i.e. bereavement which often resulted in an absence of up to 3 months. The strategy which services have employed in order to reduce stress impacting on the employees, has mainly consisted of offering support/early intervention in these circumstances to resolve the issues where possible and secure an early return to the workplace.

Wellbeing courses with management which included early identification of stress and taking early preventive action. In total 64 managers have been trained. This training has had a positive impact within the Directorate and has now been built into the Council's Health and Well Being Strategy and has informed the development of guidance on the Intranet for Managers. In addition further development sessions relating to management of attendance and the Equality Act were also provided with a further 101 managers attending.

The decrease in cases relating to stress, depression and anxiety does seem to suggest that these strategies are proving successful.

The Directorate Management Team hold monthly sickness clinics run by Heads of Service where scrutiny is given to the progress within their service areas. These clinics focus on bringing early resolutions to absence cases. Redefined targets have been introduced for each service area which will be used as key performance indicators for Heads of Service, to review management performance and report progress against on a monthly basis. A focused piece of work is ongoing in LD Networks to understand and identify the reasons for the high levels of absence and the management interventions that are needed for improvement. Focus groups have been held and actions being identified to address the areas of concern.

The Directorate Management of Attendance Strategy Group will promote support available for managers and identify target areas and hotspots within the Directorate.

The group meet on a 6 weekly basis and current focus is on sharing good practice across the Directorate.

The total agency costs for covering sickness within the Directorate in the period May – Nov 2012 was £70,975.92.

Corporate Core

At December 2012 there were small increases in absence levels in all three categories (short, medium and long term). 58% of absence within Corporate Core relates to long term absence.

Analysis of those hitting absence management triggers within the Directorate in November 2012 shows that 53 (37%) of those who hit triggers in the month did so in relation to short-term absence, 39 (27%) in relation to medium-term absence and 51 (36%) in relation to long-term absence.

Of the long term absence cases detailed in the previous report one employee has successfully returned to work via a structured return to work and one was sensitively supported to exit the organisation.

Further analysis of the current long term sickness cases shows that they are not concentrated in any particular area of the Directorate. The analysis of the longest standing absence cases has determined that this information predominantly relates to 4 people, of which two are cancer related and are being managed sensitively, with conclusions expected in the coming weeks.

As referenced above there have been small increases in all categories of absence across the Core however this is not attributed to any one reason or area. The HR/OD service continue to work in partnership with Heads of Service and Managers across the Core to improve attendance and provide the relevant support and resources to facilitate the required outcomes. This approach has resulted in a number of absence cases being resolved with either a supported return to work or exit from the organisation.

The total agency costs for covering sickness within the Directorate in the period May – November 2012 was £29,749.09.

SECTION 6 – CONCLUSION

Sustained activity in managing attendance over the previous seven months has seen some decline in attendance levels with a more pronounced reduction in the case of long-term absence. There is evidence to show that managers are taking a more robust approach to absence management both through feedback from IIP assessments and the Helpdesk activity undertaken by HROD.

Effective performance management through day-to-day engagement and communication with employees is seen as a key mechanism for bringing about behavioural change. Managers are expected to resolve issues early and positively. The Managing People training recently rolled out across the organisation focussed

on these essential skills needed by managers and the benefits of early intervention in pre-empting conflict.

It is anticipated that through a more joined up approach in terms of policy, occupational health interventions and a general focus on health and well-being across the organisation, attendance levels will continue to improve in the coming months.

SECTION 7 – RECOMMENDATIONS

The Committee is asked to note the current performance on attendance, together with the actions being progressed to support increased attendance across the Authority.

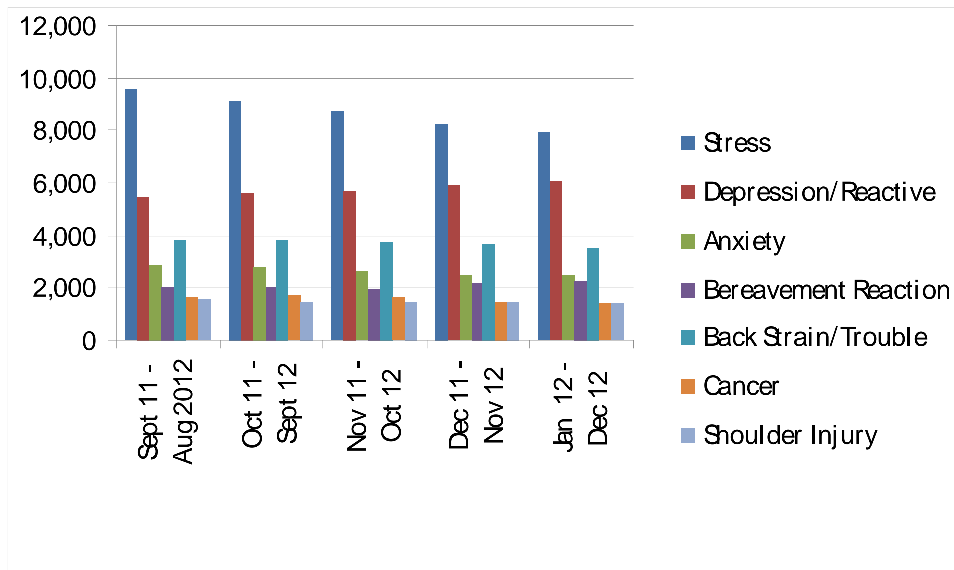
APPENDIX 1 - Change in Absence levels

The change in terms of short, medium and long-term absence in the seven months (May – November 2012) is provided below.

	Mar 11- Apr 12 Days lost	**Prop of total days lost to total days lost**	**Dec 11 – Nov 12 Days lost**	**Prop of total days lost to total days lost**	**% change over the period**
Short Term (Less than 5 days)	17,456	19.8%	18,030	21%	+ 3%
Medium Term (6-19 days)	13,274	15%	13,256	15%	- 0.1%
Long Term (20+ days)	57,644	65%	56,614	64%	- 2%
MCC Total	**88,374**		**87,900**		**-0.5%**

APPENDIX 2 – Reasons for Absence

Main reasons for absence



Reasons for Absence (Days Lost)

	Sept 11 - Aug 2012	Oct 11 – Sept 12	Nov 11 – Oct 12	Dec 11 – Nov 12	Jan 12 - Dec 12
Stress	9,575	9,136	8,753	8,241	7,959
% change from Sept 11-Aug 12 figure		-4.81%	-9.39%	-16.19%	-20.30%
Depression/Reactive	5,469	5,634	5,692	5,922	6,102
% change from Sept 11-Aug 12 figure		2.93%	3.92%	7.65%	10.37%
Anxiety	2,912	2,784	2,675	2,497	2,459
% change from Sept 11-Aug 12 figure		-4.60%	-8.86%	-16.62%	-18.42%
Bereavement Reaction	2,062	2,000	1,986	2,155	2,258
% change from Sept 11-Aug 12 figure		-3.10%	-3.83%	4.32%	8.68%
Back Strain/Trouble	3,843	3,798	3,727	3,639	3,481
% change from Sept 11-Aug 12 figure		-1.18%	-3.11%	-5.61%	-10.40%
Cancer	1,612	1,688	1,605	1,486	1,410
% change from Sept 11-Aug 12 figure		4.50%	-0.44%	-8.48%	-14.33%
Shoulder Injury	1,563	1,473	1,494	1,452	1,411
% change from Sept 11-Aug 12 figure		-6.11%	-4.62%	-7.64%	-10.77%

Note: Reactive illness refers to "Depression triggered by an upsetting or stressful life event."

APPENDIX 3 – FEASIBILITY STUDY ON FLU VACCINATION PROGRAMME

National flu levels and variations

This is generally measured via prevalence of influenza like infection seen at GP consultations (RCGP ILI consultation activity). The infection rates can vary enormously from one flu season to the next (one year to the next). It is impossible to predict if a coming winter will be a mild or severe flu season.

2009/10 saw the flu pandemic although rates in the UK were low compared to other countries. 2010/11 was a season of relatively intense flu activity (peaks of 120 cases per 100,000 population) and 2011/12 was a year of unusually low flu inflection and of flu occurring very late in the season in the UK (19.3 cases per 100,000 population at its peak).

Current Approach by the City Council to vaccination

The Department of Health recommends that Directors of Adult Services promote flu jabs to their front line social care staff with the aim of protecting high risk residents in their care (in line with the vaccination of frontline healthcare workers, for the same reason). The City Council has hence offered a free flu vaccine to front line staff in the Directorate of Adults for several years.

The flu vaccine was offered by the City Council to front line City Council staff in Children's and Adult Services as a one off in the Pandemic year of 2009/10, this was carried out by nursing staff from the "in house" occupational health unit who visited 133 locations at which these staff worked to offer vaccinations. Although there was widespread publicity in the press in general and also communication across the City Council the take up rates were low at about 9%.

The provision of vaccination to frontline social care staff in the Directorate for Adults, Health and Wellbeing should be continued on the basis it is recommended by the Department of Health, the Directorate is willing to fund it and the programme has been historically offered for several years.

The same offer is not made in Children's Services as staff do not provide personal care. The offer is publicised via broadcast emails. Eligible staff need to arrange a jab from a provider of their choice, pay for it themselves and then claim back the cost (up to £13 cap) via expenses.

Data from the SAP system shows a negligible take up rate, anecdotal feedback from the Directorate confirms this. This may be because some staff have been able to access free jabs via their GP or via an NHS vaccination programme operating at their place of work as they are co-located with NHS staff.

Vaccination – practicalities, take up rates, costs and efficacy

The influenza virus is unstable and new strains and variants are constantly emerging, which is one of the reasons why the flu vaccine should be given each year as the

vaccine is reformulated annually to make it as effective as possible against current common strains.

The vaccine is designed to be protective against these specific influenza strains and does not give widespread viral immunity (e.g. protecting against other flu like viruses or colds) or a general boost to the immune system. There is more than one vaccine available but all protect against the same, internationally agreed, strains each year. It is possible that an employee could catch a strain of flu different to that they had been vaccinated against.

For all the reasons given above, the vaccine is not 100% effective in protecting against flu; it offers moderate protection against influenza specifically. NHS patient data states it will protect about 7-8 people out of 10 who would otherwise get a vaccine-preventable strain of influenza to whom it is administered. Studies from 2011 demonstrated a 59% effective rate in adults age 18-65 that had the most common vaccine used in the UK.

For the purposes of the study, it is assumed that 75% of the staff who have a flu jab will not then succumb to the influenza viral strains it is designed to protect against. For individuals who believe, or have self diagnosed as having flu but in fact have another infection or virus, it will be completely ineffective.

Any impact on absence from a flu vaccination programme is going to be for a limited time, mainly during any peak in the flu season which is typically a 6 -8 week period.

The flu jab is offered free to the high risk groups listed below. Any employee in these groups will be able to access this themselves via their GP.

- Those over age 65
- Pregnant women
- Those with a serious medical condition (e.g. diabetes; chronic lung disease; severe asthma; chronic heart disease; serious disease of the nervous system or conditions that cause a poor immune system)
- Those living in a residential or nursing home
- Main carers of people at risk of flu complications
- Health care professionals

Take up rates of the free flu jab was 74% in over 65's at the end of 2011/12 flu season. Uptake is somewhat lower in the at-risk groups.

The NHS offers a free flu jab to front line care staff and has worked extremely hard over several years to increase the take up of the vaccination in their eligible staff. They have a targeted campaign each year and have put a lot of effort into educating staff as to the benefits especially in protecting vulnerable patients. In-house vaccination clinics (using NHS nurses) are also used as they have found this encourages higher take up than requesting staff arrange their own jab and then claim back the costs. Historically take up rates were approximately 20% now they are as high as 80% in some trusts.

For the purpose of calculations in this report a take up rate of any programme we offer to employees is assumed to be 40% where we offer the jab at in-house clinics. There is no way to accurately forecast potential take up rates but the NHS experience has been used as a guide, which may be an optimistic figure. NHS experience shows that where the employee has to arrange their own vaccine and then claim the expense back they are less likely to do so, hence it has been assumed that take up rates for this method will be lower at 20%.

Costs of vaccines vary widely with generally advertised vaccines available from as little as £5.99 on the internet. There is a wide variety of providers as the vaccination is simple to administer, with many on the high street e.g. Boots. Our own Occupational Health provider will deliver an individual vaccine for £11 or this falls to £8 if administered on a block booking basis.

Feedback from AGMA Occupational Health Group.

Feedback from this group indicated that many authorities do offer vaccinations to staff in front line care roles. All authorities reported that this was administratively a very onerous process often with high wastage and take up was still generally very low. Experiences from offering a reclaim type scheme (for example Sainsbury's pharmacy used by one authority) was that this led to even lower take up. None of the authorities had any evidence that there was a resultant benefit and all felt they continued to offer this as it had always been done historically rather than because it would be justified on the basis of a cost-benefit analysis. The consensus was that other initiatives aimed at increasing hand washing / good hygiene practices in staff may also have as much impact on absence levels by preventing the spread of general infections in the workplace.