Manchester City Council
Report for Resolution

Report to: Human Resources Subgroup – 17 March 2015

Subject: Attendance Monitoring

Report of: Head of HROD Service Delivery

Purpose of the report

Following on from the Finance Scrutiny Committee HR Sub Group meeting on 4 December 2014, this report provides the HR Sub Group with a further progress update. The report sets out Corporate and Directorate absence trends and also identifies the absence levels for Directorates for August to December 2014 inclusive. It also provides an update on the actions currently being undertaken to improve attendance since the last report and addresses the requests for information made at the last Sub Group meeting.

Recommendation

The Sub Group is asked to note the update on attendance including updated attendance figures and initiatives to improve attendance.

Wards Affected: All

Contact Officers:

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Background documents (available for public inspection):

- Finance and Overview Scrutiny Committee HR Sub Group meeting of 4 December 2014 – Attendance Monitoring report and minutes of the meeting;
- Finance and Overview Scrutiny Committee HR Sub Group meeting of 31 March 2014 – Attendance Monitoring report and minutes of the meeting;
- 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

1.1 This report gives an update on Corporate and Directorate absence trends for August to December 2014 inclusive.

1.2 Annual days lost figures for calendar years for 2014 and 2013 are similar.

1.3 There was however increased absence, particularly short term sickness, in quarter 3 of 2014 when compared to 2013 (but very similar to Q3 2012). This matches the data captured by Public Health Manchester for community based infection rates which showed lower levels of flu/colds and minor infections in 2013 compared to either 2012 or 2014.

1.4 There is some correlation seen between increased winter infections in 2014 and front facing care roles or roles which involve working outdoors (but increases are not exclusively in these service areas).

1.5 Long term sickness is still driven by a relatively small percentage of employees of which some have serious medical conditions. The analysis requested by HR Sub Group shows no correlation between sick pay ending and employees returning to work.

1.6 The biggest reason for long term sickness continues to relate to mental health. The overall percentage of long term sickness attributed to mental health remains static but there have been increases seen over 2014 in stress and anxiety (with decreases in depression/reactive).

1.7 Improved sickness data which is broken down further at service level has informed this report and is included within the Directorate Sections to give better intelligence. The impact of organisational changes on services is referenced where there may be links to sickness levels is also included in the Directorate Sections.

1.8 There is continued activity corporately on initiatives to improve attendance and updates are included in this report.

1.9 The report includes additional detail to provide answers to queries raised at the last HR Sub Group meeting in December 2014.

2 INTRODUCTION

2.1 The Finance Scrutiny Committee HR Sub Group last met on 4 December 2014. This report provides Members with an update on trends in absence and the organisational approach to improving attendance. It also includes the specific information requested by the HR Sub Group at its last meeting.

3. CORPORATE AND DIRECTORATE OVERVIEW

3.1 Organisational and Directorate trends – August to December 2014.

3.1.1 This report focuses on the trends in absence seen since the last meeting of the HR Subgroup in Dec 2014, i.e. over the 5 months from August 2014 up to and including December 2014.

3.1.2 As previously reported, marked seasonal variations affect absence levels. Therefore, the latest available data (August - December 2014) is best compared to same period for (August – December) for the preceding years. For the same reason often comparison is made between Quarter 3 (Q3) of 2014 with previous years (with Q3 being Oct/Nov/Dec).

3.1.3 All data included in this report was produced using the revised methodology for calculation which provides data for average lost days within a month per FTE. This calculation takes account of different working patterns and also the size of the workforce. It does not include any rolling data for previous months, rather it just includes time lost in that month (or quarter or year) reported.

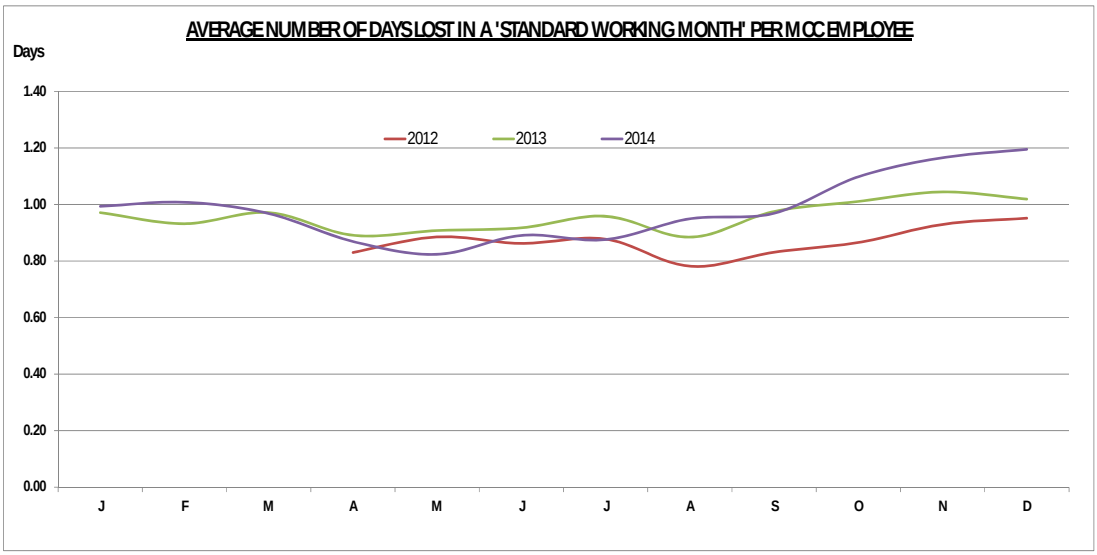
3.2 OVERALL DAYS LOST DUE TO SICKNESS.

3.2.1 AVERAGE NUMBER OF DAYS LOST IN THE 'STANDARD WORKING MONTH' PER FTE (full time equivalent).

3.2.2 Looking back over 2014, the average number of days lost in a month was higher in January and February in 2014 than it was for these months in 2013. From April 2014 to July 2014 there was an improving picture with average days lost in a standard working month per employee remaining lower than the comparable monthly results of 2013. By late summer this improving trend was reversed and August, October, November and December all showed significant increases on the previous years' absence levels.

3.2.3 Similarly the average days lost in a quarter per FTE was slightly lower in both Q1 and Q2 2014 than it was for these quarters in the previous year however the Q3 results showed a marked increase from the absence rate of Q3 of both 2012 and 2013.

3.2.4 When looking at calendar years there is actually little difference between 2013 and 2014 – the mean (or average) of the monthly results for 2013 was 0.96 in 2013 and it was 0.98 for 2014. Hence despite the winter increases in absence the years as a whole were very similar when looking at sickness for the organisation.



Graph 1 – Average number of days lost in a 'standard working month' per Council employee.

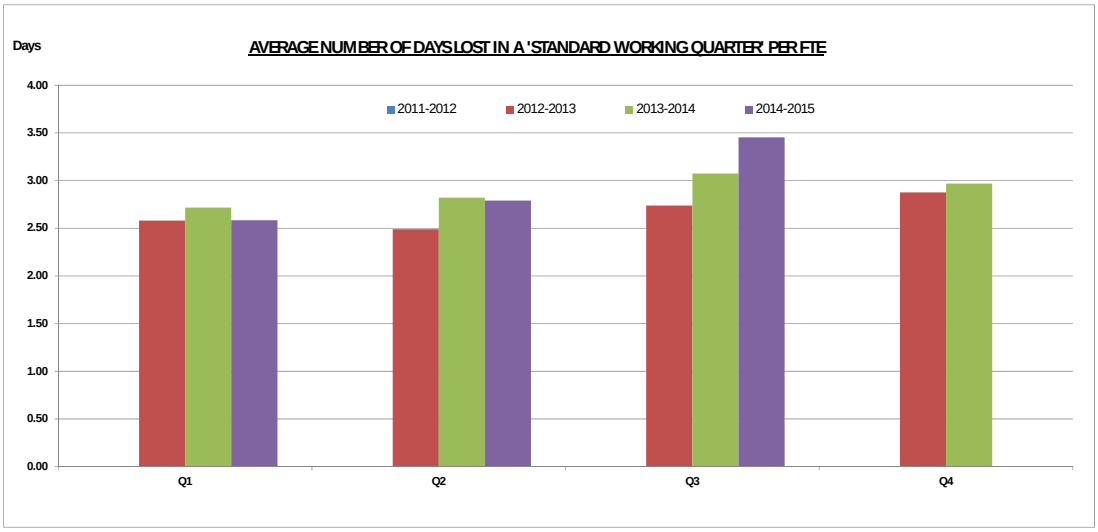
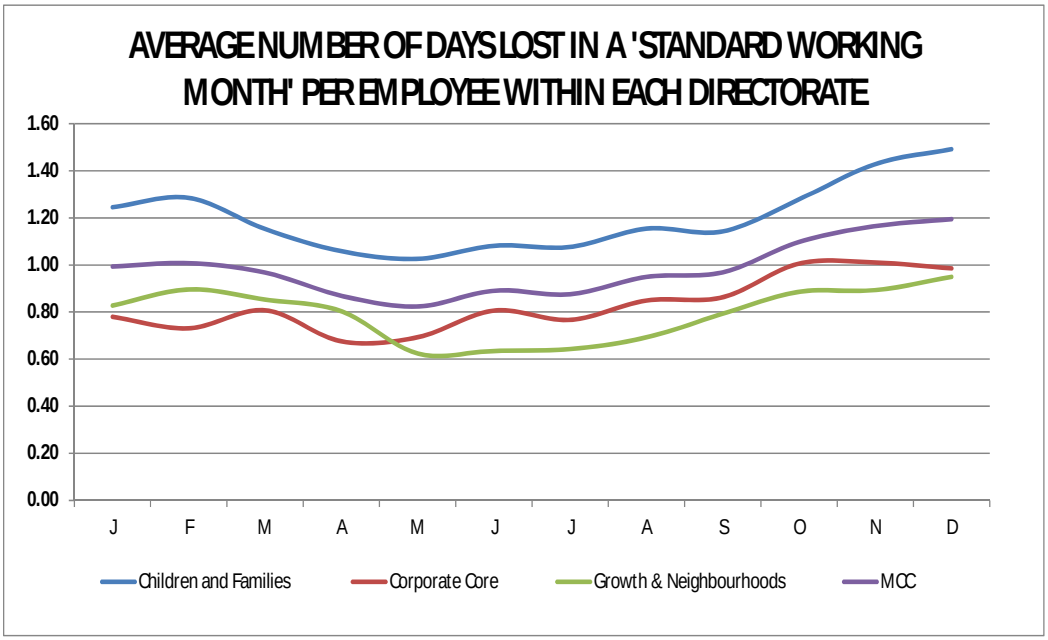


Chart 1 – Average number of days lost in a 'standard working quarter' per FTE

3.2.5 In the report to the HR Sub Group of 4 December 2014 it was noted that the Directorate of Children and Families (C&F) has consistently the highest sickness levels within the Council, usually 0.3 –0.4 days lost per month higher on average (roughly equates to 4 additional days sickness on average per employee per year in this Directorate).

3.2.6 The same pattern is true for the second half of 2014 with the difference becoming more marked by the end of the year. The average days lost figure for C&F in December 2014 was slightly over 0.5 days lost per month higher than the rest of the Council. As C&F Directorate contains around 43% of the Council's workforce (in terms of FTE) its absence figures have a big influence of the overall sickness figures. Graph 2 and Table 1 below clearly illustrate this point. Another point to note on a Directorate level is that for 2013 it was

Corporate Core who had the lowest average days lost in a standard working month figure on average for the year but in 2014 it was Growth and Neighbourhood who had the lowest absence rate on the same basis.



Graph 2 – Average number of days lost in a 'standard working month' per employee within each Directorate.

	J	F	M	A	M	J	J	A	S	O	N	D	Mean Monthly Result	FTE as at December 2014
Children and Families	1.25	1.29	1.15	1.06	1.03	1.08	1.08	1.15	1.14	1.28	1.43	1.49	1.20	2815
Corporate Core	0.78	0.73	0.81	0.68	0.69	0.81	0.77	0.85	0.86	1.01	1.01	0.99	0.83	2423
Growth & Neighbourhoods	0.83	0.90	0.85	0.80	0.62	0.63	0.64	0.69	0.79	0.89	0.89	0.95	0.79	1342
MCC	0.99	1.01	0.97	0.87	0.82	0.89	0.88	0.95	0.97	1.10	1.17	1.20	0.98	6580

Table 1 - Average number of days lost in a 'standard working month' per employee within each directorate over 2014.

3.3 DURATION OF ABSENCE

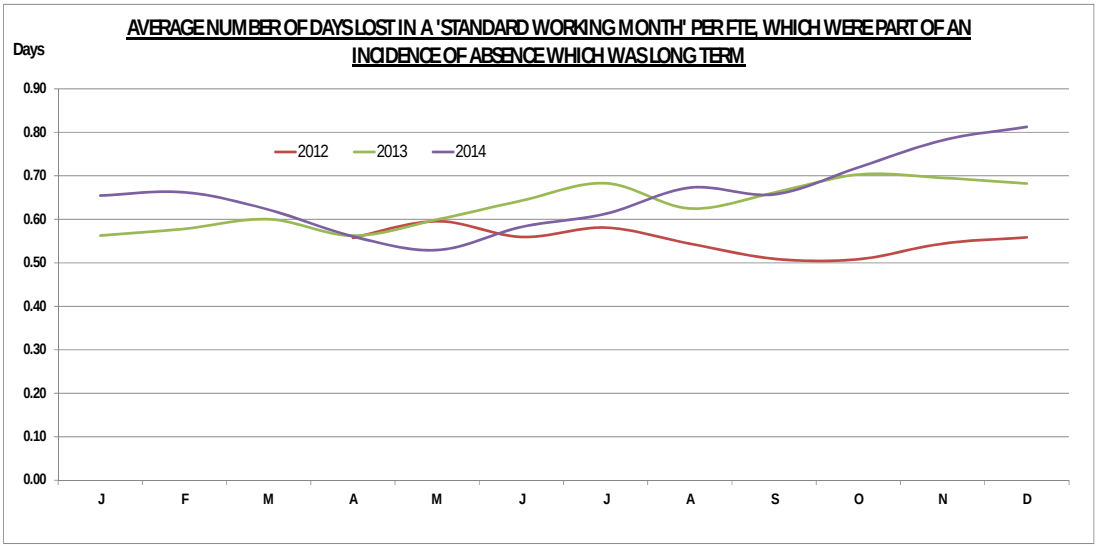
3.3.1 AVERAGE NUMBER OF DAYS LOST (which were long term) IN THE 'STANDARD WORKING MONTH' PER FTE.

3.3.2 This measure is an indication of trends in the amount of time lost each month per employee due to sickness which was long term. Long term sickness is sickness of more than 20 working days and is generally much less seasonal in nature than short term sickness. Long term sickness (LTS) is the biggest contributor to total days lost due to sickness and LTS patterns usually closely match the pattern seen for all or total days lost to sickness.

3.3.3 Higher absence rates than last year were seen from January to March in 2014, followed by lower absence rates than last year in May, June and July,

and a comparatively worse August. However, the figures for September and October were very similar to the previous years and it was only in November and December that more significant increases on the previous year's monthly absence rates were seen.

3.3.4 On a quarterly basis the average days lost were lower in 2014 than in 2013 until Q3 which showed an increase from 2.08 (2013) up to 2.31 (2014).



Graph 3 – Average number of days lost in a 'standard working month' per FTE, which were part of an incidence of absence which was long term.

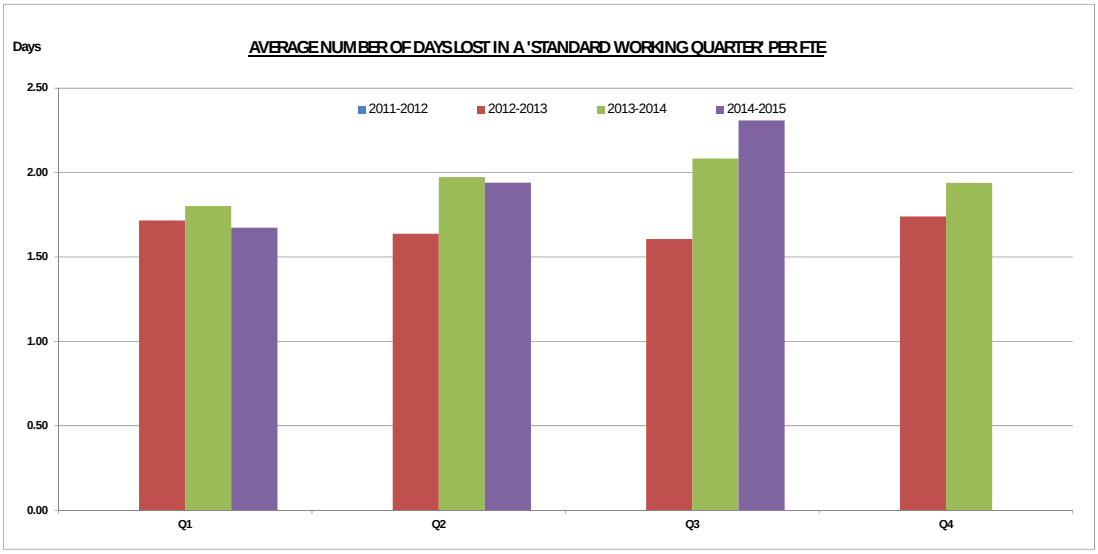


Chart 2 - Average number of days lost in a 'standard working quarter' per FTE, which were part of an incidence of absence which was long term.

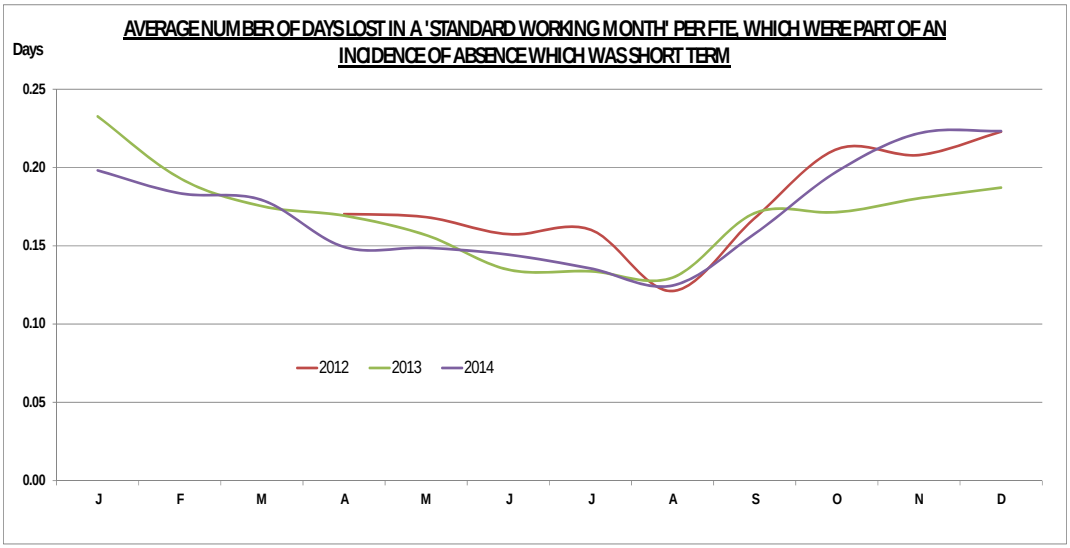
3.3.5 AVERAGE NUMBER OF DAYS LOST (which were short term) IN THE 'STANDARD WORKING MONTH' PER FTE

3.3.6 Monthly absence rates for short term absence follow a clear seasonal pattern with higher absence rates seen in winter months before gradually declining to a low in Summer (August). Short term sickness is sickness of duration of 5 working days or less.

3.3.7 January and April 2014 had slightly lower absence rates than the comparable months of 2013, whilst October, November and December had comparably higher absence rates. It is worth noting that the monthly short term absence rates for October, November and December in 2014 almost identical to those of 2012.

3.3.8 On a quarterly basis the average number of days lost (which were part of a short term incidence of absence) in the year per FTE showed a decrease for 2014 in Q1 & Q2 against both 2013 and 2012. However there was a marked increase in Q3 2014 compared to 2013 (however this was identical to Q3 of 2012-2013).

3.3.9 There is more information about the common underlying medical reasons for sickness of varying durations later in the report. Generally though; the levels of short term sickness are dictated by the prevalence of staff reporting sickness due to seasonal/winter short term infections. It is worth noting however that sickness related to poor mental wellbeing or the early stages of mental illness may be reported as due to minor infections due to reluctance for individuals to disclose the real underlying reason or because it is undiagnosed/unrecognised at that stage.



Graph 4 – Average number of days lost in a ‘standard working month’ per FTE, which were part of an incidence of absence which was short term.

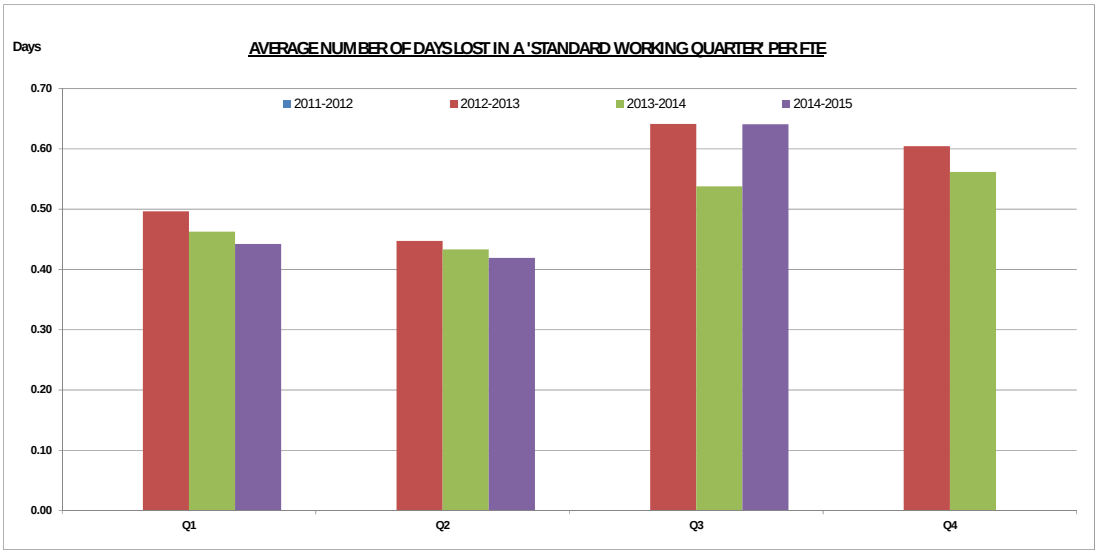


Chart 3 - Average number of days lost in a 'standard working quarter' per FTE, which were part of an incidence of absence which was short term.

3.3.10 AVERAGE NUMBER OF DAYS LOST (which were MEDIUM term) IN THE 'STANDARD WORKING MONTH' PER FTE

3.3.11 The average number of days lost in a month (which was part of a medium term incidence of absence) per FTE, shows little variation and typically ranges between 7 and 9 days on average. There are no noteworthy differences between different years. The figures indicate that changes in the time lost due to medium term absences are not driving overall trends in sickness and hence the graphs are not included. The key priority with medium term sickness is to try and prevent it from turning into LTS by encouraging managers to intervene early (for example offering physiotherapy or counselling).

3.3.12 PERCENTAGE OF EMPLOYEES WHO WERE EMPLOYED AT THE START AND THE END OF THE YEAR, WHO DID NOT HAVE A SINGLE INCIDENCE OF ABSENCE IN THE YEAR.

3.3.12 Analysis of the percentage of employees (employed at both the start and the end of the quarter) who did not have any incidence of absence shows that there a higher percentage of employees who had no sickness for Q1 and Q2 this year than in 2013. In Q3 this pattern reversed and the number of employees who had no sickness was less than the same quarter of 2013 but is very similar to Q3 2012. There is more detail given below which looks at the duration of absence also (i.e. Long, Medium or Short) for Q3. It shows that the decrease in the number of employees having no sickness in Q3 2014 vs. 2013 was primarily driven by short term sickness (which was attributable to "winter" type infections). .

- 92.91% of employees did not have an incidence of absence which was long term in 2014 compared to 94.03% in Q3 2013.

- 95.22% of employees did not have an incidence of absence which was medium term in 2014 compared to 95.67% in Q3 2013 i.e. no discernable change.
- 76.71% of employees did not have an incidence of absence which was short term in 2014 compared to 79.16% in Q3 2013 i.e. the increase was greater for short term.

	Percentage of employees not absent in 2013	Percentage of employees not absent in 2014
MCC	40.73%	40.39%
Children and Families	37.23%	37.17%
Corporate Core	38.40%	41.48%
Growth and Neighbourhoods	50.86%	44.79%

3.3.13 When looking annually i.e. comparing calendar years for 2013 and 2014, the overall Council figure has changed little. Directorates have seen changes which will be influenced by organisational changes i.e. movements of services between Directorates. (This measure is calculated by establishing who had sickness for staff employed by the Directorate at both the start and end of the year).

3.3.14 <u>REASON ANALYSIS</u>

3.3.15 The most common reasons for long term and short term absence in Q3 of 2014-2015 have been identified and figures have been tracked back over time for these reasons in order to identify any trends. Medium term has not been included as no trends or patterns are noteworthy.

3.3.16 <u>Short Term Sickness – Medical reason given for sickness.</u>

3.3.17 See Graph 5 below for more detail on the most common medical reasons given for Short term sickness over the last 3 years.

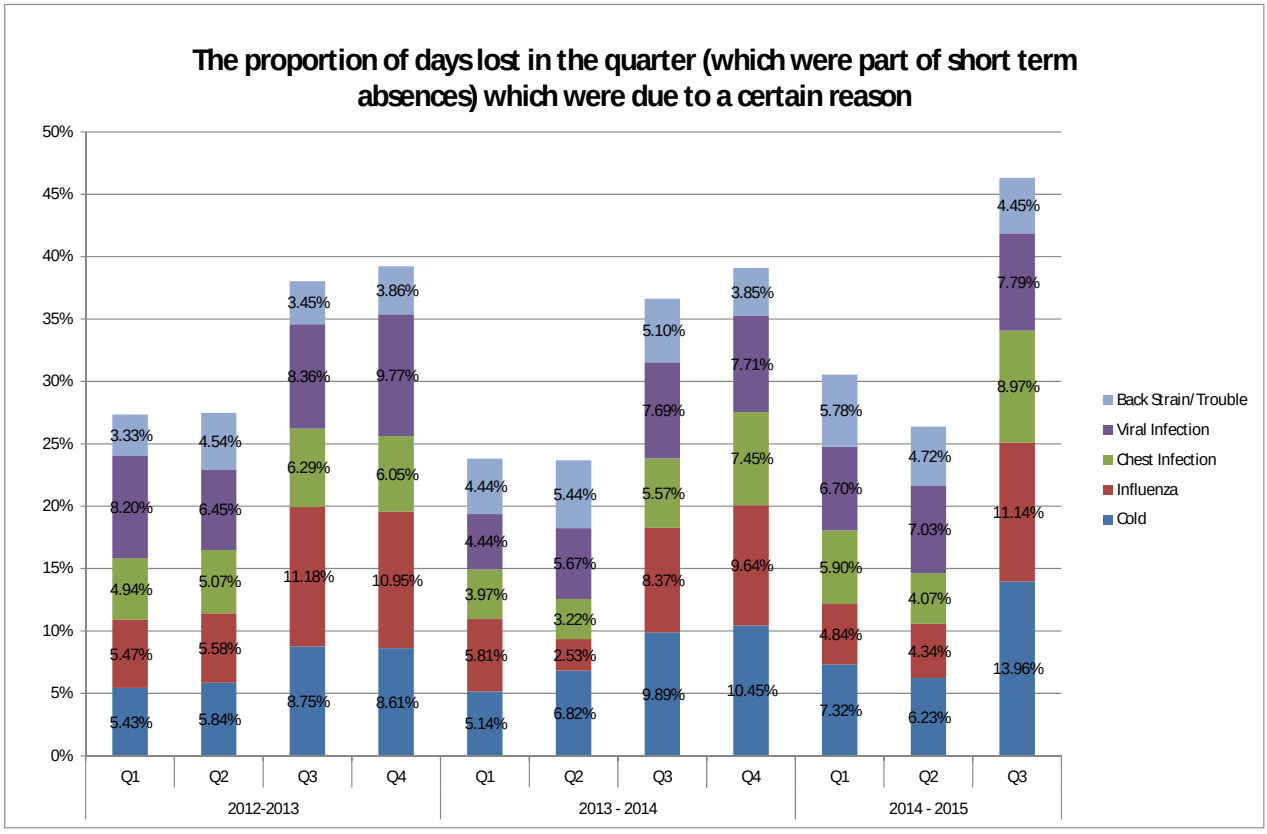
3.3.18 As many minor infections (often short term in direction) are generally seasonal then Q3 and Q4 often show higher overall percentages as this coincides with the October/November/December period (Q3) and January/February/March (Q4).

3.3.19 The percentage of days lost in Q3 (which were part of a short term incidence of absence) which were recorded as being due to ‘colds’ is higher than it was in Q3 of 2013 and 2012 (13.96%, compared to 10.45% and 8.75% respectively).The percentage of days lost in Q3 which were recorded as being due to ‘influenza’ is higher than it was in Q3 of 2013 and very similar to 2012 levels (11.14%, compared to 8.37% and 11.18% respectively).

3.3.20 The percentage of days lost in Q3 which were recorded as being due to 'chest infection' is higher than it was in Q3 of 2013 and 2012 (8.97%, compared to 5.57% and 6.29% respectively).

3.3.21 Sickness reported as Colds, Flu and Chest infections (generally considered as seasonal infections) were particularly prevalent in sickness reporting in Q3 of 2014.

3.3.22 Colleagues in Infection Control in Public Health Manchester confirmed that the reported prevalence of Flu and Flu like illness, as monitored in the community in Manchester, have been higher in winter 2014/15 so far than they were in winter 2013/early 2014. This matches the patterns seen in the Council's short term absence and the underlying medical reasons for sickness. Flu or influenza is a very specific term which applies to set viral strains and is more severe in symptoms and longevity than other viruses. It has been noted that the Flu vaccine provided in winter 2014/15 has not been as good a match for the actual strains of Flu in the community in previous years which would make it less effective. Flu-like illnesses would include chest infections and colds rather than Influenza proper. Employees will rarely be aware of the medical designations and may not be sure of the virus that caused their symptoms and so often they report a sickness absence as Flu when it was in fact a more minor Flu-like illness.



Graph 5 – The proportion of days lost in the quarter (which were part of short term absences) which were due to a certain reason.

3.3.23 Long Term Sickness – Medical reason given for sickness.

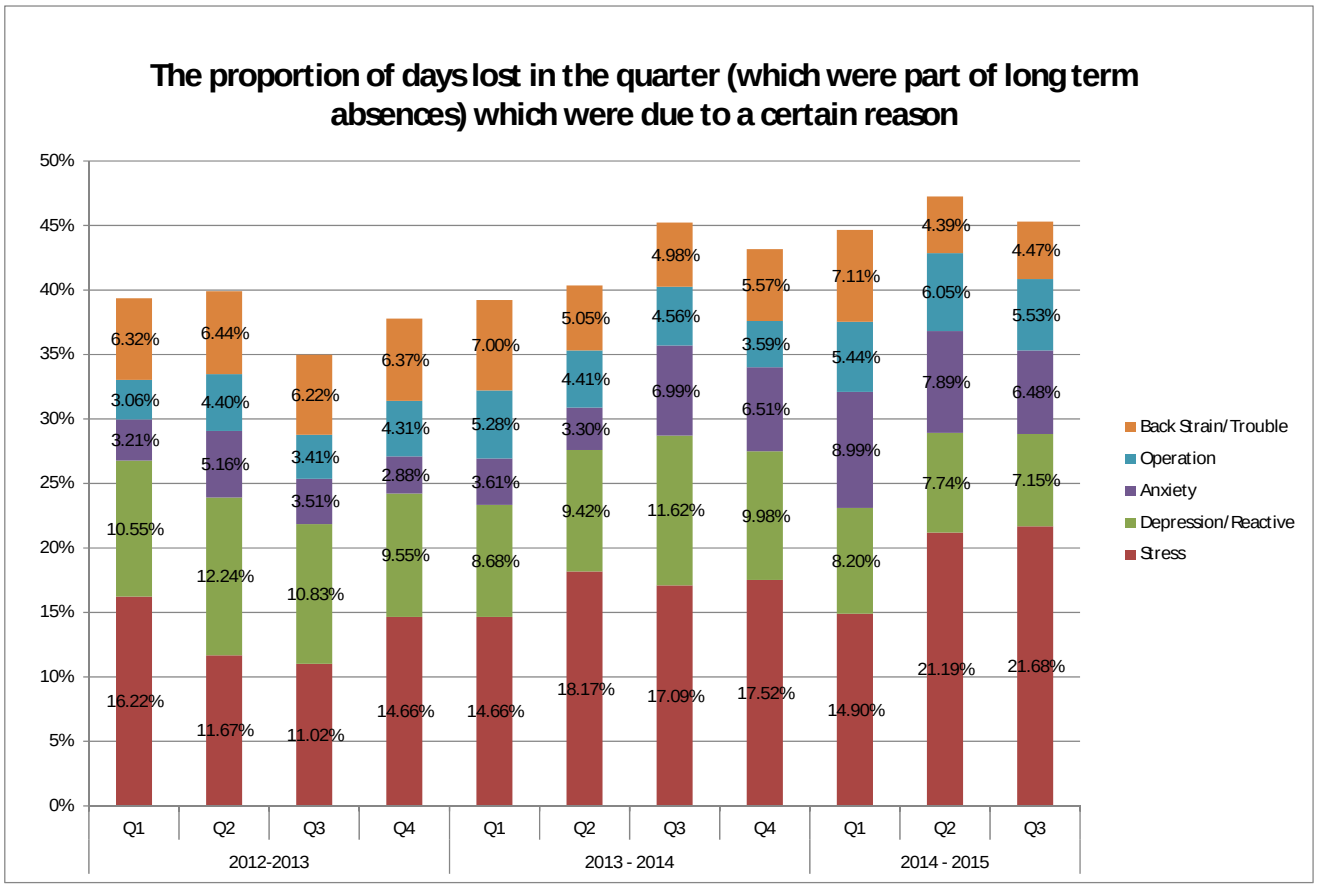
3.3.24 See Graph 6 below for more detail on the most common medical reasons given for long term sickness over the last 3 years.

3.3.25 These medical conditions are not generally seasonally affected in the way that short term infections may be (although there is some evidence that mental health symptoms can be heightened for some people in the Autumn/Winter).

3.3.26 The percentage of days lost in Q3 (which were part of a long term incidence of absence) which were recorded as being due to 'depression/reactive' is lower than it was in Q3 of 2013-2014, and 2012-2013 (7.15%, compared to 11.62% and 10.03% respectively). Indeed this years Q3 result is the lowest for the past 10 quarters.

3.3.27 The percentage of days lost in Q3 (which were part of a long term incidence of absence) which were recorded as being due to 'stress' is higher than it was in Q3 of 2013-2014, and 2012-2013 (21.68%, compared to 17.09% and 11.02% respectively). Similarly the percentage of days lost in a quarter (which were part of a long term incidence of absence) which were recorded as being due to 'anxiety' has shown a marked increase from historic levels, jumping up to between 6% and 9% from Q3 of 2013-2014, after typically being approximately 3% pre Q3 of 2013 – 2014.

3.3.28 There is a clear Corporate trend for an increasing proportion of Long Term sickness to be related to both Stress and Anxiety when looking at Quarter 3.



Graph 6 - The proportion of days lost in the quarter (which were part of long term absences) which were due to a certain reason.

4. SERVICE LEVEL DATA

4.1 Work has been continuing to develop further the depth of sickness absence information available using the improved methodology of calculation.

4.2 A range of detailed measures (including all those included in the Corporate analysis above) can now be produced at all levels of the organisational structure i.e. not just at Corporate or Directorate level but broken down further to service level.

4.3 This information has enabled more detailed analysis at a departmental and team level to be included within this report. This is included in the Directorate sections and focuses on the areas and issues of greatest concern.

4.4 Further work is required in developing the ability to produce this detailed analysis in a streamlined and regular manner. Once this is complete the service and team level data can be shared regularly with Directorate Management teams to support senior managers in pin pointing key areas of concern. It is expected the in depth reports will be shared regularly by the end of Q1 of the next financial year.

5. CORPORATE MEASURES TO IMPROVE ATTENDANCE LEVELS

5.1 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 aim of the Employee Health and Wellbeing (H&W) Strategy is to encourage and support all employees to take care of; and make small improvements to their health to yield benefits at home and in the workplace. In support of this aim the Employee Health and Wellbeing Steering Group (which included representatives from all of the recognised Trade Unions) has overseen ongoing targeted activity for the last 2 years. An update on activity over the last few months since the last Sub Group meeting is given below.

5.2.2 There has also been a continuing push to promote regular physical activity and to capitalise on New Year's resolutions to support employees to get fitter. There is strong evidence that higher activity levels greatly increases an individual's mental wellbeing and can help build individual's resilience levels. Offering options which can easily fit into people's routines (i.e. within the workplace) makes it more likely that they will be sustainable.

5.2.3 Additional fitness classes and running groups were added at various locations from early Jan - these include Zumba; Bollywood Dancing and Body Conditioning classes (to try and add a fun element and appeal to those who perceive they are less fit). Also Yoga classes were added to support relaxation and mental wellbeing as physical wellbeing. The uptake on these classes has been really encouraging and January 2015 showed the highest levels of participation so far. In January 2015 alone employees engaged in 574 hours of H&W related activity at the Town Hall alone as part of the activities that have been set up under the H&W strategy (primarily running and fitness groups).

5.2.4 Evidence in the Public Health arena demonstrates there are many positive impacts on a person's wellbeing and health from engaging in regular physical activity. The analysis below demonstrates that for staff who engage in run groups and circuit classes at the Town Hall they have absence levels significantly below the Corporate average and decreasing which is opposite to the organisational trend. The sample below contains about 100 employees as data for newer classes could not be included. Overall out of around 3,000 employees who work in the Town Hall complex there are about 300 who engage in fitness classes, run groups or who cycle to work. The next phase of the H&W work on physical activity will be to consider how this can be scaled up. Deciding whom to engage and how to do this effectively will be the next challenge (models of behaviour change show that you need to target people who are interested but not actively engaged in the behaviour you want to encourage rather than those who are resistant to the change). This will be discussed at the next H&W Steering Group meeting.

	2014	2013
Running Group or Circuit Group Participant (Town Hall)	2.43	3.33
MCC	11.92	11.71

5.2.5 A survey produced for IiP (Investors in People) by Stephen Bevan (Chair of Fit for Work UK) in 2010 also found clear links between organisations that promoted good health and wellbeing for their employees and increased motivation, effectiveness and loyalty in the workforce. Hence the benefits of healthier staff to the workplace are much broader than just attendance.

- A staff health and wellbeing survey has now been drafted and will use intranet technology to capture and group data to preserve individual's confidentiality. The survey will have brief questions on all areas of H&W but will focus particularly on mental H&W and stress. This will be sent out in May 2015 and the results will give a more accurate picture of perceptions of the workforce about their health, what they feel contributes to poor wellbeing and what could be most effective in improving mental wellbeing. The findings will help inform future actions taken to help reduce poor wellbeing due to stress and mental ill health.

- The staff health and wellbeing pages on the intranet were expanded to add over 20 pages which are dedicated to mental health and wellbeing. These were launched in September 2014. As well as this range of advice and information for all staff there was a focusing in giving more guidance to managers and there are now several "how to" guides for managers which include the following –

  1. Managing staff following bereavement
  2. Spotting signs and having sensitive conversations
  3. Implementing reasonable adjustments for mental health
  4. Managing a return to work following mental ill health

  There is also a section on supporting colleagues and how to broach conversations when you are concerned about someone's mental wellbeing.

- The new staff intranet pages were launched to coincide with the national "Time to Talk" day on 5 February which was instigated by the "time to change" campaign which is a pressure group aimed at reducing stigma about mental health. The day was promoted via staff communication channels and there was also some activity arranged within the Town Hall complex to raise the profile further and to help promote the message that by talking more about mental health we will help reduce stigma. The activities included a stall in the rates hall with public health staff available to speak to people and lots of information for people to take away. There were also lunchtime mindfulness sessions and a staff workshop on building resilience. There were good take up levels and interest shown by staff and residents.

- Discussions are well underway to identify a provider and define the content for a workshop for staff on coping with stress and building resilience. Initial sessions of this training should be up and running in Spring and would be fully evaluated to see if they provide a benefit to employees. An update will be provided at the next Sub Group meeting.

- The pilot workshop "Mental Health Awareness Training for Managers" took place in February 2015. There were 15 attendees from all 3 Directorates with a reserve list as the interest in this workshop topic was high. Managers who attended were all managing, or had previously managed, an employee who had been sick due to a mental health condition. Initial feedback was good but there will be a follow up phone interview with all managers who attended 2-3 months after the course finished to see if there has been any sustained change in their behaviour resulting from attending the workshop. The main focus of the workshop was to raise awareness of the need for early intervention and openness with staff and to build confidence of managers to discuss mental wellbeing with their teams.

- A network of Health Champions has been established. This is a group of staff who after attending the "Understanding Health Improvement" training then volunteered to have an ongoing role to engage fellow staff in improving their health and this total around 20 employees from about 40 trained. This is also part of the behaviour change pilot. The first meeting of the network took place early in 2015 and the group were full of ideas about initiatives that could happen in the workplace to promote better wellbeing to their colleagues. They all still had enthusiasm for the topic (even though it is several months after the training) and they all had real examples of where they had made changes to improve their health (such as giving up smoking, loosing weight or making time for something that helped them unwind) or had encouraged others to do so. As a short term method of group communication a lotus notes group is going to be set up for the group so ideas can be shared. We will also produce an agreed action plan.

- The first identified piece of work is for some of the group to undertake training on Cardio Vascular Disease (CVD) and how to explain this in a simple and understandable way to others. The training will also cover how individual's can reduce their individual risk of CVD and how to have conversations with others to help encourage and support them to do this. The Health Champions who have this training can then be available to speak to staff after they have had a Health Check as this should make the Health Check process more effective.

- CVD is the biggest killer in Manchester but identifying risk early and making changes to lifestyle can make a real difference in reducing the potential impact of related illness. The previous visits to City Council sites identified a high proportion of staff that had increased risk of CVD (including diabetes) and so we know this is a prevalent area of ill health in the workforce. The Healthbus has been booked to visit more City Council sites in Spring and it will be arranged that the Health Champions with the CVD training can help support these visits. Members of local regeneration teams and an adult social care

centre have also been offered the opportunity to attend the training and use these skills with the residents they support.

5.2.6 The last HR Sub Group meeting asked for consideration to be given of the feasibility of a dedicated space for employee health and wellbeing. The interim use of Heron House continues but is only short term and could end at very short notice. Corporate Property have been asked to help further with finding a longer term solution and to factor it into longer term accommodation reviews but it is likely to be later in the year before anything more definite is confirmed in relation to long term accommodation plans.

5.3 Improving Motivation, Engagement and Attendance Using Behavioural Insight (Behaviour Change Pilot) – Overall approach and progress

5.3.1 The Workforce Behaviour Change Pilot comprises three separate initiatives, each at varying stages of progress and using different methods of evaluation. The three strands gathered under the title of Improving Attendance are;

- Improving attendance: reaffirming compliance requirements, targeted awareness raising and roll-out of the online managing attendance reporting tool
- Health champions: developing access to health and wellbeing initiatives
- Employee running groups: Volunteer led, workplace based, priority areas and city wide scale up

5.3.2 The project group has sought over the course of the pilot period to monitor the progress and emerging effectiveness of each initiative, and to understand the combined effect on absence.

5.3.3 The pilot has been reviewed in December 2014 to consider its progress. The project group recognises that the pilot has experienced challenges in the robustness of both its behaviour change and evaluation methodologies, and consequently its ability to report demonstrable outcomes that are directly attributable to its activities.

5.3.4 The project group has therefore made recommendations for:

- A refresh of the intranet language and content to ensure clarity over staff and managers' responsibility for managing attendance and the role of HROD;
- Ensuring greater impact by using a more robust behaviour change model to directly influence key behaviours;
- Developing a clearer evaluation method to demonstrate the link between behaviour change activity and attendance.

5.3.5 The pilot refresh will commence with a project group workshop on 4 March 2015.The project group will apply the MINDSPACE behavioural insight tool, developed by the Institute for Government and the Cabinet Office 2010. The MINDSPACE tool will support the group to more clearly define **whose**

behaviour is being targeted for change, **what** change is desired, **how**, **when** and **where** the opportunities are to achieve this and **to what end**.

5.3.6 The MINDSPACE model sharpens the focus on how knowledge, messenger, habits, rewards, sanctions, commitments and pledges can influence behaviour; the project group will consider the desired changes in absence-related behaviour in relation to all of these areas.

5.3.7 The emerging insight will then be applied to the 6 Es staged approach to behaviour change planning; *Explore, Enable, Encourage, Engage, Exemplify and Evaluate* to inform the action plan for the next phase of the project.

5.3.8 The progress of 'improving attendance' strand of the pilot project is detailed below:

a) Online Absence Notification System

5.3.9 The 'Reinforcing the Management of Attendance Policy' initiative, led by HROD, seeks to improve managers' behaviours regarding the application of and compliance with the Council's Managing Attendance policy. This initiative involved the roll-out of an online absence notification system (ONS) which went live from 1 April 2014. This system enabled managers to report absence using an easy to use electronic system. The system also allows managers to record whether the absence is disability related and prompts managers to remind them to complete the Return To Work (RTW) process.

SYSTEM USAGE – APRIL 2014

Directorate	**Absence Notifications April 2014**
Corporate Core	192
Children & Families	295
Growth & Neighbourhoods	129
TOTAL	**616**

SYSTEM USAGE – OCTOBER - DECEMBER 2014

Directorate	**October 2014**		**November 2014**		**December 2014**	
	Notifications	*% RTW completed*	Notifications	*% RTW completed*	Notifications	*% RTW completed*
Corporate Core	442	*89*	396	*86*	412	*80*
Children & Families	504	*84*	543	*77*	530	*69*
Growth & Neighbourhoods	214	*88*	194	*86*	187	*82*
TOTAL	**1160**		**1133**		**1129**	

5.3.10 The usage of the system in the period October 2014 – December 2014 shows the significant increase since the system went live i.e. electronic notifications have doubled since that time for all Directorates. Additionally, data from the system shows that more than 85% of the absence notifications have had a RTW completed. This figure is slightly lower for Children and Families i.e. 77%. Work is ongoing with the services in C&F to ensure that managers conduct RTWs and AMRs in a timely way. Over this period, 115 of the absence notifications sent in by managers stated that the absence was disability related i.e. 3.4% of all notifications in this quarter.

b) Learning Sessions with managers

5.3.11 To complement the roll-out of the online absence notification system, learning sessions were held initially with managers within the pilot areas and then rolled out in other areas identified with high absence levels. The aim of the session was to increase managers' appreciation of behaviour change and improve their capacity to have sensitive conversations with their teams around managing absence. Appendix 1 provides a summary of the sessions delivered, services covered and the attendance levels at these sessions.

5.3.12 These sessions have been evaluated both quantitatively and qualitatively in terms of managers' attitudes, awareness and understanding of behaviour change in managing attendance before and after the learning session. Results collected and analysed confirm that there has been an improvement in manager's understanding in all three areas, particularly with respondents having a good understanding of how behaviour change can influence attendance, knowledge and awareness of the health and wellbeing intranet site as a source of information and advice for staff, and understanding of the main causes of long term and short term absence. Managers were asked to comment on methods they would use to take the learning back into the workplace, and the majority of respondents have held team meetings locally to cascade the critical learning points.

c) Attendance Incentives

5.3.13 Research with other organisations, public and private; show that using prizes to reward staff with 100% attendance has been found to have a positive impact on improving attendance. However, as a public sector employer we need to be prudent in how we spend public money. Organisations do report experiencing a drop in their sickness absence rates with the introduction of prize draws. Research also shows that short-term attendance improves where tangible rewards are offered to employees who have no sickness absence over a specified period.

5.3.14 The scheme currently being implemented consists of an Attendance Prize Draw comprising quarterly draws with a prize of £250 for the winner with 100% attendance over a quarter i.e. 3 months without any sickness absence, and half yearly prize draws with a prize of £500 for 6 months without any sickness

absence. Thus, over the full year there will be 4 rewards of £250 each and 2 rewards of £500 each. The first draw will take place in early May 2015 and cover the period January 2015 – March 2015**.**

5.4 Disability Related Absence

5.4.1 The HR Sub Group were interested in examining whether disability information declared at the time of recruitment could be used to inform line managers, enabling them to better manage disability related absences of their staff. This issue has been considered in this section and further legal advice sought on the matter.

5.4.2 The Council currently collects equality monitoring data from job applicants at the time of recruitment using the Equal Opportunities Monitoring - Self Classification Form. The information is then stored separately from the recruitment process and the data entered into SAP to enable workforce monitoring to take place at a general level without identifying individuals. The Equal Opportunities Monitoring – Self Classification Form states clearly:

> "The information on this form will be treated in the strictest confidence. The results will be used to produce overall statistics about our workforce, and to take action to prevent discrimination."

5.4.3 The use of this monitoring form is mandatory for external applicants. Currently, completion of this form is not required for internal moves within the organisation. In order to get an and up to date information on the equality profile of the Council's workforce, including the disability profile of its employees, all new starters, whether appointed through an external or internal process should be encouraged to complete the equal opportunities monitoring form. However, as this is completed on a self classification basis the information will be what the individuals choose to declare.

5.4.4 In considering whether wider organisational use could be made of the information declared on the equal opportunities monitoring form, note has to be taken of provisions set out in the Equality Act. Section 60 of the Equality Act 2010 makes it generally unlawful for an employer to ask questions about a candidate's health or disability before they are offered a job or at the point that an appointment is being made. The purpose of Section 60 is to prevent information about a candidate's disability or health being used to reject their job application without first giving them the opportunity to show that they have the skills to do the job.

Section 60 prohibits:

- Enquiries by or on behalf of an employer about a candidate's disability and health during the recruitment process up to the point when a job offer is made.
- Written and verbal questions put to a candidate and to any third party – for example, their current or ex-employer.

5.4.5 Section 60 allows such questions about health and disability to be asked

before offering a job only in exceptional situations including where it is for the purpose of monitoring the diversity of people applying for the job. In such cases this information should be collected separately from other information given in the application for the job and should not be seen by the panel.

5.4.6 Legal advice has confirmed the above and also points out that quite apart from the legal restrictions; linking disability information from recruitment episodes to management of attendance has limited use. Individual episodes of absence may/may not be linked to an individual's disability or a condition may have developed at some point in the employee's career. The most effective way to gather this intelligence, and link it to the necessary support required, is for a manager to have the early conversations with their team members and understand what individual support needs might be. This could be done at the induction stage or at one-to-one's with individual team members. Understanding issues, dealing with these sensitively and putting in place support needed by staff to manage their conditions will not only help to prevent employees going off sick but also enable an earlier return to work should they fall ill.

5.4.7 Within the current management of attendance process, managers are supported/ reminded about having these conversations in a variety of ways:

- The online absence notification system has a field that asks whether the absence was disability related
- The return to work form also requires the manager to provide information about underlying condition along with any follow-up action
- The learning sessions with managers have focused on having difficult and sensitive conversations
- Where referrals are made to Occupational Health, questions about reasonable adjustments are encouraged to enable managers to support individuals back in to work
- Further option of seeking support through the provision of equipment and adaptations.

5.4.8 Based on the above, the important message to managers is that they need to talk to their staff in a sensitive way, as part of the induction process and good day-to-day management, to understand whether there are any disability issues and what, if any, support might be needed in the course of an employee's working life.

5.4.9 Members also requested information on the number of disability discrimination claims received by the Council. In the calendar year 2014, four disability discrimination claims were received from non-schools staff. Of these 1 was withdrawn and 1 settled. 2 cases are still ongoing at tribunal. In the same period only one disability discrimination questionnaire was received by the Council.

5.5 Implementation of Reasonable Adjustments

a) Occupational Health Outcomes

5.5.1 Members were interested in knowing about the extent to which reasonable adjustments are facilitated within the organisation and any blockages that might hinder this. An exercise was conducted to assess whether recommendations about reasonable adjustments made by the Occupational Health Service provider following a referral are being implemented by managers. A random sample of Occupational Health 20 reports issued in December 2014 were studied and manager's contacted.

5.5.2 The reports used to generate the sample met the following criteria:

- The report was issued in December 2014
- The report was in respect of an individual who was deemed likely to be covered by the Equality Act
- The report made a recommendation/s for reasonable adjustments

5.5.3 It was found that in 18 cases, it was confirmed by the managers in question that the reasonable adjustments had been put in place and enabled the employee to return to work. Note that in most of these cases, there were multiple reasonable adjustment recommendations made as follows and these were implemented in full:

Phased Return Work - 8
Counselling - 5
Temporary Adjusted Duties - 10
Medical Move - 1
Stress Risk Assessment - 2

5.5.4 In the remaining 2 cases, it was confirmed by the managers that the individuals were still on long term sickness absence. Both managers confirmed that the adjustments would be put in place when the employee returned to work. Both of these cases will be kept under review to ensure that this happens.

5.5.5 This exercise provides reasonable reassurance that managers do, in the large majority of cases, apply reasonable adjustments where it is appropriate to do so and this usually enables the employee to successfully return to work.

b) Equipment and Adaptations Provision

5.5.6 The Equipment and Adaptations provision is managed by the Corporate Health and Safety function within Internal Audit and Risk Management. Managers meet the first £300 of costs from their own budgets with funding above this level provided from Access to Work and the Corporate Health and Safety budget. Where equipment can be recycled this is done. No current requests for reasonable adjustments are refused on the basis of cost with the shortfall being met from the Health and Safety Budget.

5.5.7 The current approach does rely on the Access to Work - Job Centre Plus (ATW) model where employees contact ATW direct who then commission an individual assessment of needs arising from their specific condition. This

assessment informs the level of funding ATW will provide to assist the employer in implementing recommendations.

5.5.8 Due to DWP policy changes there has been a reduction in the level of support provided through ATW, in terms of both funding and the items ATW will part fund. Employers now fund the first £1,000 plus 20% of the remaining costs of equipment and as the majority of items are sought are below this threshold, most costs now fall entirely on the Council.

5.5.9 There are currently 25 cases being supported by the Corporate Health and Safety Team. The range of equipment and adaptations needed vary as below:

DISABILITY	**Equipment & adaptation**	**Cost (£)**	**Lead-in times to obtain**
Dyslexia & Dyspraxia	Speaking Software	350	4 weeks
	Read and Write Software	250	4 weeks
	Mind Mapping software	150	4 weeks
	Voice Recorder	130	4 weeks
	Headset	30	4 weeks
	Coping Strategy Training	4 – 10 sessions @ 220 per session	2 weeks
	Dyslexia Testing	470	Up to 6 weeks
Back Problems/ Ergonomic Solutions	Specialist seating	300 - 600	3 weeks
	Employees over 25 stone	1,000	6 weeks
	Desk risers	25	2 weeks
	Inflatable lumbar support	42	2 weeks
	Powered desks	450	6 weeks
	Foot rest	10 - 80	2 weeks
Visual Problems	Zoomtec software and camera	300	4 weeks
	Desktop magnifier	1,200	6 weeks
	Larger computer monitor	150	3 weeks
	Handheld magnifier	300	6 weeks
Hearing problems	Headset and cable (induction loop)	70	3 weeks
	Phonak Roger Pen and associated equipment	1,200	4 weeks

5.5.10 Issues/blockages have been identified with the current process and solutions are being implemented to improve the provision of support via ATW for employees:

- A significant proportion of the requested equipment via ATW is for chairs which provide a reasonable level of back support. As these are currently commissioned from a specialist disability provider, the requirements being specified and purchased can often be of a higher specification than required and takes longer to provide.

  A project has started to address this issue by specifying standard seating that meets these requirements and empowering managers to commission these requirements directly from a provider.

- Managers not clear on process, leading to delays in support and potential inconsistencies in approach.

  Manchester College has been commissioned by the Equalities Team (HROD) to develop accessible guides for managers and staff, including information on supporting employees with disabilities. There were 2 focus groups held in February 2015 facilitated by a tutor from Manchester College - one was for representatives from the staff groups on 9 February and one was for managers and HR/OD and other stakeholders held on 12 February. Guidance is expected end March 2015.

- Delays in receiving recommendations from ATW which can take up to two months between assessments and completed report when, for most employees, ATW do not fund proposed solutions below £1000.

  A pilot approach is being developed to commission individual assessments from a specialist vendor which would potentially result in significant reductions in waiting time and a more pragmatic approach to the specification of requirements. Proposal to Head of Audit and Risk Management on this option by 31 March 2015.

- Delays in the ordering of ICT equipment due to planned roll-out of the desktop refresh and lack of suitable cascade devices required for support software. Also commissioned ICT equipment does not always perform as required by the disabled employee because assessments undertaken through ATW do not reflect the Council's ICT infrastructure.

  In order to ensure timely resolution, the timing of acquiring ICT equipment is now tracked and reported to Head of Audit and Risk on a monthly basis. Also ICT now have a process for evaluating recommendations to ensure the specified equipment and software is compatible with existing ICT infrastructure and core applications so as to cut down any further delays.

5.5.11 Customer feedback, especially dissatisfaction has centred on the issues highlighted above. Solutions for these have already been put in place. Health and Safety team track all the cases they are aware of and complex cases are

assigned lead officers to ensure speedy resolution. Some dissatisfaction is also expressed by employees who may have unrealistic expectations on the range and type of equipment they believe is needed to assist them at work. This issue can cause significant delays where multiple examples of equipment are rejected by the employee as not meeting their needs.

5.6 Impact of Earlier Intervention by HROD in Managing Absence

5.6.1 The online absence notification system rolled out authority wide in April 2014 to encourage managers to report and record absence contains a series of prompts to aid managers in managing absence e.g. the prompt to conduct a return to work. This is part of the initiative to make managers more self-reliant.

5.6.2 HROD use reports to check on compliance rather than progress chasing all managers. Hotspots are identified and report on these provide to Heads of service on an ongoing basis. This was especially put in place based on feedback received from proactive managers who took exception to being contacted repetitively on a matter that they had already dealt with. HROD have thus scaled back on phoning everyone, instead reports to identify hotspots and focus on these with the managers in the service e.g. there might be a specific intervention spanning a period of two months focused on ensuring that all managers within the service conduct timely return to works and hold attendance management review meetings. Another intervention could be that absence becomes a standing agenda item in team meetings with managers highlighting the impact of absence on the service. However, every absence episode that lasts over 100 days has oversight & a plan for resolution. Additionally, case reviews are held with managers to ensure that a strategy is in place with a planned solution. HROD will assist managers to establish options available.

5.6.3 Based on a sample of cases where HROD have recently advised managers on interventions to facilitate early returns, it would appear that the advice provided has, in the majority of cases, had a positive effect. Out of a total of 5 case studies where HROD advice was provided, 4 have returned to work as a result of HROD helping managers to identify strategies to overcome barriers to a return to work. Listed below are strategies that were identified.

- Amendment to shift start and finish times to help employee manage stresses around home/work life balance
- Amending duties on a temporary basis to remove a stressor
- Placing the employee in contact with Access to Work to help her travelling to and from work
- Making an Occupational Health referral and ensuring recommendations are followed and implemented

5.6.4 In the other case, although HROD supported the manager in identifying a number of actions to help facilitate a return, the employee did not feel able to return. This case is being referred to an Attendance Management hearing.

5.6.5 HROD have also been involved in broader initiatives to help reduce levels of sickness absence. An example of this is within the Children and Families Directorate. An exercise was undertaken by HROD in October 2014 to tackle the overall levels of stress related sickness absence. At the time 41% of all long term absences across the Directorate were stress related. HROD service delivery contacted the individuals managing these cases to provide advice to help facilitate returns. As a result a number of interventions were put in place including temporarily adjusted duties, application of flexible working arrangements, stress risk assessments, counselling and phased returns to work.

5.6.6 Following this exercise there was a 12% decrease in the number of stress related long term sickness cases across the Directorate from 41% in October 2014 to 29% in November 2014. This rose slightly in December 2014 to 32% but there was an overall reduction of 9% over the period October 2014 – December 2014.

5.7 Operation of Sick Pay

5.7.1 Our payroll records show that in 2014, there was a total of 4,723 staff that were paid an element of sick pay. Of these less than 1% returned to work in the month that they went on to half pay. Additionally, there were about 1% of staff who went on to nil pay. Based on current information, no discernible link can be draw from the information available between sickness entitlement and return to work.

5.8 Special / Compassionate Leave

5.8.1 The Council values its employees and wants to support those with caring responsibilities. Three in five of us will be a carer at some point in our lives. Caring can take on a variety of forms, including preparing meals, managing finances, taking someone to appointments, doing shopping, bathing or toileting, giving medication, giving emotional support, and doing laundry.

5.8.2 Whilst no one is under any obligation to inform their employer of their caring responsibilities, the Council wants to maintain a culture that encourages carers to be open about their needs and in turn the Council will be supportive, providing that service delivery requirements can be maintained.

5.8.3 A toolkit for carers in the workplace has now been devised which brings together, in one place, the range of support, working arrangements and compassionate/special leave available to help and support those with caring responsibilities. This toolkit contains information about current legal provisions, special leave provisions, extended unpaid leave, a carer's passport template to manage information about the circumstances of the carer and any agreed support already in place to enable the carer to maintain a work life balance. It also includes a provision to review a request for special leave which has been refused by a manager. As the new special leave arrangements require changes to the Special Leave policy, the revised arrangements will be submitted to a future Personnel Committee for approval.

5.8.4 In addition to this there is a link to the Carers' Information Pack, which was originally produced for Manchester residents and contains useful generic information on arranging a carer needs assessment, planning for emergencies and other useful contacts, such as charities which provide support to carers in general and specialist charities for example for cancer or dementia.

5.8.5 It is felt that given the range of options available to help carers, employees with caring responsibilities will feel better supported. This could help to reduce absence which might have resulted from the pressure of caring.

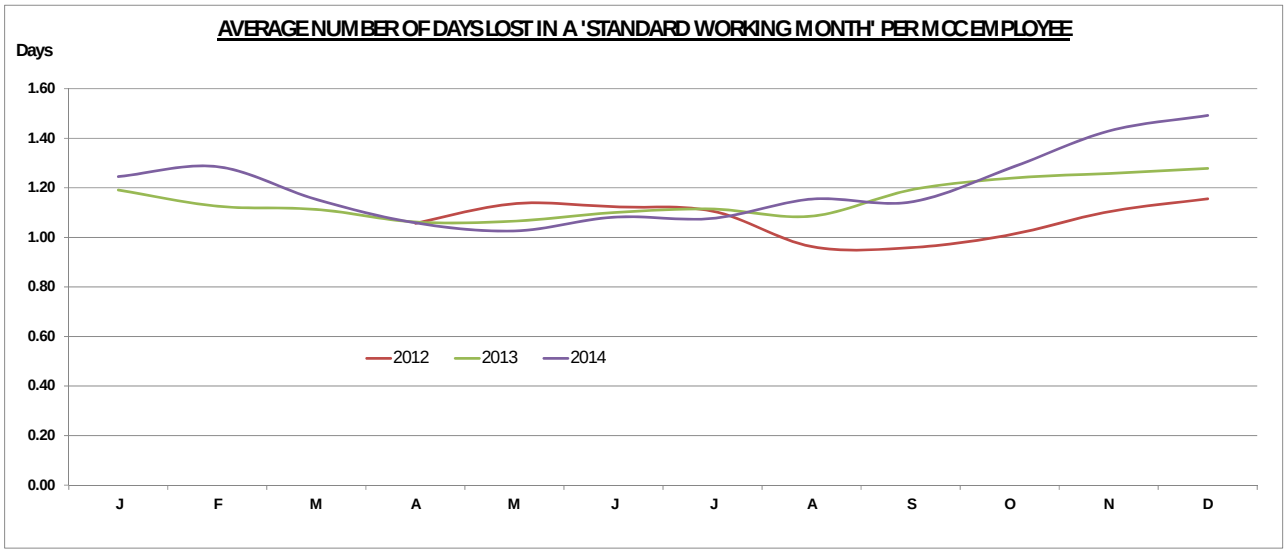
6. DIRECTORATE MEASURES TO IMPROVE ATTENDANCE LEVELS

6.1 This section highlights specific Directorate absence trends or patterns and the activity targeted on reducing absence at Directorate and Service level. In the last report for the HR Sub Group data was included at primarily Directorate level with just the Top 4 Divisions in terms of highest absence (smaller areas within Directorates) identified across the whole of the Council. In this report the data has been broken down and analysed at Divisional / Group level and also Section (another level down i.e. smaller groupings of staff) for each of the three Directorates. This means that added intelligence is included to identify the "hot spots" within services.

6.2 Children & Families Directorate.

6.2.1 Overall Absence Trends

Average number of days lost in the standard working month per FTE showed an increase for August, October, November and December in 2014 (September was the exception). November and December saw the most significant increases, increasing by 0.17 and 0.21 days respectively. If looking quarterly then Q3 saw a significant increase up from 3.77 in 2013 to 4.19 in 2014.



Graph 7 – Average number of days lost in a 'standard working month' per Children and Families employee.

6.2.2 When analysing the days lost data further and looking specifically at the average days lost that were part of long term sickness then September had lower figures; there was little difference in October's figures but August, November and December had markedly higher average days lost figures than in the same months in the previous year. Looking quarterly, Q3 saw an increase from 2.69 in 2013 to 2.93 in 2014.

6.2.3 Monthly absence rates for short term absence follow a clear seasonal pattern with little variation between this year's and last year's monthly figures for the average number of days lost in a month (which were part of a short term incidence of absence) per FTE until later in the year. November (0.23) and December (0.22) 2014 had comparably higher absence rates (increases of 0.6 and 0.4 days respectively). This was reflected again in quarterly analysis where Q1 and Q2 had lower figures for short term sickness in 2014 however there was a marked increase in Q3 up from 0.53 in 2013 to 0.63 in 2014 (the 2014 figure was however similar to Q3 in 2012).

6.2.4 When comparing the medical reasons given for short term sickness for Q3 this year versus last, it shows that there has been a significant rise in the proportion of days lost in 2014 which were recorded as being due to 'cold', 'influenza', 'chest infection', 'viral infection' and 'vomiting' (all of which increased by approximately 2-3%).

6.2.5 Looking at reasons for long term sickness the percentage of days lost in Q3 which were recorded as being due to 'depression/reactive' is lower than it was in Q3 of 2013 and 2012. Indeed this years Q3 result is the lowest for the past 10 quarters. Conversely the percentage of days lost in Q3 which were recorded as being due to 'stress' is higher than it was in Q3 of 2013 and 2012 and this is part of a longer term increasing trend. The corporate level trend with regards to 'anxiety' is reflected (a marked increase beginning at Q3 2013-2014), however this year's Q3 result (5.25%) is the lowest percentage since Q3 last year.

6.2.6 <u>Directorate Activity and Interventions</u>

6.2.7 The current (i.e. latest figures for March) total number of long term absence cases (more than 20 consecutive days) is 115. The majority of these cases are within Networks (17%) followed by Social Care (16%) and Reablement (10%). It should be noted that absences cases within Reablement had started to decline, however 7 cases are newly added, whereas the cases within Social Care have all been absent for more that 100 + days, with 44% of the cases being absent for more than 200 days. Of these cases:-:

- 26% relate to stress, anxiety and depression. The majority of all stress related absences are within Social Care.

- 23% relate to musculoskeletal problems. The majority of cases are within Social Care and/or, Networks where manual handling is one of the main functions of the role.

6.2.8 The remainder are a mix of reasons e.g. cancer, operations, chest infections.

6.2.9 All of these cases are subject to active management interventions. There are a number of areas within the directorate with absence levels higher than the organisational average.

6.2.10 The top Divisions within Children's and Families in terms of absence are:

GROUP	AVERAGE MONTHLY RESULT	FTE DEC 2014
Strategic_Business_Support	1.63	128.69
Business_Delivery	1.44	696.38
Safeguarding	1.36	295.56
Care	1.32	934.46

6.2.11 The above figures are Group figures; these can be broken down further to section level which is sub divisions of the Groups. Service sections with high average levels of absence over the 12 month (Jan 2014 – Dec 2014) period include:

Safeguarding - Residential Childcare Services (1.80 days)
Business Delivery - Homelessness (1.73 days)
Strategic Business Support - Business Change and Information (1.56 days)
Business Delivery - Community Provision (1.46 days)
Business Delivery - Service Improvement (1.28 days)

6.2.12 Of the above, Residential Childcare Services and Community Provision have seen significant increase in absence in winter 2014.

- **Residential Services -** There has been a reported increase in long-term absence due to work related stress. The service have indicated a need for more support from HROD to help deal with absence.

- **Business Change and Information** - The increase in absence is attributed to a strong strain of flu/cold over the winter months. All cases have now either been resolved or have strategies in place to resolve.

- **Community Provision –** There has been increase in long-term absence due to serious health conditions. Managers feel that cases are now being managed appropriately.

- **Service Improvement** - Increase in absence is attributed to stress and anxiety over service redesign. There has been an increase in vacancies over the period in question which has resulted in greater workloads for

staff in work leading to increase in absence due to muscular skeletal reasons. These vacancies have now been filled and it is anticipated that this will lead to a decrease in absence over the coming months.

6.2.13 Social Work teams continue to be an area where absence is a particular concern within both Care and Safeguarding Divisions. Days lost in social work teams are largely attributable to long term sickness cases. Absence levels across both areas have increased since the last report Care by 52.25% and Safeguarding by 19.85%. Safeguarding Services also includes Children's residential care, Fostering & Adoption, the Permanence social care team and the Safeguarding Improvement Unit. Residential Care has historically been an area with high levels of sickness.

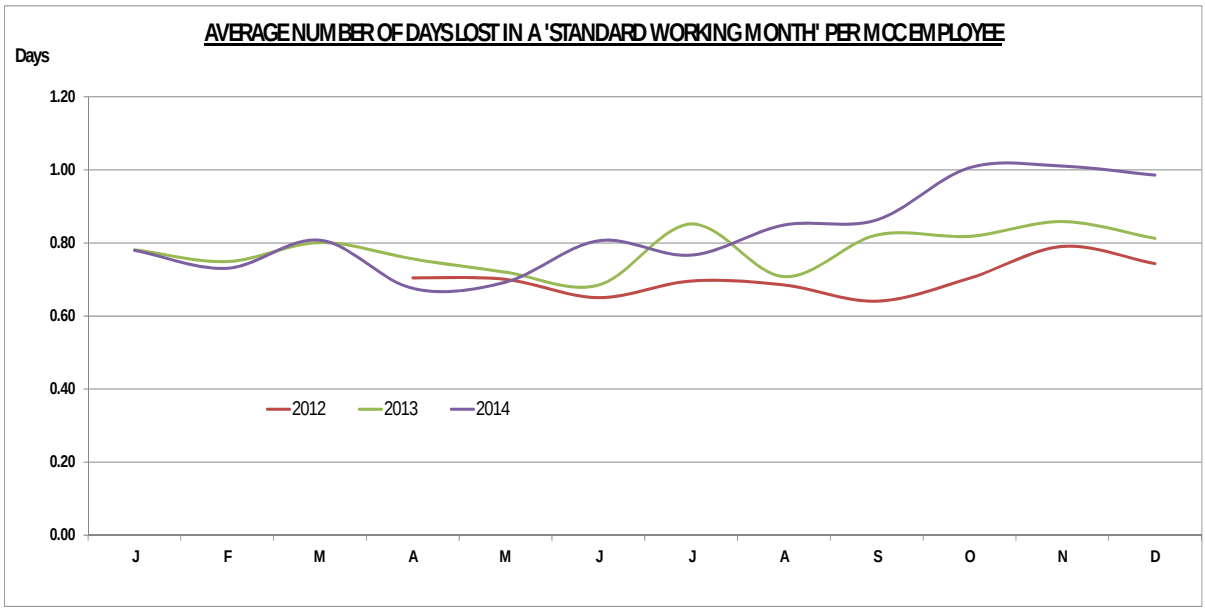
6.2.14 Activity identified in the last scrutiny report is part complete. The service continues to place focus on resolving absence cases and HROD are supporting managers to actively manage absence cases. Management within Family Recovery Service and Children's Residential Care have proactively requested more regular meeting with HROD to jointly work to resolve cases.

6.2.15 Supported accommodation for customers with Learning and Physically Disabilities (Networks) within Business Delivery Division continues to have high levels of absence relating to musculoskeletal disorders. Manual handling is one of the main functions of the majority of roles within the service. Absence Levels across Business Delivery have increased by 43.75%. Since the last report this service area has been proactively progressing all identified actions to support the proactive management of absence across the service area.

6.3 **Corporate Core Directorate**

6.3.1 Overall Absence Trends

6.3.2 When looking at the "average days lost in a standard working month per FTE" measure for August – Dec 2014 then higher levels absence rates were seen from August to December (increases of 0.14, 0.04, 0.19, 0.15, and 0.17 days compared to same period in 2013).



Graph 8 - Average number of days lost in a 'standard working month' per Corporate Core employee.

6.3.3 The average number of days lost (which were part of a long term incidence of absence) per FTE was higher in 2014 for every month except July, when compared to the monthly results of 2013. The increases ranged from 0.03 to 0.15 (December) with the mean increase across the year being 0.07 days. This increase in days lost due to long term absence (as opposed to short term absence) is driving the trend of increased monthly absence rates in the directorate. Analysis at Service level later will help identify which services within Corporate Core are those which are driving this increase in long term sickness.

6.3.4 The average number of days lost in a month (which were part of a short term incidence of absence) per FTE was generally lower than 2013 figures from January to September. However, the short term absence rate in October, November and December was slightly higher in 2014 than it was for these months in 2013. Despite a comparatively 'bad' Q3 for short term infections , the mean monthly result for 2013 was 0.19 days lost in a month per FTE, and this decreased to 0.18 in 2014.

6.3.5 Reasons for absence showed increases in sickness reported for colds/chest infection/flu as a percentage of all short term sickness in Q3 this year compared to 2013. For long term the percentage recorded as depression/ reactive has decreased in Q3 year on year for the last 3 years but anxiety has increased year on year from 4.95% in Q3 2012 to 9.82% in Q3 2014.

6.3.6 When looking at actual numbers of days lost by medical reason for all absence then stress is consistently the highest ranked reason. It is also increasing in terms of total days lost to this kind of sickness – it increased by 39% when comparing days lost in Q1-3 for 2013 against Q1-3 for 2014. Anxiety has almost doubled for the same periods. Days lost due to cancer

have dramatically reduced for this directorate since a peak in 2012 and especially so in 2014.

6.3.7 The service areas across the Corporate Core that have higher levels of absence than the average number of day's absence are:

	AVERAGE MONTHLY RESULT SINCE JAN 2014	FTE in Jan 2015
City Solicitor's Division	1.07	248.87
Revenues Benefits & Shared Services	0.90	506.92
Performance (PRI, ICT, HR/OD & Reform & Innovation)	0.86	449.38

6.3.8 It should be noted that absence levels within the Shared Service Centre are below average but are referenced here as this service is within the same organisational unit as Revenues and Benefits.

6.3.9 The service areas (Divisions) that have been identified in the table above as having higher than average absence levels areas with high numbers of FTE. The data has been broken down further to section level which are sub divisions of the Divisions. Reviewing the data in detail for these sections means a number of smaller teams can be identified which are the hotspots of absence and impacting on the whole service statistics.

6.3.10 The 'hotspots' identified at Section level are:

- Regeneration Legal (1.41 days)
- Legal delivery and Service Development (1.38 days)
- Customer Service Organisation (1.28 days)
- Operations (1.23 days)
- Council Tax (1.15 days)
- ICT (1.07 days)

Of the above, Regeneration Legal, Legal Delivery and Service Development and ICT have seen increase in absence in winter months of 2014.

6.3.11 **Directorate Activity and Interventions**

6.3.12 When reviewing the reasons for absence during Q3 of 2014/2015 mental health related conditions continue to be the main reason, equating to 22.59% of all absence in the Core. This is followed by winter/short term infections (17.13%) and muscular/skeletal related absence (14.10%). This trend is consistent with those figures reported for Q1.

6.3.13 The areas with the highest long-term absence are Legal 41% (11 cases), Customer 30% (8 cases), ICT 12% (3 cases), Research & Intelligence 7% (2 cases), Business Units 55% (29 cases) and Revenue and Benefits 17% (10

cases). Of these cases 12 have now been resolved with 10 returning to work and two individuals exiting the Authority.

6.3.14 **Interventions**

6.3.15 To support managers with managing attendance over the last two months, there have been a further six Managing of Attendance Behaviour Change briefings for managers in the Core. These sessions explore what behaviours managers need to demonstrate to apply the MoA policy effectively.

6.3.16 In addition to the above, regular meetings between HROD and Heads of Service take place to discuss overall absence levels, trends, hotspot areas and strategies for resolution. As referenced earlier this has identified a number of areas that have increasing absence levels. The work ongoing in these areas to increase attendance and reduce absence levels is detailed below.

6.4 **City Solicitor's**

6.4.1 The average days lost per employee per month within City Solicitors Division is 1.07 days which is an increase of 0.14 since last reported. This increase primarily relates to an increase in absences due to mental health related matters.

6.4.2 The Legal Management Team closely monitors sickness levels across the service. There is a nominated lead member of LMT who is responsible for the production of reports which detail number of days lost through sickness; the report provides a breakdown by service group. Sickness is reviewed by LMT on a quarterly basis. Absence records and monitoring are regular items at Group and Section Management Team meetings.

6.4.3 Additionally management workshops, which are lead by the Legal Management team, take place on a regular basis. These sessions include key messages and service priorities along with bite size sessions on key topics including attendance. Two management training sessions have taken place (February/March) which focused on managing stress and personal resilience. The Corporate health and safety manager provided support to these sessions.

6.4.4 The Division holds quarterly staff briefings the next briefings are due to take place in May and will focus on personal resilience and well being.

6.4.5 Managers in the Division are required to, and, actively manage all incidences of absence through sickness in accordance with the Council's policies and procedures.

6.4.6 Whilst there is no evidence to suggest that the absence is connected to workplace opportunities it is important to highlight that the service have invested a significant amount of time and focus over the last 12 months in developing the workforce. This has resulted in a number of internal movements and promotions; this has also resulted in a number of external

appointments which provides additional capacity and expertise in a busy service area.

6.4.7 It is anticipated that the steps taken as referred to in the preceding paragraph together with the measures being taken to address absence through sickness by the managers in the Division, along with other factors, will result in a reduction in levels of long term absence due to sickness over the next 12 month period.

6.5 **ICT**

6.5.1 There has been a noted increase in absence within ICT primarily related to stress - both in the workplace and due to personal circumstances. Within ICT there is a broader piece of work ongoing related to the development and implementation of a revised operating model. This will deliver a clear programme of activity, communication plan and approach to development and culture change. Whilst it is recognised that this is further change for the workforce, this has been positively received and it is anticipated that these positive changes will improve motivation, moral and attendance.

6.5.2 Managers from ICT where invited to attend a Mental Health Awareness workshop which took place in early February, the objective of which is support the identification of mental health issues and provide tools and resources to support sustained attendance. A number of stress risk workplace assessments have also taken place, the outcomes of which should support individuals to maintain attendance with the required support and adjustments.

6.6 **Business Units**

6.6.1 There is a targeted focus on improving attendance across Business Units with the service engaging a dedicated management resource via an ***m people*** placement. This resource has been engaged to review management arrangements, identify any potential barriers and development requirements. The output will be produced via an end of placement assignment and will inform any further interventions, changes and next steps.

6.6.2 The approach adopted by the management resource has included workplace interviews with various managers from across all business unit areas. Whilst this piece of work is ongoing early feedback indicates:

- Systems and timescales are focussed around having intranet access this can be challenging for staff based at schools that do not have system access.
- The need for a service lead compliance audit
- Concerns about the practical elements of policy e.g. unpaid special leave requiring Head of Service approval
- Concerns about good attendance not being rewarded

6.6.3 Management of Attendance refresher training has been arranged for all managers in Facilities Management and Catering. The review has highlighted

the need for regular meetings across both services between Area Managers and the Heads of Service (with support from HR when required) in order that long term sickness cases can be reviewed and management strategies are put in place.

6.6.4 The average days lost per employee per month is 0.80 which is a decrease of 0.1 reported last period. However the impact of these measures will be kept under review and monitored to track whether this translates into a consistent trend.

6.7 **Customer Service Organisation**

6.7.1 The approach to managing attendance as described in the last report to scrutiny has continued in the Customer Organisation. This has also progressed with a series of meetings having taken place with employees on a 1:1 basis to address excessive levels of sickness absence. This involved the staff member being shown their absences over the last 12 months and challenged about patterns. The intention of these meetings was to further highlight and emphasis the importance of personal responsibility and accountability for attendance. This has been followed up with a regular notice in the weekly news bulletin highlighting the importance of attending work and maintaining personal health and wellbeing.

6.7.2 In addition to the above the service are also revisiting engagement events and team briefings to highlight any concerns of attendance and promote good attendance supported by the health champions.

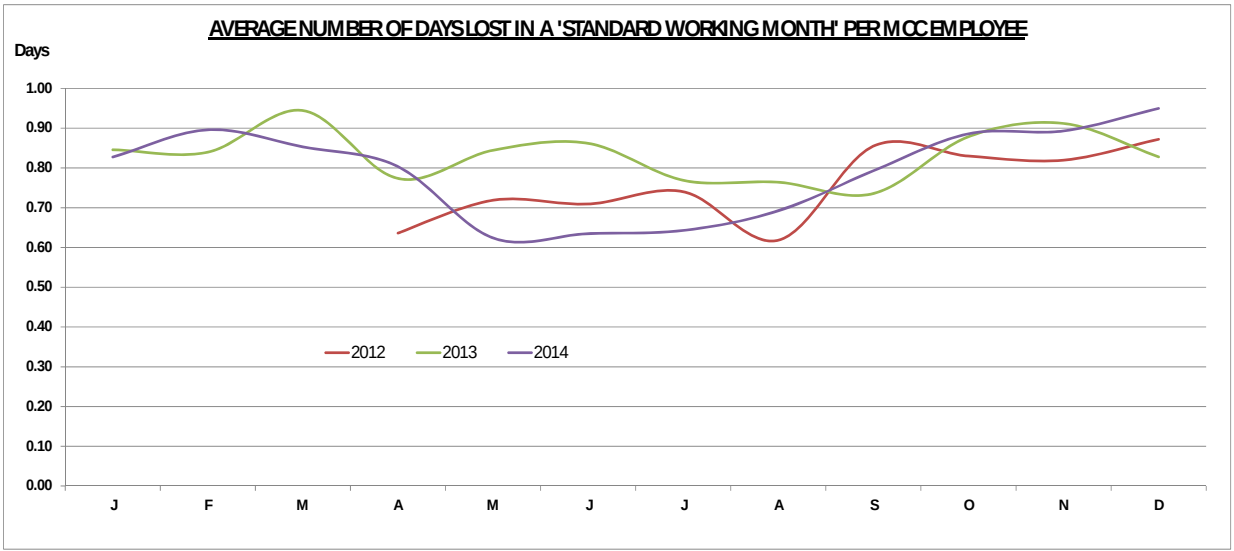
6.8 **Revenues and Benefits**

6.8.1 As referenced previously, there are a number of small hotspots across the service with high levels of absence. The interventions introduced where referenced in detail in the previous report and are ongoing. The impact of these interventions are being monitored and if appropriate will be included within the next report to the HR Sub Group.

6.9 **Growth & Neighbourhoods Directorate**

6.9.1 Overall Absence Trends

6.9.2 The average number of days lost in a month was markedly higher in February, April, September and December 2014 than it was it was for these months in 2013 (up 0.6, 0.6 and 0.12 days respectively). For most of the months it was lower and for March, May, June, July and August results were markedly lower than these months last year (down by 0.09, 0.22, 0.22, 0.13, and 0.07 respectively). The average number of days lost in the quarter per FTE in Q1 and Q2 2014 was lower than the comparable quarters in 2013 (Q1 was down from 2.48 to 2.06 and Q2 was down from 2.27 to 2.13). However Q3 saw an increase up from 2.59 in 2013 to 2.73 in 2014 which was driven by significantly higher absence levels in December.



Graph 9 - Average number of days lost in a 'standard working month' per Growth and Neighbourhoods employee.

6.9.3 When analysing this days lost data further and looking at specifically at the average days lost that were part of long term sickness the average number of days lost was significantly lower throughout 2014 and this was particularly true from March to August. The decrease was most significant for the months of May and June (0.41, 0.43 days in 2014 compared to 0.62, 0.63 days in 2014 respectively). However, the result for December 2014 (0.63) was 0.10 days higher than December 2013. Looking Quarterly then Q1 and Q2 2014 were lower than the comparable quarters in 2013 (Q1 was down from 1.80 to 1.28 and Q2 down from 1.52 to 1.31) however Q3 saw a marginal increase up from 1.72 in 2013 to 1.76 in 2014.

6.9.4 Contrary to the pattern for long term sickness, average number of days lost in a month which were part of a short term incidence of sickness (STS) per FTE has shown a small increase for most months when 2014 figures are compared to the comparable months in 2013. The most significant increases were in the months of October, November and December (0.06, 0.03 and 0.06 respectively).

6.9.5 The percentage of short term days lost in the quarter which were recorded as being due to 'colds' was 22.56% in Q3 2014. This represents a significant increase on Q3 of 2013 (10.26%) and of Q3 of 2012 (8.21%). This is the highest result over the past 10 quarters.

6.9.6 When compared to previous quarters, Q2 and Q3 of 2014-2015 have seen a significant increase in the percentage of long term days lost in the quarter which were recorded as being due to stress. In Q2 'stress' represented 22.90% of all days, and in Q3 this rose further to 29.01%. These results are significantly greater than any result over the past 9 quarters (which ranged from 16.19% to 5.39%). Conversely the percentage of days lost in the Q3 2014-2015 which were recorded as being due to 'depression' is 2.59% and this represents a reduction of 10.20% from the figure in Q3 2013-2014

(12.79%). These trends are also seen when looking at the actual numbers of days lost due to long term sickness as well as the relative proportions.

6.9.7 The top Divisions within Growth and Neighbourhoods in terms of absence are:

DIVISION	AVERAGE MONTHLY RESULT SINCE JAN 2014	FTE in Jan 2015
Neighbourhood_Strategy_&_Delivery	0.92	523.11
Regeneration	0.91	65.61
Community_&_Cultural_Services	0.89	275.64

6.9.8 The service areas (Divisions) that have been identified in the table above as having higher than average absence levels areas with high numbers of FTE. The data has been broken down further to section level which are sections of the Divisions. Reviewing the data in detail for these sections means a number of smaller teams can be identified which are the hotspots of absence and impacting on the whole service statistics.

6.9.9 The service sections with comparatively high average levels of absence over the 12 month (Jan 2014 – Dec 2014) period include:

- Community & Cultural Services - Central Library Customer Service (1.39 days)
- Neighbourhood Strategy & Delivery - NDT Central Area (1.33 days)
- Neighbourhood Strategy & Delivery - City Centre Team (1.31 days)
- Community & Cultural Services - Central Delivery Team (1.06 days)
- Community & Cultural Services - Archives Plus (1.03 days)

6.9.10 Of the above, Central Library, NDT Central Area and the City Centre Neighbourhood Delivery Team have seen relative increase in absence in winter 2014. A number of these absences are linked to stress, some of which is work related.

6.9.11 <u>Directorate Activity and Interventions</u>

6.9.12 The main category of absence in quarter 3 of 2014/15 when looking across all terms of absence is the same as reported for quarter 1, with mental health being the main cause (25.5%). The second highest category is winter/short-term infections (17.92%), followed by muscular/skeletal related absence (113.67%). This has been a consistent picture since quarter 2 of 2013/14 whereas prior to this muscular/skeletal accounted for the highest proportion of absence in the directorate.

6.9.13 This shift aligns with the changes across the organisation and formation of Growth and Neighbourhoods Directorate when Business Units transferred to the Corporate Core which included a large number of front-line manual

workers and a number office based and predominantly professional services transferred in. It would therefore be expected that there would be a reduction in MSD related absence due to the change in the workforce composition around this time.

6.9.14 When analysing the detailed absence reasons for the latest quarter (including short, medium and long term), stress remains the highest cause of absence at 20.14%. Looking at the detail of individual stress related cases, only a very small number are due to work related stress and they have not increased. It should be noted that this is typically where there has been significant change within the workplace, such as redesign and change of roles.

6.9.15 Appendix 1 gives the average days lost per FTE. figure for all Directorates; for Growth and Neighbourhoods this is 0.76 days, which is an increase of 0.07 days from the previous report. The service areas within the Directorate where the average days lost per FTE is higher than the directorate average remain Regeneration, Neighbourhood Strategy and Delivery (NDT) and Community and Cultural Services (CCS).

6.9.16 The total number of long term absence cases (more than 20 consecutive days) is currently 24. The areas with the highest absence of this type are NDT at 41% (10 cases) and CCS, Capital Programmes and Planning, Building Control & Property all have 4 cases each (16.6%). Of the total cases:

- 37.5% relate to stress, anxiety and depression, which is small reduction on this type of absence since the last report. These mental health related absences are within NDT, CCS, Capital Programmes and Planning, Building Control and Licensing. Two thirds of these cases relate to personal circumstances, the other third are work related. Of these areas with the highest levels of stress related absence, all but CCS have been going through significant change and redesign over this period.
- 16.6% of the long term absences cases relate to musculoskeletal issues. Of these, 75% are within NDT operations and the remainder is within Business Support.
- The remaining long term absence cases are a mixture of chronic and degenerative illness across various services.

6.9.17 All of these cases are subject to active management interventions. It should be noted that NDT and CCS have a significantly higher number of staff than other services within the directorate and so it would be expected to see a proportionately higher number of cases in these areas.

6.9.18 The average days lost per employee per month within Regeneration is now 0.8 days, a reduction from the previously reported 1 day. There has therefore been a decrease in the overall absence levels for this area over the last few months and the remaining short and medium term absence cases are being proactively managed.

6.9.19 The average days lost per employee per month within NDT is 0.87 days, which is a 0.02 increase since last reported. This is a service area which has historically had higher than average absence levels. This is the largest service within the directorate with approximately 520 FTE and the majority of operational staff within this area are Manchester residents and therefore the general health issues seen in the city are often reflected in this workforce. There is subsequently a high proportion of MSD related absence, time off due to operations and illness relating to colds and flu. This is a picture reflected nationally in both public and private sector organisations.

6.9.20 Absence levels within CCS are similar, with the average days lost per FTE per month at 0.83 days. This service also has a predominantly front-line customer facing workforce of approximately 275 FTE, which has historically had higher than average levels of absence. The number of long term sickness cases has reduced since the previous report and these remaining cases are due to a variety reason including mental health and chronic illness. There are no clear patterns in the reasons for absence and the cases are being actively managed with support from HROD.

6.9.21 There has been an increase in the absence levels within Planning, Building Control and Licensing, with average days lost per month per employee at 0.78 days. 75% of the cases are stress/anxiety related, 25% of which is work related. HROD are supporting managers to actively manage these absence cases within the service.

6.9.22 There is a significant amount of work underway in the directorate to address absence levels. Specific activity underway within NDT includes targeted communication with the management team to highlight concerns in this area of the service. In particular the total days lost and how that translates to lost officer time. Discussions have also been taking place around identified barriers for successful returns to work and approaches to address these. Managers are also being encouraged to use and access to Managers Desk Top to ensure robust oversight and management of individual cases.

6.9.23 An issue with attendance management data for Growth and Neighbourhoods has been identified over the last month there have been a number of cases where an employee has returned to work yet this has not been recorded on SAP and so this has increased the levels of absence and particularly number of long term sickness cases being recorded. Last month this was the case in 5 of the long term sickness cases identified as meeting the criteria resulting in an over recording of 320 absence days. It is intended to carry out further investigations as to why this is occurring and whether it is having a significant impact on recorded absence levels.

6.9.24 As previously reported, there is also a strong focus on increasing attendance at a cross directorate level with quarterly reports provided to DMT. Following agreement from the last report to explore some practical interventions relating to managing mental health related absence, work has taken place to identify managers to attend pilot workshops on strategies for dealing with employees presenting with stress related absence. All the managers identified are

currently or have recently managed the absence of employees with such reasons for absence.

6.9.25 In relation to musculoskeletal related absence, the training and activity plan in place is in place and being delivered to ensure robust preventative activity to minimise absence due to MSD, particularly for manual workers such as manual handling training. Work is also ongoing with Health and Safety colleagues to ensure effective processes and procedures are in place to mitigate risk of injury or long term physical impact for those in manual roles.

6.9.26 Between December 2014 and January 2015 a full end to end review of the of the application of the MoA process was carried out by an NDT Locality Manager. A number of examples were identified where managers were not applying the policy correctly, for example, action not being taken when an improvement notice had been breached. The issues identified are currently being addressed through training with managers. This will be kept under review until such time as the necessary assurances are in place.

6.9.27 Activity undertaken in relation to absence management will continue to be monitored on an ongoing basis.

7. CONCLUSION

7.1 There continues to be a very large focus placed on improving attendance and the report demonstrates the scale of the efforts being made both corporately and in some areas at Directorate level. It is disappointing that despite everything that is being done there are still some areas that have high, and in some cases, increasing sickness.

7.2 C&F Directorate continues to have the highest sickness levels and also had increases in sickness over the later months of the year. There are wide variations in sickness levels between different services (and to a lesser extent between teams within the same service area), for example, within C&F Directorate there are Group monthly average days lost figures for the year that range from 0.4 to 1.8.

7.3 In general, however, for the services/teams that have high sickness levels for the period of this report, they have consistently had the highest sickness levels over the last 12–18 months or more. There has been a significant rise in the proportion of days lost in 2014 which were recorded as being due to ‘cold’, ‘influenza’, ‘chest infection’, ‘viral infection’ and ‘vomiting’ (all of which increased by approximately 2-3%). For long-term sickness the percentage of days lost in Q3 which were recorded as being due to ‘stress’ is higher than it was in Q3 of 2013 and 2012 and this is part of a longer term increasing trend.

7.4 HROD have over the past 2 -3 years sought to address and support management of attendance over a broad base; evidently this has not been successful. A more targeted approach with services of most concern has been pursued has in some cases produced results. Further development in

production of this sickness data mean it is now available broken down to service level. This will soon be available to Directorate Management teams to clearly identify hot spot areas. This should make focused attention on these areas easier to achieve.

Appendices

Appendix 1. Information on Managing Attendance Behaviour Change Workshops.
Appendix 2. Update on Heads of Service Management of Attendance meetings.

Appendix 1.

LEARNING SESSIONS WITH MANAGERS

Session Date	Directorates/ Services Covered	No. of managers attending
BEHAVIOUR CHANGE PILOT AREAS		
17 April 2014	Corporate Core – Customer Contact Organisation	8
12 May 2014	Growth & Neighbourhoods – Neighbourhood Delivery Teams	7
9 June 2014	Children & Families – Social Work Localities	3
AREAS CONTAINING TEAMS WITH HIGH ABSENCE		
2 December 2014	Growth & Neighbourhoods – Regeneration & Community & Cultural Services	6
18 December 2014	Corporate Core – Revenues & Benefits & Shared service Centre	13
6 January 2015	Corporate Core – Business Units	14
7 January 2015	Children & Families - Safeguarding	7
21 January 2015	Children & Families – Business Delivery	8
27 January 2015	Growth & Neighbourhoods – Regeneration & Community & Cultural Services	5

(Managing Attendance Behaviour Change Workshops).

The Managing Attendance (Behaviour Change) learning sessions were initially targeted to the behaviour change pilot areas and were then rolled out in December 2014 - January 2015 to 53 managers across 6 services within each of the Directorates, where absence levels are high. Managers have attended from Regeneration and Community & Cultural Services in Growth and Neighbourhood, Revenues & Benefits, Shared Services and Business Units in the Corporate Core, and Safeguarding and Business Delivery in Children and Families Directorate.

Participants were introduced to the concept of behaviour change and what it means in the context of managing attendance, and a brief overview of the range of initiatives falling within the remit of the project. The target message of the session was about supporting staff in a way that makes a difference to them through a personal, quality approach, whilst also highlighting that employees must take personal responsibility for their own absence. Critically the sessions examined how this approach needs to compliment the more punitive aspects of the Managing Attendance Policy through positive engagement. The sessions explored the softer skills in having difficult or

sensitive conversations with employees.

Equality issues were also explored, as well as mental health issues, which is one of the main causes of long term absence in the Council. Participants were also introduced to other absence trends and challenges including the main causes of short and long term absence and other facts and figures including how absence trends vary across the seasons.

These sessions have been evaluated both quantitatively and qualitatively in terms of managers' attitudes, awareness and understanding of behaviour change in managing attendance before and after the learning session. Results collected and analysed confirm that there has been an improvement in all three areas, particularly with respondents having a good understanding of how behaviour change can influence attendance, knowledge and awareness of the health and wellbeing intranet site as a source of information and advice for staff, and understanding of the main causes of long term and short term absence. Managers were asked to comment on methods they would use to take the learning back into the workplace, and the majority of respondents have held team meetings locally to cascade the critical learning points.

Managers across each of the Directorates were asked how they have used the learning in their teams and services and some examples include:

"I now have a better awareness of the support which is available for staff and managers with regard to health and wellbeing. The course also made me more aware that as managers, we can have a significant positive / negative influence over an employee's attendance". (Children and Families)

"The session enabled me to be mindful of mental health when I dealt with an unexplained absence recently. An employee had been off on unauthorised absence for 6 weeks. After numerous invites to come in and discuss the issue with me, which had been ignored, the member of staff turned up to work unexpectedly with a clutch of sick notes and a poor explanation of the nature of the absence. I remembered the course during the meeting, and used my skills to question the employee in more depth and was able to get to the underlying issue. The employee was suffering from a stress related condition and has now returned to work with support and a referral for CBT. The employee is now enjoying being back at work and it's been a positive result all round." (Corporate Core)

"We used the presentation to aide with the awareness of MOA procedures for our team and have now started looking at the long term sick cases who have returned and what we can do to ensure that these people stay in work" (Growth and Neighbourhood).

Appendix 2.

Update on Heads of Service Management of Attendance meetings.

This note provides an update on actions from the Head of Service meetings held on 2 October 2014 and 16 October 2014 in respect of absence 'hotspot' areas. Of the 36 actions in total 4 have not yet been fully completed. This will be kept under review.

Legal Services

Action	Complete	Detail
Regarding a specific case identified at the meeting, ensure that 4 weekly AMRs are conducted as required. Position to be reassessed within 2 months by seeking a medical review. Either the employee will be able to return to work in some capacity or following a review in light of HealthWork advice alternative action will be taken in line with the MOA policy	Yes	AMRs held in accordance with advice. Referral to HealthWork has been undertaken. Strategy for conclusion now in place.

Licensing

Action	Complete	Detail
Service Head to speak to management team and highlight concerns re absence levels. In particular total days lost and how that relates to lost officer time.	Yes	All managers have been advised of concerns regarding absence levels and reminded of the need to ensure that the MoA policy is followed.
Unit Manager to conduct audit of compliance with MoA policy expectations. Have AMR's and RTW's been conducted within expected time frames. Get assurance that management are collectively following procedure by end of October	Yes	This has been undertaken and no issues identified.
New absence cases in particular will be monitored to ensure correct application of the MoA policy. HR support will be requested when required	Yes	All new cases are now being monitored and supported is being obtained from HR where required.
One particular manager identified at the meeting will need ongoing support and close monitoring by the Unit Manager to ensure compliance with the MoA policy	Yes	Support has been given to the manager and is ongoing.
HR will maintain ongoing contact in relation to the specific case example identified	Yes	HR support has been obtained and is ongoing.
Unit Manager to review all current absence cases. HR to support manager on request	Yes	All cases have strategies for conclusion. HR support has been obtained where needed.
Role profiles revised and improved to ensure managers are aware of their responsibilities by the end of October 2014	Yes	This has been picked up as part of the service review. The revised role profiles have been shared with all staff.
Service Head to check whether managers are	Yes	It is confirmed by the Service

aware of the information available through Manager's Desktop. If not manager to request support from HR		Head that all managers within the service have access to Manager's Desktop and are aware of what information is available.

Corporate Contact Centre

Action	Complete	Detail
"Under the Radar Cases" where employees have short term absence but not hit triggers to be reviewed. HR to support to see if action can be taken. The service has already contacted HR and will be meeting in the next week to review cases.	Yes	The meeting with HR has now taken place. It was agreed that managers will highlight regular absences/patterns of absence and challenge individuals where appropriate.
Revisit engagement events and team briefings. Team briefings to be held to highlight concerns regarding short term absences across the service. Managers will reiterate expectations and promote employee responsibility supported by health champions. MoA will remain part of the agenda in team meetings and will form part of staff appraisal.	Yes	

Trading Services

Action	Complete	Detail
Review top ten cases	Yes	
Review all current long term sick cases	Yes	Regular meetings take place to review progress on all long term sickness cases to ensure management strategies are in place.
Check compliance with the MoA policy over a 2 month period to see that AMRs and RTWs have been completed within time frame.	No	An officer was identified to undertake a 3 month placement w.e.f. 19.1.15. They will undertake all of these actions. This work will be completed by 18.4.15.
Review quality of the MoA process-detail on RTWs & AMRs	No	This will be reviewed as part of the 3 month project and will be completed by 18.4.15.
Review and update a recent MoA briefing report.	Yes	

Children and Families - Care

Action	Complete	Detail
Absence will be a team agenda item to highlight the impact upon service delivery	Yes	
3 interventions were identified ; • Management training to identify stress	Part complete	Head of Care has confirmed that there are health champions

and anxiety symptoms in their teams and how to respond accordingly • Measures to improve health and wellbeing awareness • Health self assessment and tools to assist employees to manage their health concerns in the work place		in each locality who train managers to help them recognise signs of stress and anxiety and how to respond. The Head of Care has confirmed that there are currently no other measures in place to improve health and wellbeing awareness. The Head of Care has said that the Service is currently reviewing what other measures can be introduced. HR have not received any details or timescales around this. The Head of Care has said that the Service has not introduced health self assessment arrangements or tools to assist employees to manage their health concerns. Head of Care has said that the Service is reviewing what arrangements could be introduced. HR have not received any details or timescales.
Learn from other areas that have sought to address management perceptions of their role. People Manager first - Social Work Professional second. Assess whether elements can be incorporated within Social Work management induction. MAES management induction and training programme already shared with Head of Care	Ongoing	Head of Care has said that the Service is developing a list of standards around what makes a good manager. This will be reported to Performance Improvement Board with a view to incorporating these standards into the Social Work management induction process. HR are awaiting details of timescales on this.
Ongoing key case reviews between HR and Senior Management. ABP meeting monthly with Strategic Lead Children's - North Locality.	Yes	These meetings were already in place and are ongoing.
Long term absence cases - review current strategies. HR officers will provide an update on case progress/barriers to inform the meeting between the ABP and Strategic Lead, Children's - North Locality. This information will also inform the monthly PIB report.	Yes	This is still ongoing and has proven to be very effective.
Management to call in managers following monthly meetings for review and challenge meetings. Information will be supplied to Strategic Lead, Children's - North Locality for	Yes	

the monthly meetings with the ABP. This can be used to identify and track cases that are not progressing		

Networks

Action	Complete	Detail
Highlight concerns in this area of the service with the Network Managers. In particular the total days lost and how this translates to lost officer time	Yes	These issues have been raised with all of the Network Managers at one-to-ones. Also raised at manager team meetings and sickness clinics.
Conduct a limited audit of compliance with MoA policy expectations. Establish that AMRs and RTWs have been conducted within expected time frames and get assurance that management are collectively following procedure	Yes	Audit carried out. Service Manager has said that where non-compliance was identified this was addressed with managers. Service Manager has explained that the audit did uncover instances of AMRs and RTWs not taking place but this has been addressed and necessary assurances are now in place.
Senior management to regularly monitor absence cases to ensure correct application of the MOA policy. Appropriate HR support will be given when requested.	Yes	Service Manager has said that absence cases are scrutinised at the sickness clinics to ensure MoA policy is appropriately applied and that management strategies are in place. Satisfied with the level of HR support received.
Case review of current long term absence cases. Current cases to be considered to ensure a strategy is in place with a planned solution. HR will assist management to establish options.	Yes	All long term cases are scrutinised at the sickness clinics on an ongoing basis – see above. Satisfied with level of HR support received.

Neighbourhood Delivery Teams

Action	Complete	Detail
Communication with management team to highlight concerns in this area of the service. In particular the total days lost and how this translates to lost officer time	Yes	Completed
Assess managers' use and access to Manager Desk Top.	Yes	All managers have access and use manager desktop except one who is currently waiting for a password
Discuss identified barriers within Senior Management Team. Consider other interventions that could be introduced to address these issues.	Yes	Some managers struggle to have difficult conversations with staff. This is being addressed through learning sessions. Another issue identified was that a number of managers

		were not completing the online sickness form until staff returned to work. This was as a result of a misunderstanding – this has now been rectified.
Conduct a limited audit of compliance with MoA policy expectations. Check that AMRs and RTWs have been conducted within expected time frames and gain assurance that management are collectively following procedure. Look at a 2 or 3 month period for the identified service areas.	Yes	One of locality managers has carried out a full audit of compliance with the MoA policy. A number of examples have been identified around failure to apply the policy correctly – this is being addressed through training
Review triggers reports and check if opportunities have been missed to progress cases.	Yes	Completed. This exercise has shown a number of examples where opportunities have been missed. This is being addressed through ongoing training.
Case review of current long term absence cases.	Yes	Completed.

Revenue and Benefits

Action	Complete	Detail
Specific case example - seek legal advice and conduct an options appraisal.	Yes	Legal advice obtained and options assessed. Employee has now returned to work.
Service Head to review absence in his area and establish areas for improvement.	Yes	Service Head arranged 2 workshops with his managers to discuss correct application of MoA policy and how to take a proactive (not reactive) approach to case management.
Conduct a compliance check. Determine whether managers are effectively managing MoA cases appropriately.	Yes	Service Head confirmed that some issues were identified within Finance Shared Service around application of MoA. This has now been cleared up. Cases are now being managed effectively across all areas.
To review actions taken following absence in Financial Services when employees hit triggers and challenge manager's decision making to improve performance	Yes	Service Head has said that managers now take a much more strategic approach to absence management