Manchester City Council
Report for Resolution

Report to: Human Resources Subgroup – 31 March 2014

Subject: Attendance Monitoring

Report of: Assistant Chief Executive (People)

Purpose of the report

Following on from the Finance Scrutiny Committee HR Sub Group meeting on 26 September 2013, this report provides the HR Sub-group with a further progress update. The report sets out corporate and directorate absence trends and the actions currently being undertaken to improve attendance with a focus on developments since September 2013.

Recommendation

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

- Measures to support staff through the delivery of the employee health and wellbeing strategy especially linked to specific roles.
- The work being undertaken to understand the motivations underlying attendance and the development of strategies to address short-term absence.
- Further developments in the reporting of absence data to reflect trends more accurately.
- Information on sickness levels in Neighbourhood Services, including reasons for the reported rise in absence levels shown in the previous report and the work being done to address this issue.

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 and Overview Scrutiny Committee HR Sub Group meeting of 26 September 2013 – Attendance Monitoring report and minutes of the meeting.
- Finance and Overview Scrutiny Committee HR Sub Group meeting of 7 March 2013 – Attendance Monitoring report and minutes of the meeting.
- Finance and Overview Scrutiny Human Resources Sub Group meeting of 31 July 2012 – Attendance Monitoring report and minutes of the meeting.
- Finance Scrutiny Committee meeting of 24 May 2012 – Attendance Monitoring report and minutes of the meeting.

1. EXECUTIVE SUMMARY

- The Corporate indicator shows a small upward trend in average days lost per employee over the last 6 months for the workforce as a whole, a total rise of 0.38 days. This however, needs to be seen in the context of the seasonal trend in absence levels as set out below.

- An additional measure of absence, 'the average number of days lost per standard working month per employee' enables a clearer understanding of discrete monthly changes in absence, unaffected by any peaks and troughs which may have occurred in the preceding twelve months, unlike the corporate indicator.

- There is a clear seasonal pattern to sickness absence. August is a low point each year and there are usually dips at other holiday points such as Easter and Christmas. Increased absence over the autumn and winter period can generally be seen to decline in spring.

- The impact of seasonality on long term sickness throughout the year is far less significant than is in the case with short term sickness. The predominant medical reasons given for short and long term sickness are very different. Mental health conditions are the predominant reason for long term absence, with short term infections (e.g. colds and flu) the main contributor to short term absence.

- 41% of people (circa. 3,100 individuals) have had no absence in 2013 which is a 2% increase from 2012.

- Although approximately 70% of all days lost due to absence relates to long term sickness, this relates to a very small number of employees. On average approximately 4% of employees (circa. 300 individuals) are absent in a period of long term sickness in any month. Getting these employees back to work more quickly will make a significant difference to absence levels and is a focus area for managers, supported by HROD.

- In December 2013 a total of 281 individuals hit absence management triggers and managers have been supported by HROD to both facilitate returns to work and identify any underlying issues.

- The organisation remains focused on improving attendance with a range of interventions in place and being progressed to support this. These include:

    - Delivery of proactive and targeted interventions linked to some of the major causes of absence as part of the Employee Health and Wellbeing Strategy
    - Using the behavioural insight approach to improve motivation, engagement and attendance with a pilot of focused activity in a small number of services which is both about improving wellbeing and enforcing policy
    - The continued strengthening of our occupational health provision and the use of data and intelligence gathered through the service
    - Proactive support from HROD to managers in managing absence cases which have hit absence triggers.

- o Specific tailored activity within Directorates focused on those service areas and conditions which are the biggest cause of absence.

2 INTRODUCTION

2.1 On 26 September 2013, the HR Sub-group considered a report on attendance which provided specific information requested by the Group along with an update on attendance levels across the authority in the period between January and June 2013. This meeting followed on from a previous update six months earlier.

2.2 The report provided specific information requested by the HR Sub-group covering:

- Measures to support staff and retain their attendance during the period of extensive organisational changes, including through the delivery of the employee health and wellbeing strategy.
- The further work being undertaken to understand the motivations underlying attendance and development of strategies to address short-term absence based on this
- Developments in the reporting of absence data to reflect trends more accurately.

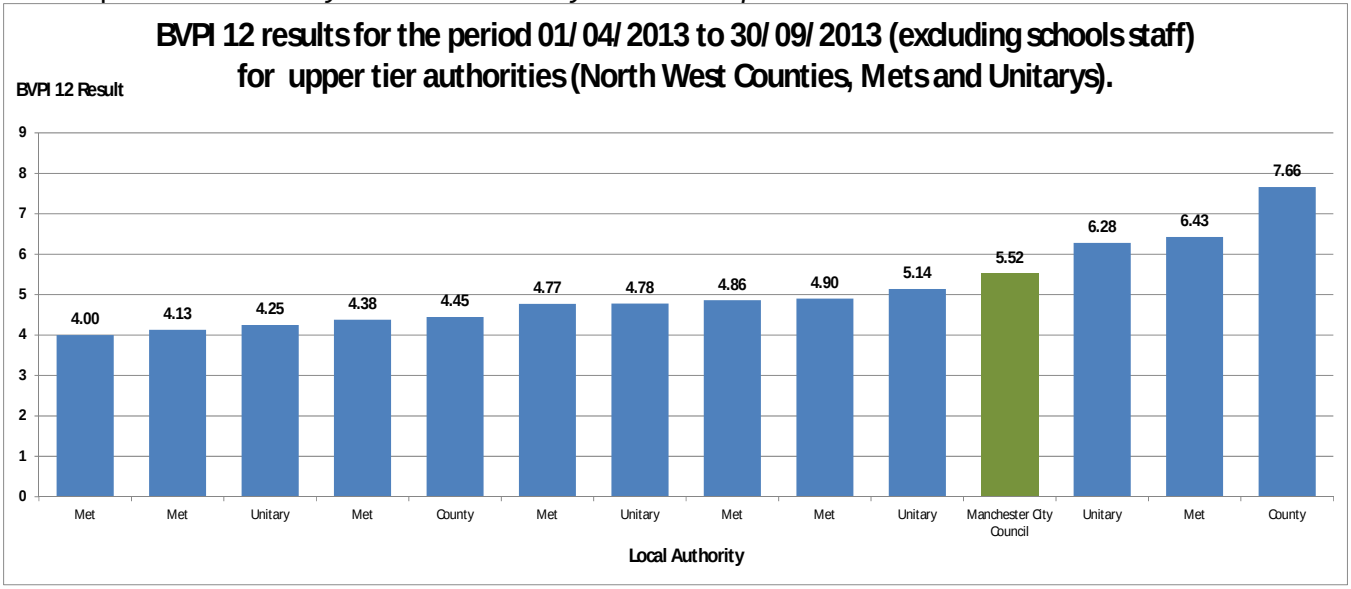
2.3 This update provides Members with detail on trends in absence and developments in the organisational approach to improving attendance. The report includes the specific information requested by the HR Sub-group at its last meeting.

3. BENCHMARKING - COMPARITIVE ANALYSIS WITH NORTH WEST LOCAL AUTHORITIES

3.1 The previous Committee report contained benchmarking data from the North West Employers Organisation's Annual Absence Report and noted an increasing sickness trend across North West local authorities as a whole.

3.2 The data below provides an updated position mid way through the 2013/14 financial year. The Council had a BVPI 12 value of 5.52 for this period against an average of 5.11 for all authorities in the sample. It should be noted that, there is likely some differential between how the various authorities calculate their return for this and hence direct comparisons would need to be treated with caution. It is worth highlighting that not all North West Local Authorities participated in this exercise.

Graph 1. *BVPI 12 Days Lost value of days lost in the period 01/04/2013 to 30/09/2013*



4. CORPORATE AND DIRECTORATE OVERVIEW

4.1 Corporate indicator of Absence

Table 1. *Average Days Lost Per Employee.*

	2010/11	2011/12	2012/13	2013/14
April		9.15	9.97	9.80
May	11.45	8.65	10.23	9.70
June	11.26	8.7	10.16	9.59
July	11.14	8.6	10.26	9.81
August	10.97	8.96	10.23	9.79
Sept	10.92	9.00	10.05	9.86
Oct	10.59	9.10	9.99	10.03
Nov	10.48	9.08	10.02	10.08
Dec	10.54	9.06	10.07	10.19
Jan	10.33	9.36	10.07	
Feb	10.26	9.60	9.93	
Mar	9.61	9.88	9.79	

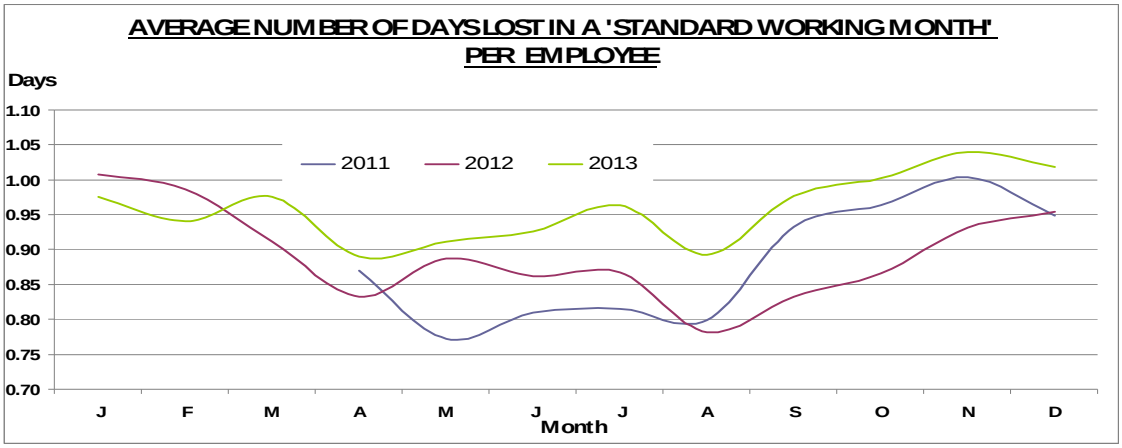
4.1.1 The Corporate indicator shows an upward trend in average days lost per employee over the last 6 months for the workforce as a whole. The highlighted section denotes the period since the previous report to Scrutiny. However, this needs to be set in the context of the general seasonal trend in absence levels as set out in paragraph 4.2.1 below.

4.1.2 The method of calculation for the Corporate indicator means each monthly figure includes data from the preceding 12 months. To give a clearer picture on the recent trend in absence, a more responsive measure based on 'the average number of days lost per standard working month per employee' is used as the basis for the remainder of this report.

4.1.3 The measure of 'the average number of days lost per standard working month per employee' enables a clearer understanding of discrete monthly changes in absence, unaffected by any peaks and troughs which may have occurred in the preceding twelve months, unlike the corporate indicator. The month-on-month measure gives an absence figure which relates to days lost in that month only; for the staff employed in that directorate / service at that time; and factors in the actual working patterns of the staff in that cohort during that month. This indicator was developed in direct response to the request of Members of this Committee twelve months ago.

4.2 Organisational and Directorate trends up to end of December 2013

Graph 2. A*verage number of days lost in a standard working month per employee*



4.2.1 As is evident through the overlaying of 2011, 2012 and 2013 days lost data above, there is a clear seasonal pattern to sickness absence. August is a low point each year and there are usually dips at other holiday points such as Easter and Christmas. Increased absence over the autumn and winter period can generally be seen to decline in spring.

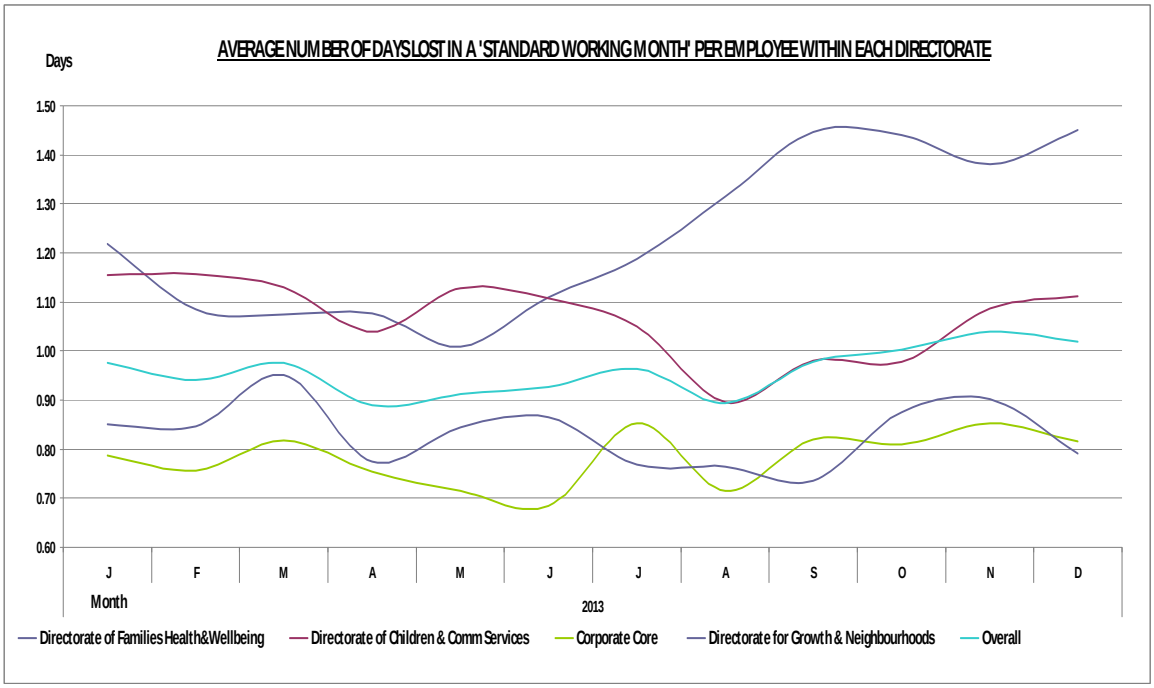
4.2.2 More information on absence reasons and durations is set out below, however at a high level, it is worth noting that the main driver for the pronounced seasonal trend is short term absence; and the main sickness reasons for short term absence are related to minor infections, colds and other viral infections such as throat infections etc.

4.2.3 This report primarily provides an update in absence trends over the last 6 months since the last HR Sub Group meeting in September. Hence it includes data for autumn and the start of winter which covers the period when days lost generally increase in line with the seasonality considered above.

4.2.4 The key organisation trends that are evident are:

- Absence has increased in the last 6 months, but this is in line with seasonality
- Whilst absence is higher than the previous two years, the variance from previous years is much lower than 6 months ago
- 41% of people, around 3,100 employees, have had no absence in 2013 which is a 2% increase from 2012.

Graph 3. *Average number of days lost in a standard working month per employee within each directorate.*



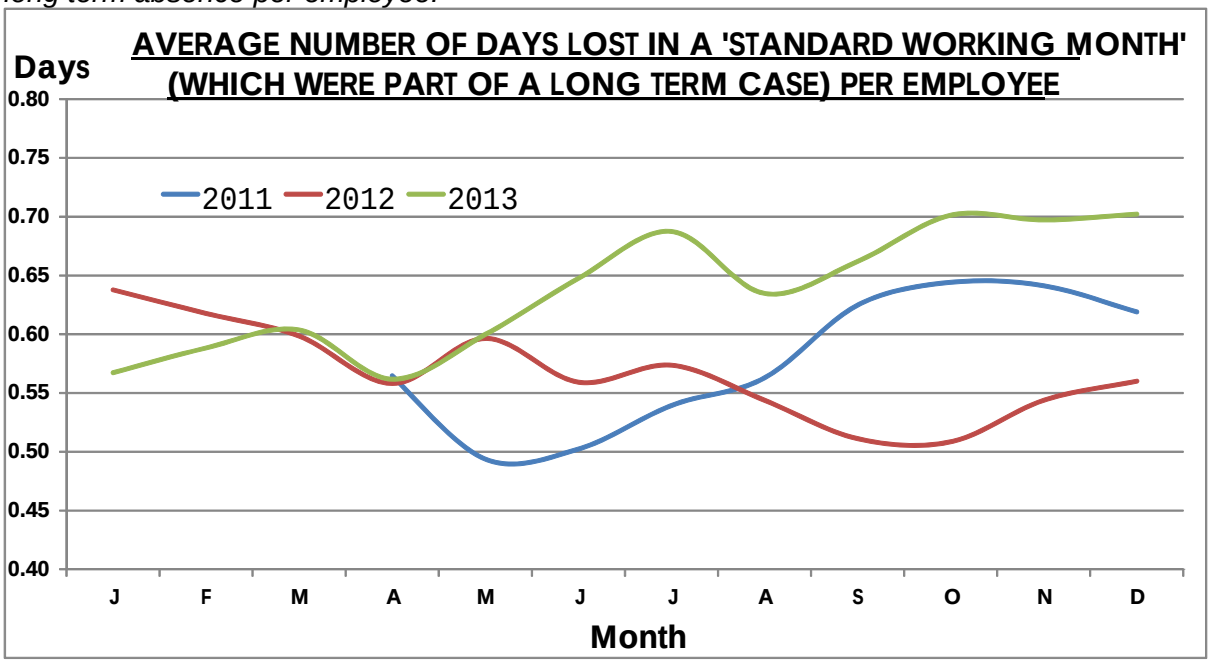
4.2.5 There have been significant organisational changes across the authority over the last six months and these large movements of staff will have had some impact on the respective levels of absence at a Directorate level as functions with different levels of sickness move within the Council. There is more detail on these organisational changes and their impact in Section 6.

4.2.6 Appendix 5 contains individual average days lost graphs for each Directorate. Some of the key trends –which detailed analysis have highlighted are:

- There are pronounced seasonal trends in the Children's and Commissioning Directorate and Growth and Neighbourhoods Directorate which follow the same decrease in school holidays pattern seen in the Corporate trend (Graph 2). Growth and Neighbourhoods follows a similar trend to Children's and Commissioning with a less pronounced decrease in summer 2013 coinciding with the transfer of Business Units to the Corporate Core.
- The Corporate Core did have the most stable and the least seasonal absence pattern until the second half of 2013 when a more seasonal trend started to show (this coincided with the transfer of Business Units from Neighbourhood Services into this Directorate).
- The Directorate for Families, Health and Wellbeing does not follow the same seasonal trends seen elsewhere. 2012 demonstrates a year where the best performance on absence was seen from July – October in the Directorate. The days lost in the Directorate have increased since July 2013 and are noticeably higher than the other Directorates since this time. This increase is due to an increase in long term absence with short and medium term remaining consistent.

4.3 Duration of absence.

Graph 4. *Average number of days lost in a 'standard working month' which were part of a long term absence per employee.*



4.3.1 This measure is an indication of trends in the amount of time lost each month per employee due to absence which was long term (taking account of differing directorate sizes). This data, when viewed in conjunction with Graph 5 below, shows that long term absence is a far more significant contributor to overall absence levels than short term.

4.3.2 Days lost across the authority due to long term sickness, as a percentage of total days lost, has increased from about 59% of days lost in Q3 2012 to 69% in Q3 2013.

4.3.3 Although approximately 70% of all days lost due to absence relates to long term sickness, this relates to a very small number of employees as the graph in Appendix 4 illustrates. On average approximately 4% of employees (circa. 300 individuals) are absent in a period of long term sickness in any month. Getting these employees back to work more quickly will make a difference to absence levels and is a focus area for managers, supported by HROD.

4.3.4 Data from Occupational Health referrals shows that over the last 6 months approximately 37% of employees referred had a medical condition which would be considered a disability under the scope of the Equality Act. The majority of referrals to Occupational Health are due to prolonged sickness.

4.3.5 Section 6 gives an overview of the number and nature of long term absence cases in December for each Directorate and an indication of how these are being managed. Differing approaches will be needed to manage long term absence dependant on any underlying medical condition(s) and relevant medical prognoses. Approaches will usually take one of two forms:

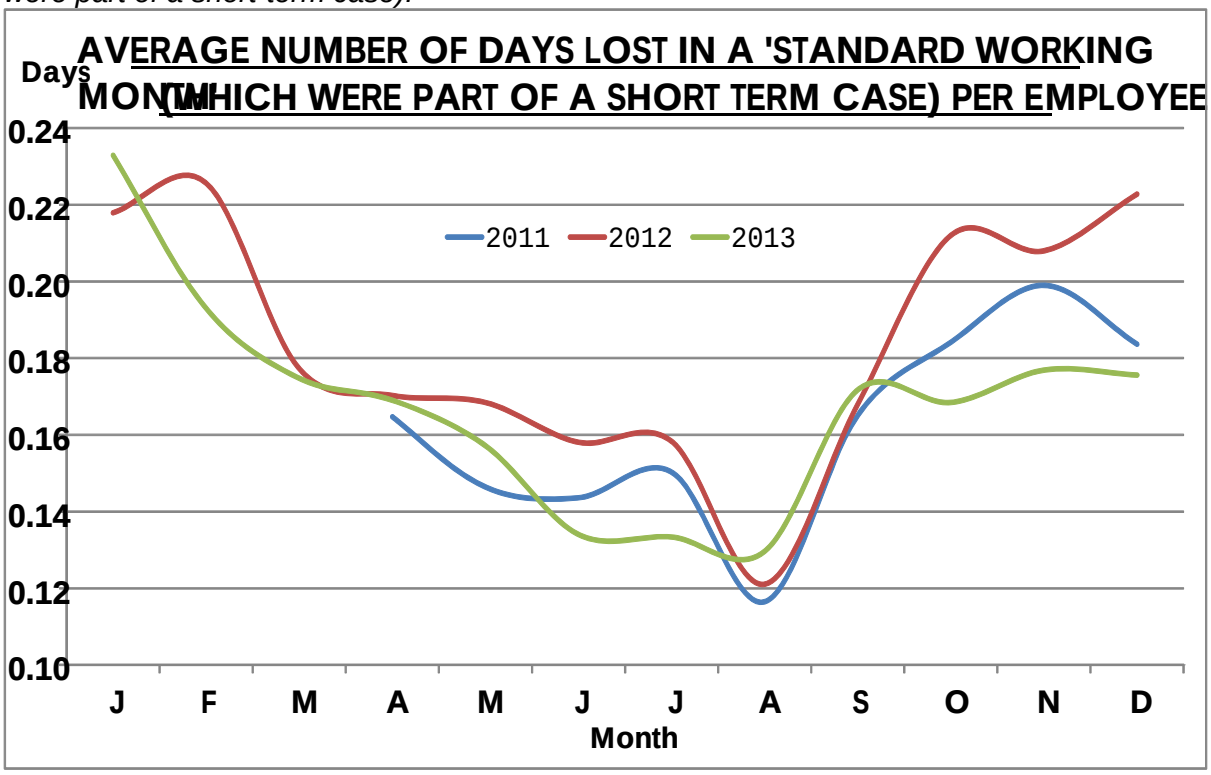
- A proactive approach to reviewing options and supporting a return in line with the managing of attendance policy where it is possible. Occupational

Health and Health and Safety support may play a key role here e.g. workplace adjustments, counselling, physiotherapy, or risk assessments such as stress risk assessments.

- An approach based on supportive contact where the employee is currently too ill for work of any kind of work no matter what action is taken by employer or employee.

4.3.6 The impact of seasonality on long term sickness throughout the year is far less significant than is the case with short term sickness. By far the largest reason for long term sickness are non-physical relating to a range of ill health that comes under the umbrella of mental health conditions.

Graph 5. *The average number of days lost in a standard working month per employee (which were part of a short-term case).*



4.3.7 The above graph is an indication of the trends in the amount of time lost each month per employee due to absence which was short term (taking account of differing directorate sizes).

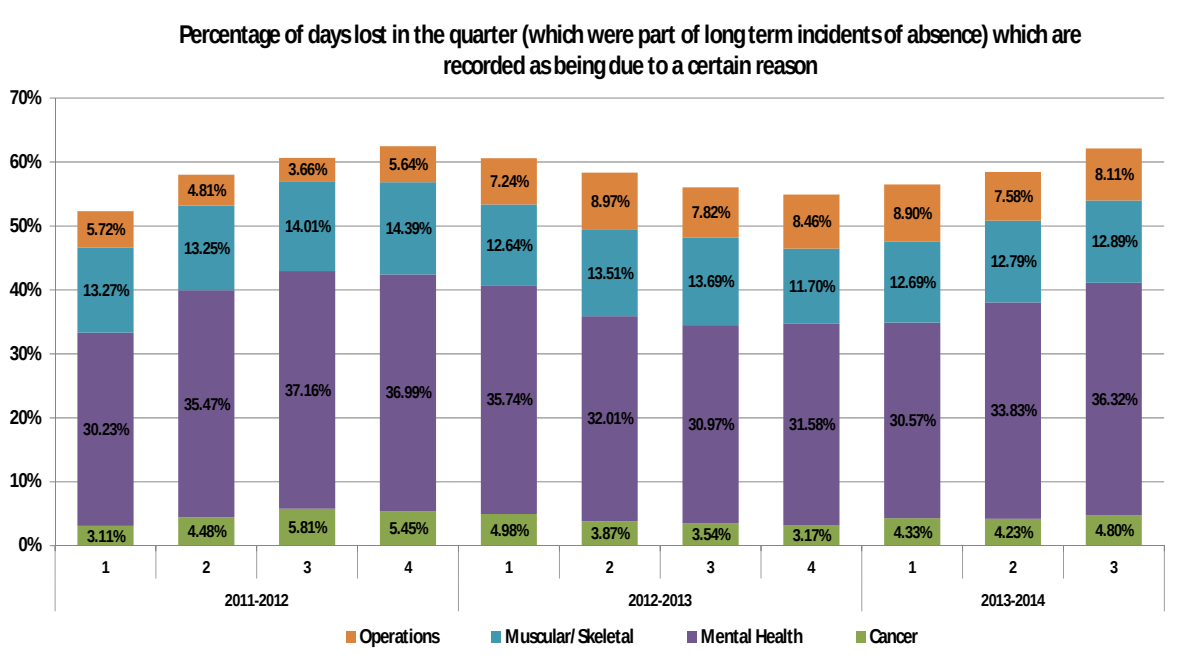
4.3.8 This data indicates levels of short term absence is over time. It is worth noting that the top point of this graph (~ 0.22 days) is significantly below the long term low point (~0.70 days).

4.3.9 Days lost are lowest in August and then increase steadily to a peak in winter. By far the most significant reason for short term sickness is minor infections (colds etc), which tend to be more prevalent in the winter months. It is for this reason that a “bug busting” campaign was conducted, under the employee health and wellbeing strategy, in winter 2013/14.

4.3.10 As the graph shows, the days lost due to short term sickness in the winter months of 2013 are lower than in the previous 2 years.

4.4 Reasons for absence

Graph 6. *Percentage of days lost in the quarter that were part of long term occasion of absence and the reason given.*

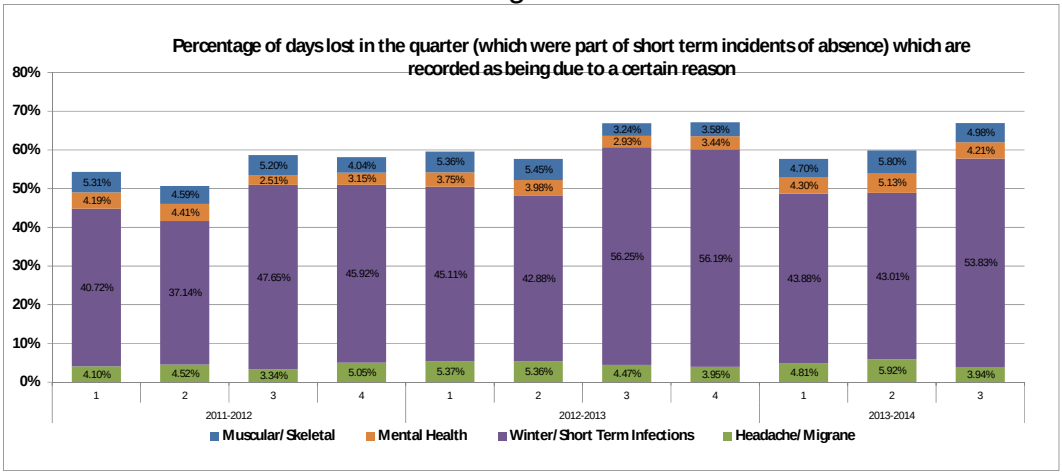


4.4.1 Mental health continues to be the main contributor to long term sickness. This grouping is made up of absence relating to stress, anxiety, depression and bereavement reaction. A slight upward trend can be seen in the contribution of these causes to absence over the last 15 months.

4.4.2 The other main contributors to long term sickness are operations/post operative debility; musculoskeletal disorders and cancer. These top 4 reasons account for about 60% of long term sickness.

4.4.3 The 2009 North West Mental Wellbeing Survey is an independent survey of the mental health of the local population with a large sample size (18,500) and the use of face to face interviews. It concluded that mental wellbeing is low for 16.8% of the North West population and 23.7% of the Manchester population. The survey showed that people with low mental wellbeing are more than three times more likely to be anxious or depressed (i.e. suffer ill health) than those with higher levels of mental wellbeing. Hence objective external data on mental health and wellbeing in the City would indicate that our workforce is indicative of the local population in terms of mental health and wellbeing. This is a priority area for the organisation with a range of both general activities and focused interventions linked to specific roles across the Children's and Families Directorates now in place. More detail linked to the delivery of the Health and Wellbeing Strategy and specific Directorate initiatives is set out below and within Appendix 2.

Graph 7. *Percentage of days lost in the quarter that were part of short term occasion of absence and the medical reason given.*



4.4.5 Sickness relating to emotional/mental health and wellbeing is a very small contributor to short term sickness (less than 5% of the days lost in the last quarter). It can be concluded that if someone becomes absent due to a condition related to their mental or emotional health they are likely to be off work for a longer period.

4.4.6 For short term sickness, the main reasons for absence are minor infections (cold / virus, upset stomach, vomiting, chest infection etc). This accounts for between 40% and 60% of all short term sickness.

5. CORPORATE MEASURES TO IMPROVE ATTENDANCE LEVELS

5.1 The effective management of attendance is a key corporate priority; details about corporate strategies and initiatives currently in place to help tackle absence levels are given below (the next section of the report deals with directorate specific approaches).

5.2 Employee Health and Wellbeing Strategy

5.2.1 The Employee Health and Wellbeing 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. If the Council encourages all employees to take care of; and make small improvements to their health, this should yield benefits for them at home and also in the workplace. The principles of behaviour change hence underpin all work carried out in support of the Employee Health and Wellbeing Strategy.

5.2.2 Recent independent research by “Investors in People” (a government organisation which promotes excellence in people management through it’s national quality standard) supports the above conclusion. This research found that individuals surveyed who felt their employer did not care about their health and wellbeing said this led to them feeling less motivated with over one in ten (13%) admitting they do not work as hard, and a further 15% noting they actually resent their employer. The survey also found more than one in five workers have ‘pulled a sickie’ in the last year, and more than one in twenty

(6%) do so more than five times a year. While most sickness absence is genuine, those who described themselves as unhappy in their role are more likely to consider taking 'sick days' compared with those who described themselves as happy, with almost three in 10 (27%) of unhappy workers having embellished the truth about being ill to take a day off on at least one occasion in the last year.

5.2.3 The Employee Health and Wellbeing Steering group is the overseeing body for the implementation of the strategy. This group comprises a mixture of HROD, Trade Union and management representatives. The group sets the direction for activity and acts as a sounding board for ideas. Priorities for targeted activity have been identified using feedback from Public Health about the health of the City as a whole; feedback from the organisation's Occupational Health Provider; 'Health Bus' feedback (see below) as well as management information and anecdotal feedback from the group. For example, the number of days lost to winter infections drove the idea for the "bug busting" activity and feedback from our Occupational Health Provider and 'Health Bus' visits about high obesity levels and low activity levels drove the development of activity around getting more active.

5.2.4 Appendix 1 shows the wide range of activity which has taken place over the last nine months to help embed the Health and Wellbeing strategy. There is now a Health and Wellbeing section to the intranet which has 25 pages and is being constantly expanded. These pages are amongst some of the most popular on the intranet and Appendix 1 provides detail on the number of 'hits'. The pages contain a wealth of information for employees and managers including –

- a "how healthy are you" self assessment tool which pinpoints areas for potential improvement.
- pages with guidance on tips on how to be healthier in a range of areas.
- guidance for managers on supporting staff with health conditions (including cancer, bereavement, musculoskeletal disorders and chronic/long terms conditions).
- a calendar showing health related activities across the City.
- signposting to good quality information what may be useful to employees from sources such as NHS, leading health charities and professional organisations (e.g. British Dietetic Association).

5.2.5 As well as setting up dedicated intranet pages there have been eight focused interventions aimed at raising interest and awareness in improving health in a specific area. These were:

- Movember campaign – to publicise and increase awareness of cancers relating to men e.g. prostate cancer.
- 'Health Bus' Visits - visits to 9 employee sites by the Health Bus to carry out health checks and health MOTs for staff. As well as the individual benefit (i.e. early flagging of potential life threatening illness and referral to NHS support) this also provided an anonymised professional snapshot of the health of the workforce.

- Macmillan roadshows – to provide information, advice and 1:1 support for employees affected by cancer (themselves or relative/friend). This included advice on spotting signs of cancer, emotional support, benefits advice and signposting to NHS services or support groups. 5 separate sessions were held .
- Bug busting initiative - as well as information on the intranet, broadcast emails, a poster campaign and an online quiz were developed. Additionally a 45 minute session run by infection control specialists was offered across the organisation. The interactive session included a presentation on how to reduce your infection risk and a practical session on effective hand washing. Over 40 of these sessions have been either delivered or are scheduled to be delivered.
- Fitness classes – There was an initial 6 week trial of fitness classes at 5 different locations for staff. Cost to staff is £1 a class. Delivered by trained instructors from Active Lifestyles. Take up was high and the classes have been continued after the trial period.
- Weight loss support - Discounted weight watchers membership via the employee benefits scheme and advice for staff on which weight loss programmes deliver the most sustainable results without any negative impacts on health.
- Healthy Diet advice and factsheets - Fortnightly communication to staff with tips about small steps they can take to improve diet (e.g. Change4Life healthy swaps programme, healthy snacks, eating for a healthy heart etc).
- Employee running groups - In conjunction with Run England employee volunteers have been trained to become run leaders and are now leading weekly run groups from various premises to provide a safe/sociable way into running for beginners.

5.2.6 Employee engagement and interest levels have been high in all activities indicating an underlying interest in becoming healthier. As the aim is to influence behaviour, a key focus of all activities is on quality communications which engage employees and demonstrate the benefits of participation using real life stories.

5.2.7 A priority area for 2014 is to strengthen the approach to supporting good emotional health and wellbeing, a key area for the organisation as the above analysis on reasons for absence indicates. This covers a very broad spectrum from short term adverse pressure effecting an individual (commonly referred to as stress) through to long term medical conditions for which the NHS or our Occupational Health provider may be engaged in providing psychological treatments and therapies.

5.2.8 There is growing interest from management teams in some areas in developing approaches which support and encourage staff to develop their personal resilience (in all areas of life). Additionally, there is widespread agreement from the Health & Wellbeing Steering group that there is potential to improve managers' skills and confidence in having sensitive conversations about emotional health and wellbeing.

5.2.9 Appendix 2 gives detail on the types of activity which are being piloted in social work. Evaluation will give information as to which activities are most successful in improving the emotional wellbeing of staff which will then be rolled out to other areas across other areas.

5.3 Improving Motivation, Engagement and Attendance Using Behavioural Insight – Behaviour Change Pilot

5.3.1 The report of September 2013 updated the HR Sub-group on the behavioural insight workforce pilot and the planned focus groups. These focus groups and an additional employee survey exercises have now taken place and employees' views on a) behaviours related to absence from work, particularly where this can be reduced, and b) the role of disengagement and de-motivation as likely underlying causes have been collated. The pilot project will focus on three specific interventions that will be tested together in three service areas. The proposed interventions, which will combine to deliver a mixture of nudge and viral change behaviour change models are outlined below. One service will be identified within each of Growth and Neighbourhoods, Children and Families, and the Core to participate in this pilot which will then be evaluated in 6 months time.

- **Reinforce existing policy approaches with Managers**

  Employee feedback showed that absence-related policy is perceived to be inconsistently implemented, and there was concern that even when the process is followed, it does not consistently deliver effective outcomes to reduce absence. Proactive reporting of hot spots in terms of non compliance will be utilised to increase manager accountability supported by the Corporate Management of Attendance Steering Group. This group consists of trade unions representatives, senior managers from Directorates and HROD officers and meets regularly to review the effectiveness of attendance management. The group provides a sounding board for planned initiatives and policies relating to managing attendance. Planned initiatives in this area include –

  - **Online System for Absence Reporting**
    More timely and accurate capture of information from operational managers has been achieved through rolling out an online absence notification system which has been piloted since January 2014. System prompts remind managers to ensure they have the relevant meetings with the employee (e.g. return to work interviews when sickness ends, attendance monitoring reviews if they have hit triggers) and that they update the reasons for absence if required. Additionally, the system enables notification of disability related absence to enable this to be corporately revealed, measured and quantified. This also enables the organisation to ensure appropriate support, such as aids and adaptations, have been put in place.

  - **Learning Sessions for Managers**
    Learning Lunch sessions are scheduled to be delivered in April and May to managers, initially within the behavior change pilot areas. These sessions

will reinforce to managers their key responsibilities in terms of managing absence i.e. reporting absences promptly; keeping in touch with absent employees from an early stage; monitoring absence rates; and conducting return-to-work interviews in a sensitive and constructive manner and providing employees with support and that they understand what support is available to them - from HR, from trade unions and occupational health specialists, for instance. These sessions will make managers aware of what is on offer and how it can be accessed.

- **Employee Engagement**
  A communication strategy is also being developed to reinforce the workforce's responsibilities in relation to complying with managing attendance policy and to embed key messages regarding the importance of good attendance. The Management of Attendance area of the Council's Intranet is currently being redesigned to help underpin this strategy and the updated pages will be launched in April.

- **Health Trainer Champions programme**
  The Health Trainer Champions programme has been developed by Public Health specialists to motivate employees to improve health and wellbeing for themselves, their teams and the communities that they work with. The programme will test the potential for a wider programme to motivate employees to improve health and wellbeing using an evidence-based viral change approach. This will also support the delivery of the local authorities' public health responsibilities by helping to improve the health of Manchester residents. Initial training for new Champions will take place in April.

- **Running Group Pilot**
  This initiative is a corporate health and wellbeing activity, but will have additional promotion and monitoring in the pilot areas. Following a viral change methodology, trained Run Leaders (who are members of our workforce) will enable people of all abilities to engage in the activity, and in turn pass on the benefits of their experience to encourage others to follow suit. Run Leaders are now in place across many locations, with the potential to increase these numbers and / or make arrangements to link enthusiastic participants with a group where one is not immediately accessible. The pilot will track the success of this initiative in improving participation in the run clubs, with the ultimate aim of improving health.

5.4 Occupational Health Service

5.4.1 The Occupational Health contract has been in place since March 2012. The contract continues to be closely managed in order to ensure the best service possible. The two year review of the contract is scheduled to take place on 2 April 2014. As well as the measurement of hard KPI data, qualitative monitoring is also considered. This includes an analysis of reports and their effectiveness in assisting managers to make informed decisions where medical issues play a part.

5.4.2 Directorate Management teams discussed the performance of the provider and gave feedback on the value of the provision in late 2013. It was felt, generally, that information provided was valuable in aiding management decisions.

5.4.3 There are continued good take up levels of physiotherapy and counselling treatments provided to employees and a robust health screening surveillance programme was implemented for the occupational risks of noise, vibration and night work in Spring 2013. The provider is also playing a proactive role in helping the identification of key hotspots in terms of specific health issues and ensuring focused interventions such as counselling as well as more preventative support are targeted here.

5.5 The HROD Helpdesk

5.5.1 The HROD Helpdesk provides managers with ongoing support on managing attendance effectively. On a monthly basis all managers that have staff who have hit the management action or trigger levels are identified and contacted to discuss the subsequent action they are taking. This project has been in place for 18 months and the aim is to engage managers in considering options available and supporting them in taking the most effective action to achieve a return to work.

Table 2. *Number of staff hitting absence triggers*

CASES	December 2012	June 2013	Dec 2013
Short term (less than 5 days)	130	153	169
Medium term (5 – 16 days)	173	206	179
Long term (20+ days)	243	242	281

This table shows the number of employees who have hit triggers within the month and whether this was in relation to short, medium or long term sickness (see note1).

Note[1] The triggers for absence are five or more days in the previous three months or three or more occasions of absence in the previous three months.

Table 3. *Number of short, medium and long-term cases*

	FH&W	Children & Comm.	Corporate Core	Growth & Neighbourhoods	Total
Short-term cases	36	43	65	25	169
Medium-term cases	52	44	53	30	179
Long-term cases	87	65	86	43	281

This table shows the breakdown of individuals who hit triggers in December 2013 on a directorate basis.

5.5.2 A number of positive examples of management action have been cited by helpdesk staff. These often involve managers who are openly engaging with their staff during sickness and proactively considering and pursuing different options to enable an early return to work. The specific types of actions commonly used include:

- Regular and constructive communication with the employee about barriers to work and how to remove them
- Use of regularly reviewed phased return plans including reductions in hours or duties or ability to work from home etc.
- Referral to Occupational Health and then review of advice provided in line with service needs and quick implementation of workplace adjustments.
- Offering short term counselling or CBT or physiotherapy.
- Consideration of any underlying problems and open conversations about job fit
- Enhanced individual support following periods of heightened organisational change or early identification of support when stress is cited (e.g. conducting a stress risk assessment and agreeing corrective actions).
- Use of mechanisms under the policy where required e.g. incremental warnings

5.5.3 Some barriers to effective attendance management still exist amongst managers such as:

- perceptions that medical professionals and employees themselves control a return to work and hence managers not considering what they themselves can do to help facilitate an earlier or supported return
- a belief that taking action under the management of attendance policy can be de-motivating to staff
- perception that if staff have a condition covered by the Equality Act that no action can be taken to manage their attendance.

5.5.4 Based on the above the following activities will be progressed in the coming months:

- Focused activity on “myth busting” with managers to challenge some of the unhelpful perceptions and provide evidence of what works and why.
- Improved escalation to Directorate Management when there are clearly areas where action is being avoided.

6. DIRECTORATE MEASURES TO IMPROVE ATTENDANCE LEVELS 7.

This section highlights specific Directorate absence trends or patterns and the activity targeted on reducing absence at Directorate and Service level. Appendix 5 contains the Directorate level data which is referred to within this section.

6.1 Children’s & Commissioning Services.

Overall Absence Trends

Children’s and Commissioning Services has seen a similar pattern of absence over the last year, there has however been a marked reduction in the average days lost related to short term absence in Quarter 3 this year compared to the previous two years. Additionally the % of employees who were absent in a month was approximately 2% lower in most months of 2013 compared to the previous year. Finally the % of days lost relating to mental health decreased from around 44% in Quarters 1&2 to 38% in Quarter 3.

The decline in Childrens and Commissioning Directorate's absence levels corresponds with a number of service changes across Early Years and Residential Care and the transfer of a large proportion of Social Workers to Families Health and Wellbeing in Q3.

Directorate Activity and Interventions

Analysis of absence management triggers within C&CS in December 2013 illustrates that a total of 152 employees hit absence triggers. Of these 65; (42%); related to long term absence.

Within the directorate long term absence continues to represent the highest proportion of days lost. There are currently 46 employees absent due to long-term sickness. Of these cases:

- 16 (34%) relate to stress/depression anxiety and bereavement reaction
- 13 (28%) relate to chronic underlying conditions (e.g. Cancer / Heart Related)
- 17 (38%) relate to other conditions of a many and very varied nature

All of these cases are subject to active management. However, in some cases management options and actions are restricted by the nature of the illness and the medical prognosis. For example, 5 (11%) of the cases within the Directorate are associated with Cancer, in such cases management interventions can be limited to ensuring that appropriate support is in place and that there is regular contact and updated medical information sought as a return to work at the current time is out of the question.

Divisions within the directorate where absence consistently exceeds the corporate average include Residential Services, Fostering and Adoption Services and Social Work & Specialist Family Support. These frontline service areas have seen fluctuations in absence but the average days lost per employee has been consistently high over the last 12 months.

A range of measures have been utilised by these service areas to address absence. Due to the issues associated with workforce turnover of Social Workers which is experienced both locally in Manchester and nationally, concerted efforts have been made to address absence cases associated with Social Workers. Work has been undertaken to better understand reasons for high staff turnover and absence amongst social workers including analysis of exit interviews and the social work health check survey.

The outcome of this work is that a range of mechanisms are being piloted with social workers to support their emotional health and wellbeing and to reduce sickness related to mental health conditions. These include -

- Health and Wellbeing Self Assessments
- A Health needs assessment for both staff and management
- Active involvement within the service in the "Health Champions" pilot
- Training for mangers related to mental health in the workplace
- Building Resilience workshops

Appendix 2 contains more detail about this pilot as did the Health and Wellbeing section of this report.

It is envisaged that these interventions will have a positive influence on both turnover and absence related to sickness.

A monthly Workforce Intelligence report is presented to Children's and Commissioning DMT and as part of this absence levels and trends are identified especially where there are increases. From this service managers are tasked with providing an overview of absence issues and actions put in place to tackle it. The direction from DMT is crucial in ensuring management engagement and has a real impact on absence levels. For example since DMTs request for focus to be applied to absence levels in Residential Services which has shown a 7 % improvement in attendance levels in Quarter 3 of 2013.

6.2 Growth & Neighbourhoods Directorate

Overall Absence Trends

Growth and Neighbourhoods is a newly formed Directorate and this is the first reporting of attendance for this Directorate to Finance Scrutiny Committee – HR Sub Group. It should be noted that the data represents a year which started with Neighbourhood Services Directorate (which included a specific set of services) and ended with the new Growth & Neighbourhoods Directorate which is configured by a different set of services. Therefore, whilst comparisons have been made to the old Neighbourhood Services Directorate the configuration of the directorate is different and hence it is not a like for like comparison. Further to which it should be noted that in direct response to a request by the Committee at the last meeting there is a particular focus on Neighbourhood Delivery.

At the Finance Scrutiny Committee – HR Sub Group Committee meeting in September 2013 a query was raised about the apparent spike in absence in Neighbourhood Services Directorate in the month of June (as shown in the graph for Neighbourhood Services Directorate in Appendix 5). The Finance Scrutiny HR Sub Group asked that the increase be investigated to provide more explanation of the reasons for this. The spike did not represent a genuine increase in absence levels and was merely the effect of large scale employee movements during June and the calculation methodology which used an average FTE value for the reporting month. The transfer of Business Units to the Corporate Core Directorate and the transfer in of other services into Growth and Neighbourhoods from July 2013 have corresponded with several changes in absence trends within the Directorate.

The pronounced decrease in absence in August seen in previous years was not evident in 2013. This is likely to be symptomatic of the movement of term time only catering staff out of the Directorate.

Days lost relating to short term absence has decreased slightly compared to 2012 however days lost related to long term sickness is approximately 0.1 - 0.2 days higher than 2012 levels. The proportion of all days lost that is long term has increased from on average 62% in 2012 to 70% in 2013.

Directorate Activity and Interventions.

When looking at the days lost in a quarter which were part of a long term absence the most significant reason for such absence days is Mental Health related absence (Stress, Anxiety, Depression and Bereavement reaction). The percentage of all long term sickness due to mental health sickness has increased significantly from 17% in quarter 1 to 32% in quarter 2 and again to 36% in quarter 3 of 2013. This may relate to the changing composition of the workforce.

The second highest category of reason for absence is musculoskeletal. There has been a reduction in the proportion of long term days lost in a quarter for this sickness reason from 18% to 12% from Quarter 1 to Quarters 2&3. The reduction of this type of absence may be partly attributable to the transfer of catering staff who have a high degree of manual handling in their role; but also to targeted work to reduce this type of absence including the delivery of a number of workshops to assist managers with strategies for dealing with musculoskeletal related absence.

There were 98 individuals who hit management of attendance triggers in December 2013; of these:

- 20 (20.5%) relate to mental health issues (stress, anxiety, depression)
- 19 (19%) relate to musculoskeletal conditions
- 12 (12%) relate to cancer/chronic conditions

11 of the cases attributable to stress, anxiety or depression involved Neighbourhood Delivery Operatives and in the majority of cases individuals have stated that this is as a result of the ongoing review of current working practices and subsequent changes to shift arrangements. There have been some successful returns to work as a result of active management of cases, meeting with individuals to discuss options and potential outcomes if staff fail to engage, such as Attendance Management Hearings. In order to support staff during significant periods of change there have been a significant amount of staff briefings, regular engagement and a bespoke workshop has been developed for staff which focuses on building resilience and developing personal strategies to handle change. Management in areas with the highest levels of absence were also encouraged to engage the support of HROD as early as possible where work related stress related absences occurred to enable targeted support as appropriate.**

As a result of this work 6 of the 8 employees absent in quarter 3 have returned to work. This has had a positive impact on the number of days lost as a result of long term sickness which will continue as a result of other imminent returns to work.

Other long term absence cases within the Directorate relate to chronic conditions such as Cancer and ME. Appropriate support is being provided for these individuals and management of the cases has been adapted accordingly with guidance and advice from Occupational Health.

6.3 Directorate of Families, Health & Wellbeing

Overall Absence Trends

In Families, Health and Wellbeing absence levels show a general increase from April/May throughout summer months to higher levels around the onset of winter months (July to October 2012 was a notable exception in having less days lost than 2011 and 2013). This pattern is in contrast to seasonal patterns seen in other Directorates.

Quarter 1 absence levels were better in 2013 than 2012, however absence levels increased in the second half of 2013 and levels exceed those seen in the previous two years for the same period. Long term absence is driving the overall increases seen in days lost, short term absence has actually reduced compared to the previous two years. 71% of all absence in the Directorate was long term in Quarter 3 of 2013 and there were increases across all areas of the service. Around 6.5% of employees were long term absent every month in Quarter 3 of 2013, this is higher than the same period in 2012 for which the average was 4.5%.

Unprecedented organisational change has taken place in 2013 with the development of a new senior management structure and service redesigns across all areas of the Directorate. This has resulted in changes in the overall make up of the Directorate workforce which does impact on the validity of comparisons to past data. The most significant of the organisational changes have been;

Quarter 1

- the transfer in of Public Health staff from the NHS
- movement of Families Commissioning service to Children & Commissioning Directorate
- the development of the new senior management structure

Quarter 2

- the development and movement of resource into the new Locality model

Quarter 3

- transfer of Children's Social work staff into the Locality structure

Some of the fluctuations in absence levels can be related to changes detailed above, for example the former commissioning service in Families, Health & Wellbeing had very low levels of absence, whilst Children's Social Work has higher than average levels of absence.

<u>Directorate Activity and Interventions</u>

The main reason for long term sickness relates to mental health conditions. The percentage of long term sickness that related to mental health was 40.45% in Quarter 3; this is the highest for all Directorates for that period.

During quarter 1 and quarter 2, feedback from Occupational Health has indicated that they have seen an increased number of referrals from Families, Health & Wellbeing as a consequence of stress. Employees have been stating to Occupational Health that they are feeling more stressed due to staff cuts and shortages and are concerned about making errors and mistakes which could affect their careers. The degree of change within the Directorate and fundamental reductions in front line

provision and impact on service users may be an underlying cause of these perceptions in the workforce.

A focused piece of work was undertaken in the second half of 2013 to review all employee absences where stress or mental health was the reason for absence. This was to ensure that any work related issues were dealt with and that appropriate levels of support were in place. Of those cases reviewed work related issues were a main factor in 40%; this included staff under disciplinary investigation and staff already raising issues through the employee dispute resolution procedure. In 30% of cases reviewed both work and personal issues were factors with assaults in the workplace in addition to personal problems being main contributors. There were 12 cases of which 10 have now been resolved. This focused activity is currently being repeated.

Analysis of absence management triggers within Families, Health & Wellbeing in December 2013 illustrates that a total of 175 employees hit absence triggers. Of these 87 employees (50%) hit triggers in relation to long term absence. Since December more than half of the employees who hit triggers for long term sickness in December have returned to work; but 39 remain absent. All of these are subject to active management supported by Occupational Health and HR.

The Directorate Management of Attendance Strategy group meet bi-monthly, in addition to the targeted work detailed above other work directed by this group has included –

- The Head of Business Delivery has undertaken sickness clinics across all service areas reviewing practice and strategies for the resolution of long term sickness cases.
- One of the issues identified through the sickness clinics was the amount of absence related to ‘bereavement reaction’. This was highlighted and new corporate guidance for managers was developed and is available on the Health & Wellbeing intranet pages. All managers were issues the guidance and as a result there appears to have been a reduction in absences related to bereavement reaction.
- Regular review of strategies to resolve the top long term absence cases. There are currently 6 employees who have been off for more than 200 days, of these 2 are now on notice to leave, 3 with a return date planned and 1 recovering from surgery (after which they will return).
- Review by Heads of Service of all short term absence cases.

6.4 Corporate Core Directorate.

<u>Overall Absence Trends</u>

Corporate Core has seen a rise in absence over the last year (to Dec 2013) compared to previous years. A marked increase in days lost per employee coincided with the transfer of Business Units from Neighbourhood Services in July 2013 (Quarter 2, 2013) and this has remained higher than previous years ever since. The increase in days lost seen for the Directorate during 2013 is driven by increases in long term sickness which are higher per employee than the previous two years.

Short term sickness does not show the same increase; in fact average days lost per employee for short term sickness reduced for Quarter 3 compared to the same period in 2012.

The pattern of absence has also fluctuated over the past twelve months with a reduction recorded in August (compared to the two previous years) which correlates to the term time working pattern of employees within Catering and Town Hall Services of Business Units. Although mental health related illness remains the most significant reason for long term sickness there has been a noticeable increase in the percentage of long term sickness which relates to muscular/skeletal injuries since the transfer of Business Units into Corporate Core (and a correlating decrease for this type of sickness in Growth and Neighbourhoods).

Directorate Activity and Interventions

204 employees hit absence management triggers within the Directorate in December 2013 of which 86 employees (42%) hit triggers for long term absence. Of these 86 employees there are 43 who are still absent. Of these, 8 are within Chief Executives and 35 within Corporate Services. The main reasons for absence within the directorate are:

· 37 % stress/depression/anxiety and bereavement reaction.
· 21% chronic underlying conditions (e.g. cancer/heart related);
· 42% other long-term absence cases (post operative debility etc).

All these cases are being actively supported by HR to assist Managers in managing the absence and a number have strategies in place for resolution, while others are awaiting further information, in order to identify an appropriate strategy for resolution. However, in some cases management options and actions are restricted by the nature of the underlying medical condition. For example, 9.5% of the cases within the Directorate are associated with Cancer. In these types of cases Managers ensure that the Managing Attendance Policy is followed in a way that is appropriate to the individuals needs especially considering their treatment path and regularly reviewing the latest prognosis from their doctors. This individually driven approach has facilitated a number of returns to work of employees in the last 6 months following cancer treatment.

Divisions within Corporate Core with reported absence above average levels include Financial Management, Legal Services, Customer Services Organisation, Business Units, Revenues and Benefits and the Shared Service Centre. All these areas have experienced an increase in the average days lost per employee over the period January – December 2013 due to a number of long term absence cases.

Divisions which have the highest sickness levels have been actively targeted in the last 12 months. A range of measures have been utilised by these services areas to address absence including -

- regular review of absence by service area with the relevant Head of Service
- coaching and support to managers and guidance on key areas i.e. equality act provisions
- focussing on early intervention to try to prevent absences becoming long term
- managers utilising the Health and Wellbeing guides to support employees and facilitate return to works

- organising case reviews on more complex cases to ensure appropriate interventions are in place
- a more proactive approach to challenging absences and progressing cases through the MOA process more effectively including applying sanctions where appropriate (especially in Customer Services Organisation).

This approach has had an impact; for example in the Customer Services organisation; where absence has reduced by around 10% over the 6 months to December 2013. This approach of targeted support in areas of high absence will continue to be utilised in other areas of the Directorate with the emphasis being within areas of Business Units and the continued monitoring of absence.
As the Customer Service Organisation is a targeted area within the Directorate it has been selected to be actively involved in the "Health Champions" pilot and the Directorate will monitor the outcomes of this pilot and its effectiveness.

7. SERVICE LEVEL DATA

As set out within the previous report, in response to Members' requests, analysis showing month-on-month trends in sickness absence has been developed at Corporate and Directorate level. Since October, Officers have been working to develop reports which show this analysis at a lower level and this capability is now in place. Over the coming weeks and months, these reports will be further developed and tested across a number of service areas, including the Health Trainer Champion pilot areas. This will provide a baseline and historic trend to enable future progress to be tracked and support managers in identifying emerging issues. Once tested, the intention is to utilise this analysis as part of the reports to service managers on an ongoing basis.

8. CONCLUSION

8.1 Better intelligence data about absence has enabled this report to provide greater detail as to absence patterns and trends both on a Corporate and Directorate level.

8.2 Improvement in attendance remains a key priority and the HROD service will continue to support managers in working to improve attendance by using a mix of approaches aimed at improving attendance through a motivated and healthier workforce as well as reinforcing existing policy approaches with managers. The delivery of the Health and Wellbeing strategy work programme and Behaviour Change Pilots are two key activities to deliver sustainable improvement.

8.3 Fundamental to improvements in attendance levels is the role that managers play on a daily basis with their staff. The engagement and up-skilling of managers in this role is vital to achieving the improvements sought. This must be led not only by HROD but Strategic Directors and Directorate Management Teams.

8.4 The Sub Group is asked to note the updates provided as requested at Finance Scrutiny Committee meeting on 26 September 2013 and current performance

on attendance and actions being progressed to support increased attendance across the Authority.

Appendices

1 H&W activity 2013 / 14 summary table.
2 Pilot activity for social workers to support improved emotional health and wellbeing
3 Summary of findings from health checks on City Council employees
4 Graph - City Council employees absent with long term sickness per month as a percentage of headcount.
5 Graph x 4 - Average days lost in a standard working month by Directorate.

Month/year	Activity	Description	Staff take up and levels of engagement
Early 2013.	Employee Health and Wellbeing Board	Steering group established to help shape direction for implementing the H&W strategy. Mixture of TU and management reps from across the authority gives a varied perspective	Sub groups (small working groups) established for some topics. Regular updates provided to OD Board.
September 2013	Dedicated H&W section on the intranet.	Suite of H&W pages launched, 25 pages in all containing wealth of advice and information to support employees to improve their health. Dedicated section for managers to focus on supporting staff with various health issues (e.g. managing staff recently bereaved).	Between 100 and 650 hits on the pages per day in 1st month, almost 1000 distinct users accessing the pages, about 1 in 5 staff with access have visited the pages. According to comms team this is one of the most successful launches of any content on the intranet in terms of employee interest
September 2013	H&W comms working group established to plan and implement employee H&W activity and comms.	Small group with reps from central comms, HROD and Public Health. Meets weekly. Info is cascaded to directorate comms officers. A visual has been developed to use on all H&W comms to make it easily recognisable and to help promote awareness of H&W activity with employees. Regular comms and activity driven by this group and is reported back to the H&W Board.	N/a
October 2013	Healthbus visits (carrying out health checks for staff).	9 visits made to 8 different MCC premises included depots. The NHS Health Check establishes potential risk of developing Cardiovascular Disease (CVD): Heart Disease, Stroke, High Blood Pressure, Diabetes or Kidney Disease and reducing this risk.	287 City Council employees received a full health check or health MOT from the bus visits. Take up highest at Wenlock Way (outside of Town Hall).
November 2013	Movember	Raising awareness of men's cancers. Fun competition (various categories) for moustaches grown.	This generated a lot of interest especially amongst teams supporting a colleague. There was an average of 41 visits a day on the Movember pages.
Oct - Dec 2013	Macmillan	Drop in roadshow at various MCC premises with trained Macmillan staff to provide information, advice and 1:1 support for employees affected by cancer (themselves or relative / friend). Includes advice on spotting signs of cancer, emotional support, benefits advice or signposting to NHS services or support gps. 5 sessions in all.	By the end of the first 4 visits Macmillan reported they had been approached by well over 200 staff. Positive emails were received by staff e.g. "this has really helped people just speak about the issue in the office, as well as raising general awareness".
Dec 2013 – March 2014.	Bug busting	Reducing winter infections in the workplace. Comms to promoting easy steps for staff to take to reduce spread of infections. Poster campaign re hand washing. 45 minute sessions run by infection	22 sessions have been planned in (part way through delivering them) for various services and locations. Also organising up to 20 sessions for school catering staff.

		control specialists across the organisation. Includes presentation on how to reduce infection risk and practical sessions on effective hand washing using a lightbox tool.	
Jan 2014 launch	Fitness Classes	Promotion to get staff more active. Ran 6 week trial of fitness classes at 5 different staff locations for council staff. Cost to staff is £1 a class. Delivered by trained instructors from Active Lifestyles.	With the exception of 1 class which had very low take up all the others had sufficient numbers to be viable and are set to be continued. Extra class to be added at the Town Hall complex, and larger venue to be used at Wenlock way to accommodate high demand.
Jan 2014 (ongoing)	Weight management	Sensible and unbiased information available to staff about weight loss programmes which get the public health seal of approval. Discounted weight watchers membership via Vectis and trying to set up a WW group in the Town Hall.	Over 700 hundred distinct users visited the H&W pages in January 2014. As well as the calendar they visited the healthy eating, eating better and smart swaps pages.
Jan – April 2014	Healthy Diet	Fortnightly comms to staff with tips about small steps they can take to improve diet (e.g. Change4Life healthy swaps programme, healthy snacks, eating for a healthy heart etc).	See above re intranet visits.
Feb 2014 launch	Employee running groups.	In conjunction with Run England we are training employee volunteers to become run leaders. They will lead weekly run gps from various premises to provide a provide a safe / sociable way into running for beginners.	Approximately 25 individuals volunteered to be run leaders. A closed training course was delivered on 1st February for City Council staff. 9 groups begin in mid Feb. February at lunchtimes / evenings

IMPROVING EMOTIONAL WELLBEING - PILOT IN SOCIAL WORK - QUARTER 2 & 3 (2014).

Draft Plan

	Activity	Description
1	Communication across the service to launch and promote the employee H&W strategy	Ensure that staff get the message that their health should be important to them - and it is important to the City Council too. Their managers will support employees to look after their help and even make improvements.
2	Opportunity to complete an individual online self assessment "How healthy are you".	Confidential online survey developed by public health specialists. Feedback is given automatically at the end of the test with tips for which are the key areas for taking any action and what is already positive. Support from internal health champions to discuss results or create individual action plans.
3	Healthbus	There is a strong link between physical and mental health and so investing in activities that promote taking care of all elements of health and wellbeing supports the overall aim and reinforces that employee health is important.
4	Health Champions	Volunteers from the social work workforce will be trained to help promote, encourage and support fellow staff to improve all aspects of their health and wellbeing. They will be knowledgable about support and resources available.
5	Training for line managers	Training to cover - raising awareness of the importance of good emotional wellbeing and how to spot the signs for concern. Reinforcement of the managers role and the need for early engagement with staff. How to have those conversations and building confidence to do this.
6	CAPS	Clinical supervision support model. Opportunity to review cases within current workload to identify best practice approaches and areas for improvement. Supports individuals in dealing with challenging and emotionally difficult aspects of their role.
7	Service stress risk assessment	A service risk workshop to be lead by H&S which would identify issues across the service (as has just been done in the customer contact centre) and how to address them.
8	Building resilience workshops / support gps	Deliver workshops which help individuals assess their resilience levels and develop ways to become more resilient and how to maintain resilience in future. Covers all aspects of life.
9	Use of WRAP (wellness recovery action plan).	This is a nationally recognised tool effective in supporting employees with mental health conditions to stay in work and be productive at work. People are supported to create their own wellness recovery action plan and seek any support they may need.

10	Counselling support	1:1 Counselling treatment by qualified counsellors is already provided via the Occupational Health Service. As part of the pilot it will be explored if a less formal / intensive support would be more effective for some employees i.e. drop in sessions with a psychological wellbeing practitioner.

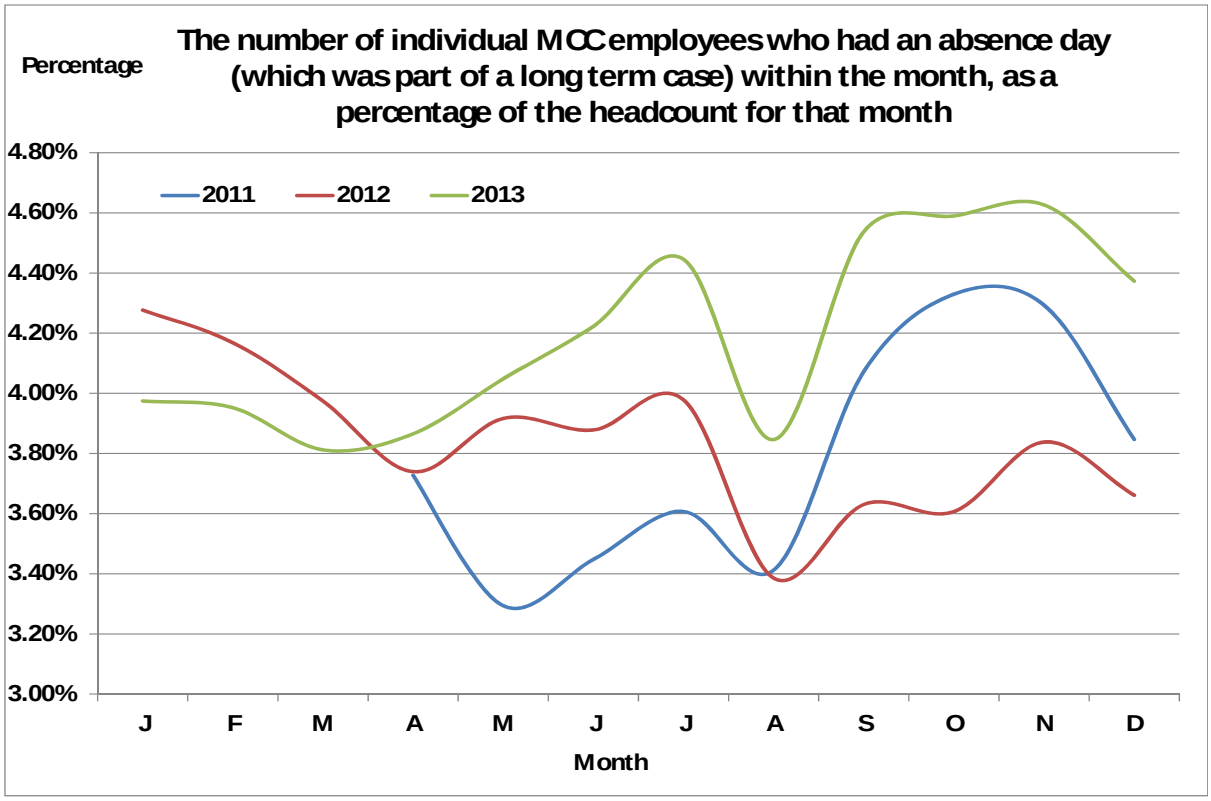
Summary of Health Checks Results for the City Council

- 130 clients from the City Council received a Health Check (a further 157 received a health MOT the results of which gave a similar picture).
- Of those receiving Health Checks there was an equal gender split and the average age was 49 years old. 77% were white British.
- Almost half of those seen required an immediate medical intervention.
- About a quarter of employees seen were identified as being pre diabetic.
- Almost three quarters of those seen had an increased risk for type 2 diabetes, hypertension and cardiovascular disease. Two thirds of had a significantly increased risks.
- The average risk of cardiovascular disease during the next 10 years was calculated for those seen. This suggests that 10 of the 130 people seen will get a vascular disease in the next ten years unless there is a change; and for many there was an urgent need for them to lower their risk.
- All individuals seen were given individual feedback and where ongoing support was needed then the necessary referrals were made or information sent to GPs for action.
- The summary from the Public Health professionals was that the sample of the workforce seen had got the potential for significant health challenges now or in the future and that changes in lifestyle were crucial to reducing this risk.
- This feedback was considered indicative of the City wide picture, especially for more deprived areas.

GRAPH 8

The number of individual MCC employees who had an absence day (which was part of a long term case) within the month, as a percentage of the headcount for that month.

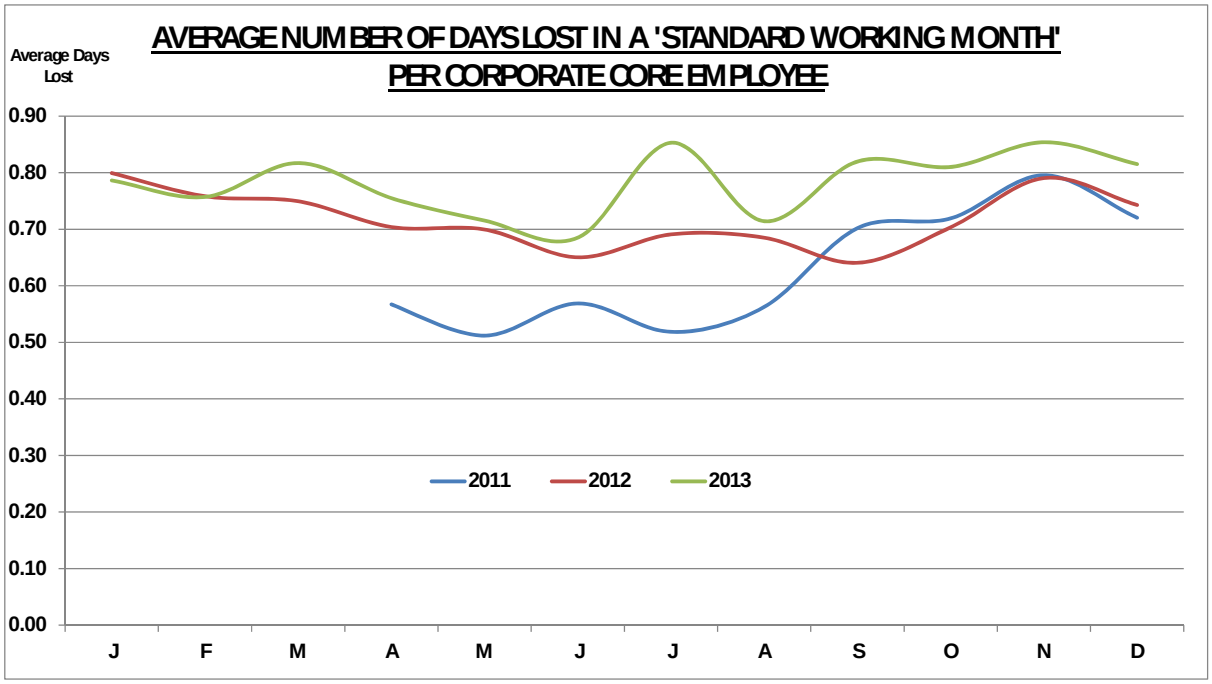
This differs from the previous graphs in that it relates to people rather than days lost in total. It should give an indicator of how prevalent absence days (short or long term) are amongst the employees.



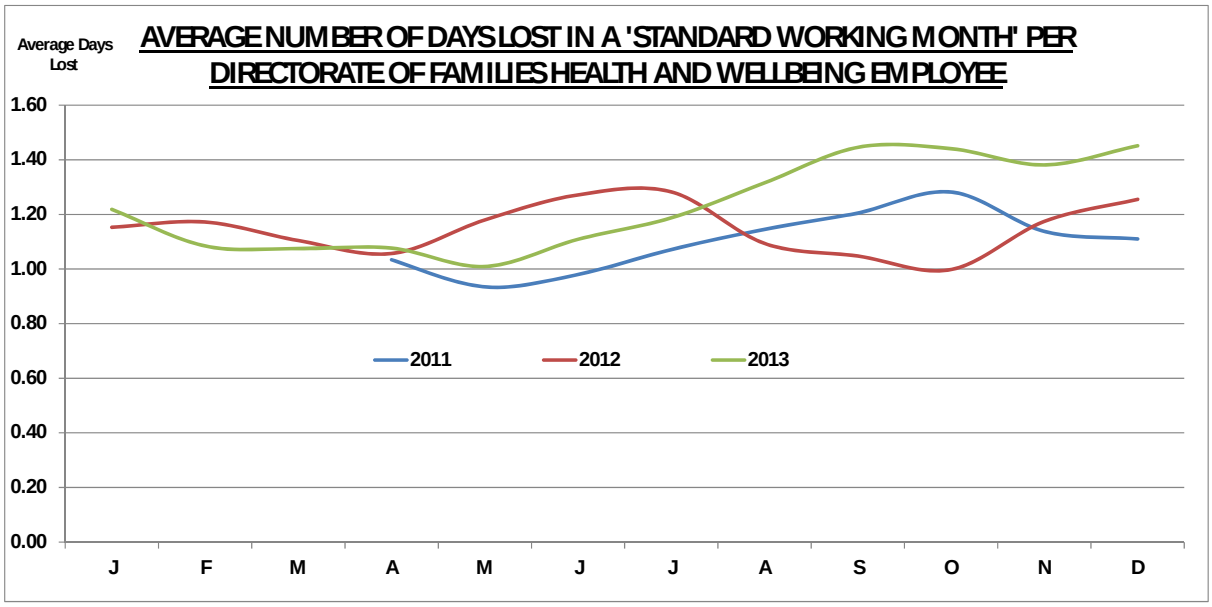
APPENDIX 5.

GRAPH 1 – DIRECTORATE LEVEL

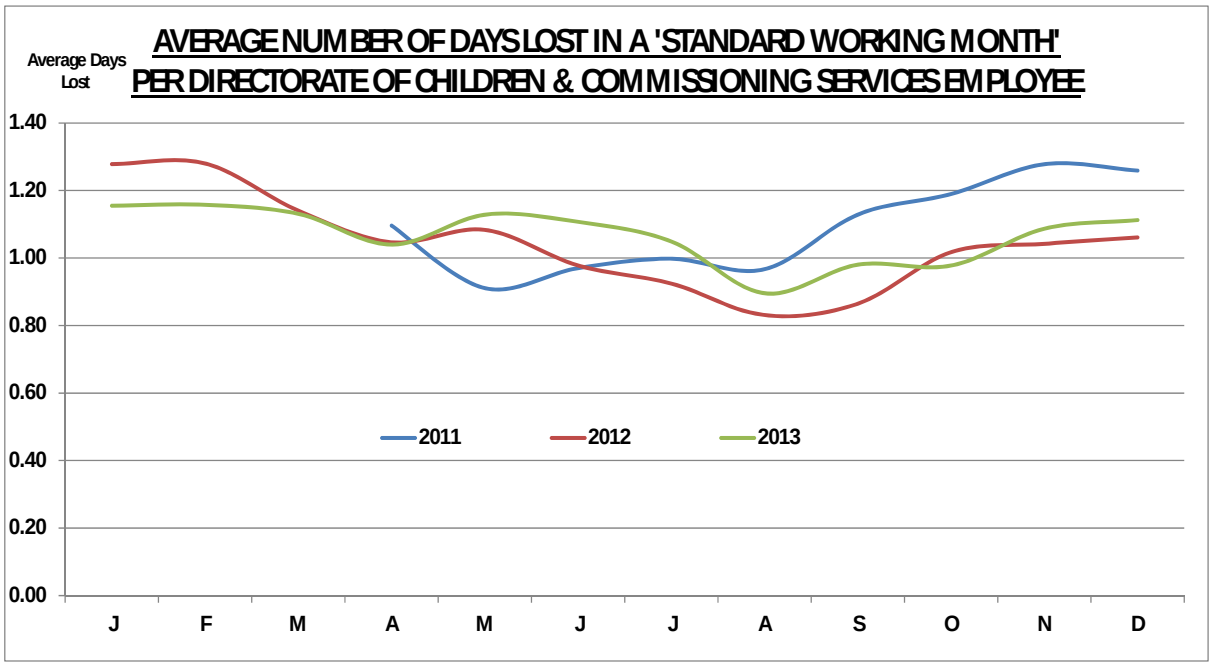
CORPORATE CORE



FAMILIES, HEALTH AND WELLBEING



CHILDREN & COMMISSIONING



GROWTH AND NEIGHBOURHOODS