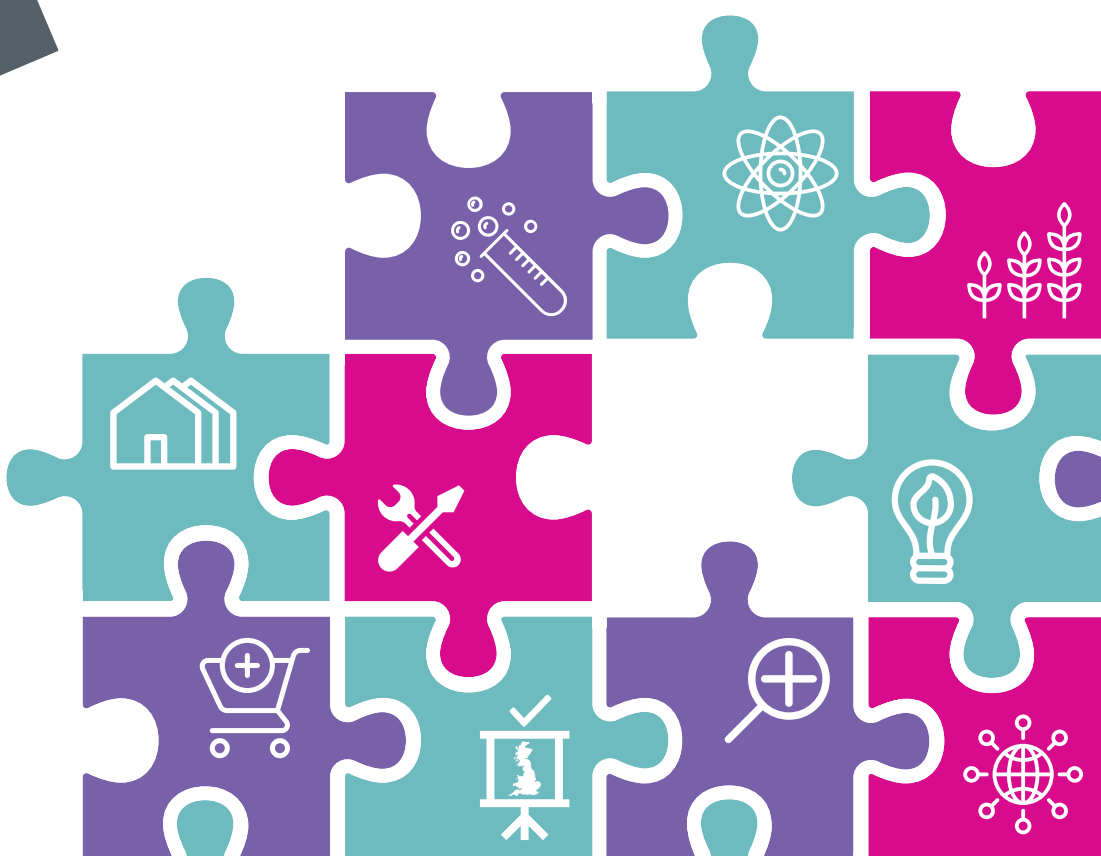
eef The manufacturers' organisation

EMPLOYEE HEALTH – MAKING INDUSTRIAL STRATEGY WORK FOR BRITAIN

EEF HEALTH, WORK, WELL-BEING AND SICKNESS ABSENCE SURVEY 2017



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1 INTRODUCTION

The health of employees in the workplace is a major factor in an organisation's competitiveness and in the productivity performance of UK plc.

The government has said it is committed to a modern industrial strategy. Its objective is to improve living standards and economic growth by increasing productivity and driving growth across the whole country.

EEF believes that the UK government should place more emphasis in its UK's industrial strategy on ensuring that our workforce can stay healthy, help improve productivity and contribute to the economy. We also need to invest in workplace health for an ageing working population.

When the government eventually develops its Industrial Strategy White Paper, we believe it is important for workplace employee health to be one of its key components.

Keeping people fit and healthy keeps people in work. This is fundamental for employers and the wider economy in terms of overall productivity and economic growth.

This means boosting productivity by getting people back into work as early as possible and reducing unnecessary sickness absence, which means making the Fit for Work service operate as originally envisaged. It means the government investing in public health programmes (centrally or devolved through employers) to improve the health and well-being of the working-age population. It means designing workplaces so that the working population is exposed to safe and healthy work at any age.

The government's Health and Work Unit is busy sifting through the responses it received following its Work, Health and Disability Green Paper consultation in October 2016 for improving support at work for people with health conditions and disabilities. Again, we hope that one of the recommendations from this process will seek to make the health of those at work a 'key' component of the government's industrial strategy.

This is our fourteenth national survey which looks at EEF member experiences of health, well-being and sickness absence. The survey questionnaire was sent to manufacturers across the UK. We received 264 responses, covering 57,059 employees. As in previous surveys, there was a high response rate from SMEs with up to 250 employees. SMEs have accounted for four-fifths (80%) of the respondents in our previous surveys. The responders are representative of the whole EEF membership by region and by manufacturing sub-sector.

Last year we provided some preliminary feedback on what impact the Fit for Work service has had on our member companies. This year we comment further on whether the Fit for Work service is delivering on its key objective of getting employees back to work earlier.

This year's survey introduced new questions. We asked companies about the barriers they face in recruiting/retaining people with disabilities or long-term health conditions and what would help them to recruit/retain people with disabilities or long-term health conditions. We also asked whether companies provided line manager training in the management of sickness absence, mental health and disabilities. As well as finding out what would incentivise companies to pay for employee health and well-being programmes, we asked what steps our members are taking to enhance the health and well-being of their employees over the age of 50.

2 KEY FINDINGS

The key findings arising from our survey are:

Fit for Work service – Year 2

- Almost four-fifths (77%) of survey respondents are aware of the government's Fit for Work service, almost exactly the same proportion as in 2015.
- Almost a quarter (24%) of those aware would not use the service, an increase from 18% in 2015.
- Almost half (46%) are aware of the service and would consider using it, a decrease from 54% in 2015.
- Just one in twenty companies has referred employees to the Fit for Work service.
- Three companies said that the service has helped their employees make an early return to work.
- More than a third (36%) of employers rely entirely on the NHS to provide medical treatment for their employees (33% in 2014 and 41% in 2015).

Work and Health – Green Paper

- Just over one-third (36%) of firms told us there are no barriers in recruiting/retaining individuals with disabilities or long-term health conditions.
- Just over one-third (37%) of employers said that better access to practical information would be the best way to support employers to recruit or retain individuals with disabilities or long-term health conditions.
- Four-fifths (80%) of companies said that they have access to some sort of occupational health provision.

Older workers

- Just under half (46%) of companies said that they offer flexible working for workers over the age of 50.
- Almost a third (32%) of firms said that they implement workplace adaptations or modifications to enhance the health and well-being of their employees over the age of 50.

Fiscal incentives

- Just under one-third (28%) of firms thought that government financial incentives would help them recruit or retain people with disabilities or long-term health conditions.
- Just over four-fifths (84%) of survey respondents were unaware of the £500 tax exemption available for medical treatments recommended by the Fit for Work service or company occupational health service.
- Just under half (47%) of employers said that the financial incentive most likely to incentivise them to pay for employee health and well-being programmes was employer/government 'matched' funding.

Absence trends

- The sickness absence rate for companies operating night shifts (2.5) is higher than companies that do not operate night shifts (2.1).

Fit for Work service

The Fit for Work service has been in operation since July 2015. Four-fifths (77%) of survey respondents are aware of the assessment service, but hardly any employers have used it – just fourteen of our survey respondents. Of those who are aware of the service, just under half (46%) say that they would consider using the assessment service but have not used it yet. A quarter (24%) said they would not use it at all. Almost all referrals are from employers, not from GPs. Only three companies agreed that it helped their employees make an early return to work.

Work and Health – Green Paper

The government Green Paper, Work, Health and Disability: Improving Lives, asked important questions about increasing levels of employment for individuals with disabilities and long-term health conditions. Although just over a third (36%) of employers said that there are no barriers to employment, just over a third (37%) said that they would have concerns about employee attendance. There was also unease by just under a third (31%) of employers that employees would not disclose their disability or long-term health condition. Just over a quarter (27%) of firms were apprehensive about the costs of workplace adjustments, and just over a fifth (21%) had concerns around the cost of sick pay.

Older workers

We know that older workers are an essential demographic in the manufacturing sector. We found that many employers are taking some essential steps to enhance the health and well-being of workers over the age of 50 so that they can continue to retain their services and at the same time address issues around long-term health and sickness absence. These steps include flexible working offered by just under half (46%) of employers, workplace modifications provided by just under a third (32%) of firms, health promotion arranged by just over a quarter (28%) of survey respondents, and phased retirement schemes offered by just over a quarter (27%) of companies.

Fiscal incentives

One effective tool which can be used to change company behaviours is to 'nudge' them through the use of financial incentives. The use of financial incentives to encourage companies to pay for employee health and well-being programmes is very topical. Just under a third (28%) of our survey respondents said that financial incentives would help them recruit or retain people with disabilities and health conditions. We know from a previous EEF survey[1] that almost four-fifths (79%) of firms would be incentivised to pay for workplace adjustments, rehabilitation or medical treatments if certain fiscal incentives were introduced.

Which financial incentive would most encourage companies to invest in worker health and well-being? Companies told us that they would be most persuaded by employer/government matched funding (47%), health tax credits (39%), lower National Insurance rates (31%), lower income protection and private medical insurance tax rates (27%), employer allowable business expenses (25%), lower VAT rates on health and well-being expenditure (23%) and a levy on employers to fund health and well-being (9%).

Absence trends

The 2016 sickness absence rate is 2.3%, unchanged from the previous year. This represents an average of 5.2 days lost to sickness absence per employee – down slightly on 2015. The data shows that there has been little change in sickness absence for the past eight years.

[1]EEF Sickness Absence Survey, June 2015.

3 KEY MESSAGES TO POLICYMAKERS

Fit for Work service

We feel a bit like a broken record. Much of what we say about the Fit for Work service is identical to the messages we gave in our 2016 report.[2] We still believe that government's Fit for Work service is a very important initiative to tackle two of the most common causes of long-term sickness absence: musculoskeletal disorders (MSDs) and mental ill health. We also believe that the service has the potential to be expanded to help more people with disabilities and long-term health conditions into the workplace.

When we look at the data from this year's survey, we can only call it disappointing. There are still very limited interactions between the Fit for Work service and EEF members. Employers are not referring employees and GPs are not referring their patients. Of the few return-to-work (RTW) plans issued, only a handful specified medical treatments. Companies seem to be unaware of the £500 tax exemption and employers do not appear to be using it. Of the fourteen companies who made employee referrals to the Fit for Work service, only three said that employees made an earlier return to work as a result of using the service.

It is not as if companies don't know about the service. Almost four-fifths (77%) are aware. We know that for SMEs (companies with fewer than 251 employees), on average 3.9% of the workforce are off for a period of four weeks or more, yet one-fifth (18%) of SMEs who are aware of the service say that they do not intend to use it. We also know that almost half (48%) of SMEs who are aware of the service would consider using it. The big question is, why aren't they using it?

Our discussions with EEF member companies expose concerns and issues that need to be addressed before there is a wider uptake of the service, especially by SMEs. These are:

- A lack of engagement by the government with both employers and GPs about the service;
- No financial incentives to encourage SMEs and larger companies to pay for interventions (including medical treatments) recommended by the Fit for Work service or company occupational health provider when they can simply rely on the NHS;
- Coming clean that the £500 tax exemption is really an employee benefit rather than an employer benefit. The employer still has to pay for the cost of any intervention, and this does not attract a tax benefit;
- The failure by GPs to refer patients to the service;
- Requiring employers to wait four weeks before they can refer;
- Lack of involvement with the employer about the content of RTW plans;
- Few instances of medical treatments being specified in RTW plans.

Work and Health – Green Paper

The government Green Paper,[3] Work, Health and Disability: Improving Lives, is significant in flagging up issues about the employment of individuals with disabilities and long-term health conditions. We would like the government to concentrate on what they can do to help manufacturing companies recruit or retain these individuals and at the same time unpick some of the myths about employing individuals with disabilities and long-term health conditions. EEF can be a key part of that process. As with long-term sickness absence, there needs to be a serious consideration about whether an expanded Fit for Work service has a place, whether financial incentives should be offered or whether it is simply a lack of access to practical information about employment and retention that is holding employers back.

Older workers

It is important to flag up the future role of older workers in the economy. Many companies are waking up to the fact that they will need to continue to rely on workers over the age of 50 to provide the skills they need, especially as the relative proportion of older people in society increases. In the context of work and health, it is important that workplaces and work tasks are designed for older people. This not only allows older workers to continue working, but should (if properly designed) also reduce the likelihood of older workers being absent from work as a result of mental ill health or musculoskeletal problems. Ergonomically designed tasks and workplaces also mean that younger workers will be less likely to suffer from long-term sickness absence, so promoting sustainable working lives.

[2]Health – the Key to Productivity: Sickness Absence Survey, 2016.
[3]Work, Health and Disability Green Paper: Improving Lives, DWP, October 2016.

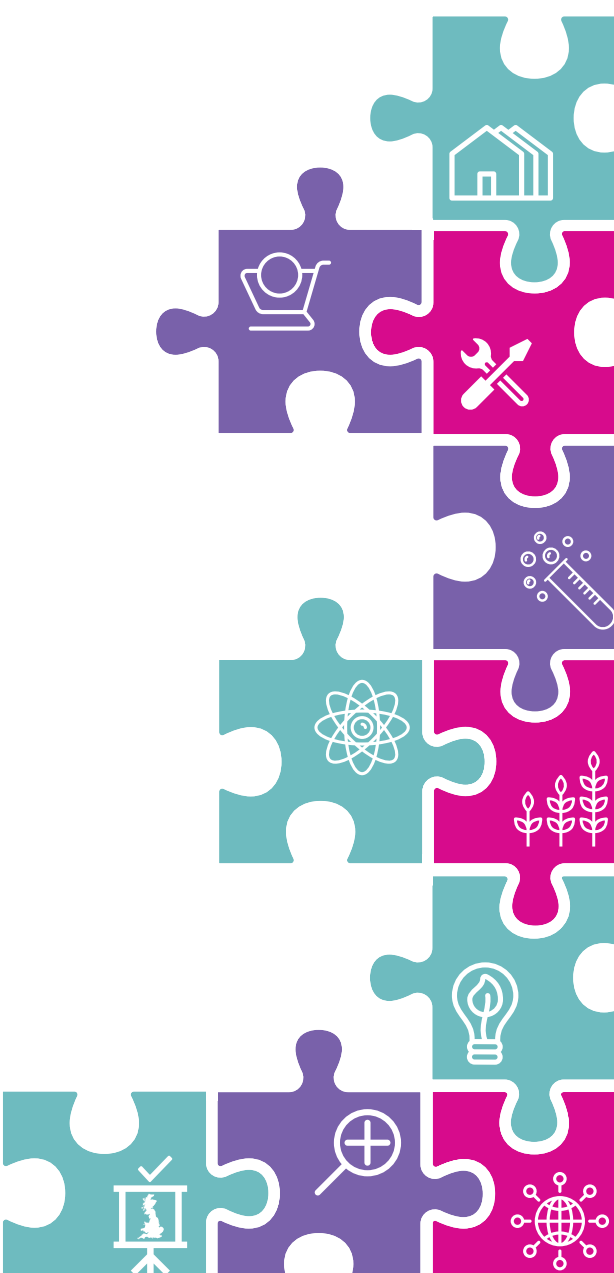
The government's strategy towards older workers should form part of the overall work and health agenda, and the government should consider how incentivising employers to introduce health and well-being programmes will be of particular benefit to older workers who might otherwise leave the world of work. It might also help delay the day when older workers become more dependent on NHS services and the benefits system.

Financial incentives

In terms of nudging employers to bring about changes in their workplaces in respect of employee health and well-being and of employment of those with disabilities and long-term health conditions, we know that financial incentives are just one of a number of tools that the government could consider. If the government wants employers to act in the interests of society at large, especially where public health and disability issues are concerned, then financial incentives start to become more pertinent.

We know that employers are well placed to become active investors in workforce health and disability employment. The government Green Paper talks about supporting employers to establish good practices and supportive workplace cultures and mentions the possible role of incentives in driving the right behaviour and innovation. The authors of the Green Paper say that they want to know whether financial or other incentives would encourage employers to try new and creative ways of supporting more people with disabilities and health conditions in work.

Our report suggests that there are many types of financial incentive that could be considered. Matched funding between government and employer seems to be something that many of our survey respondents would support. It is important for the government to assess the viability and practicality of the various financial incentives to see which offers the greatest benefit to the UK economy at a macro-economic level. We would be pleased to support the government and indeed NHS England in carrying out such an analysis.



4 THE FIT FOR WORK SERVICE: YEAR 2

The Fit for Work service: Year 2

As we said in last year's report, EEF believes that the Fit for Work service is an important initiative for tackling two of the most common causes of long-term sickness absence: MSDs and mental ill health conditions. EEF actively supports this initiative and wants it to prosper.

The Fit for Work service was fully rolled out across the UK at the end of July 2015. Last year's Sickness Absence Survey gave us an early opportunity to gauge the extent of awareness by companies of the Fit for Work service and to find out the extent to which employees were being referred during the first five months of its operation.

By the time of our 2016 survey (conducted in January 2017), the Fit for Work service had been in operation for seventeen months. We now feel able to give a more considered view on its impact in getting employees back to work earlier. This for EEF is the key success factor.

Sickness absence

For the 264 companies who took part in the 2016 survey, a total of 249,555 days were lost owing to sickness absence. See Table 1.

We know that periods of continuous absence of more than four weeks (twenty days) are defined as long-term sickness absence. The average percentage of employees across all companies that were absent for four weeks or more is 4.4%, compared with 5% in 2015. During 2016, a minimum total of 46,580 days were taken as long-term sickness absence. This is approximately one-fifth of all the reported sickness absence. Some employees are likely to have taken more than twenty days of sickness absence, so in reality this proportion will be much higher.

If we examine long-term absences by company size, we can see in Chart 1 that on average 3.9% of employees in SMEs (companies with fewer than 251 employees) are off for a period of four weeks or more. This is the cohort with least access to occupational health services (see Chart 7) and the cohort that stands to benefit most from using the Fit for Work service. It is also the cohort least likely to pay for employee medical treatments (see Chart 23) and most reliant on the NHS.

Table 1

One-fifth of all absence is long-term sickness absence

Days lost to sickness absence from our survey sample

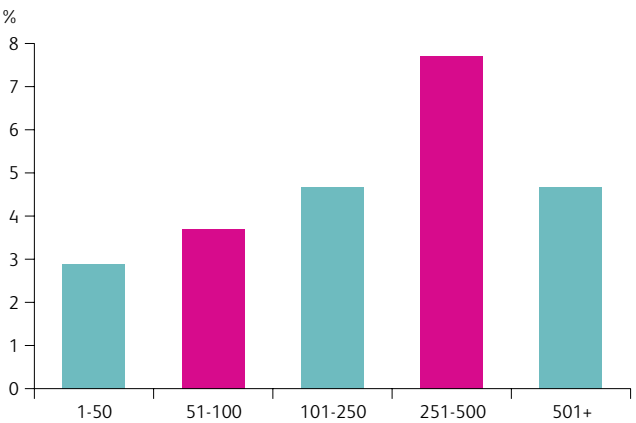
	2016
Number of companies	264
Total days lost to sickness absence	249,555
Number of employees who had periods of continuous absence of more than four weeks (twenty days)	2,329
Minimum number of days lost for those employees who were absent from work for at least twenty days.	46,580

Source: EEF Sickness Absence Survey 2017

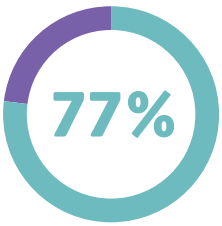
Chart 1

More long-term absences in larger companies

% of workforce off for a period of four weeks or more by company size



Source: EEF Sickness Absence Survey 2017



of manufacturers were aware of the Fit for Work service

of manufacturers who were aware of the Fit for Work service had used it.

Awareness

The good news is that there is still a high level of awareness about the Fit for Work service among EEF members, largely because we continued to be active in disseminating information about the service during 2016. Chart 2 demonstrates that the level of awareness is unchanged, at almost four-fifths (77%) of our survey respondents. However, the key factor here is utilisation. The utilisation rate is low. Just 7% said they were aware of the service and had used it. Chart 2 illustrates this to be around the same proportion as in 2015.

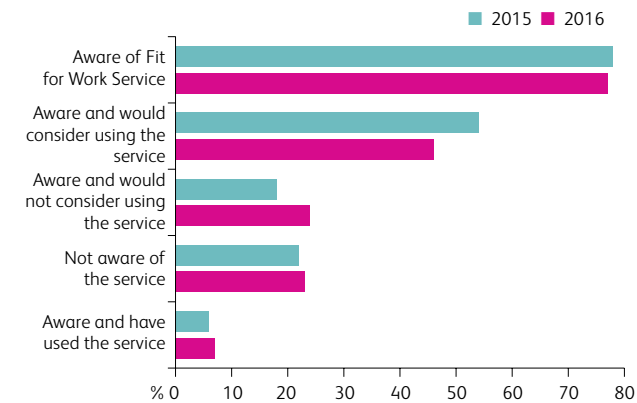
There are a considerable number of survey respondents who say that they would consider using the assessment service but have not used it yet. This has declined from just over half (54% in 2015) to just under a half (46%) in 2016, a trend we had not anticipated. Of those, almost two-fifths (38%) of companies employ fewer than 50 employees, a similar finding as in our 2016 report. We are unclear why these companies are not using the service. Perhaps employee periods of long-term absence do not meet the referral criteria for the Fit for Work service, or perhaps these companies are proactively managing sickness absence themselves through their own HR or occupational health departments. It is also highly likely that these companies do not know in sufficient detail how the Fit for Work service actually works.

There are is still a hard-core one-quarter (23%) of survey respondents who are unaware of the service – little change from 2015. When we look at the breakdown by company size in Chart 3 we can see that just over two-fifths (43%) of micro companies (1–50 employees) are unaware of the service. This is a slightly higher proportion than last year's survey.

Chart 2

Awareness and usage of Fit for Work service largely unchanged

% awareness and usage of Fit for Work service

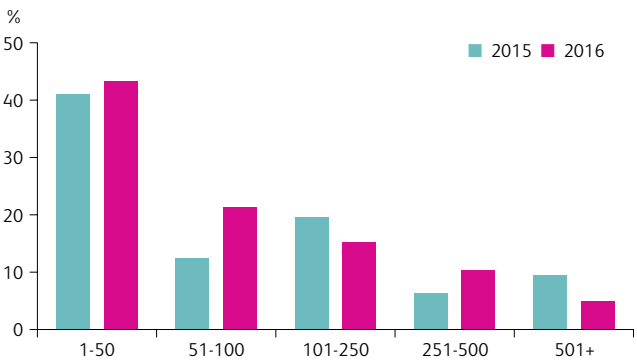


Source: EEF Sickness Absence Survey 2016 & 2017

Chart 3

Micro companies unaware of Fit for Work service

% of companies unaware of Fit for Work service by company size



Source: EEF Sickness Absence Survey 2016 & 2017

As in last year's survey, almost nine-tenths (87%) of the companies who are aware of the service are also mindful that they as employers can refer an employee who has been absent from work after four weeks of continuous absence. The level of awareness is generally high, but is at its greatest among larger employers, as can be seen in Chart 4.

The number of companies aware that a GP can refer if they believe the individual is likely to be absent from work for more than four weeks has declined slightly, from almost three-quarters (74%) of survey respondents to just over seven-tenths (72%). Again, the level of awareness about GP referrals is greater among larger employers. See Chart 5.

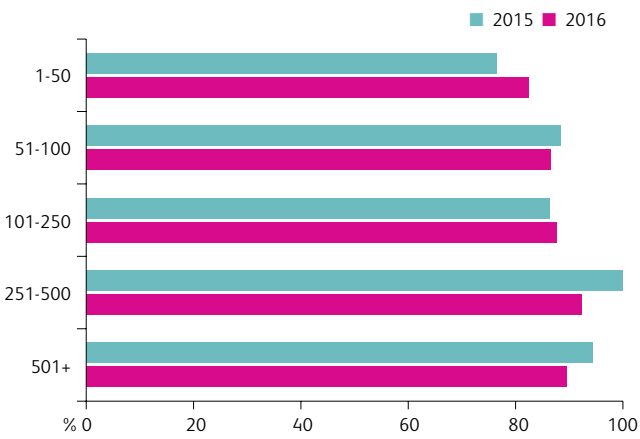
Will companies use the service?

Almost one-quarter (24%, an increase from 18% in 2015) of our survey respondents say that they are aware of but do not intend to use the Fit for Work service. Chart 6 shows that larger companies are less likely to use the service. This includes just under half (49%) of all companies employing more than 100 employees.

Chart 4

Knowledge of employer referral route high for all companies

% awareness of Fit for Work employer referral route, by company size

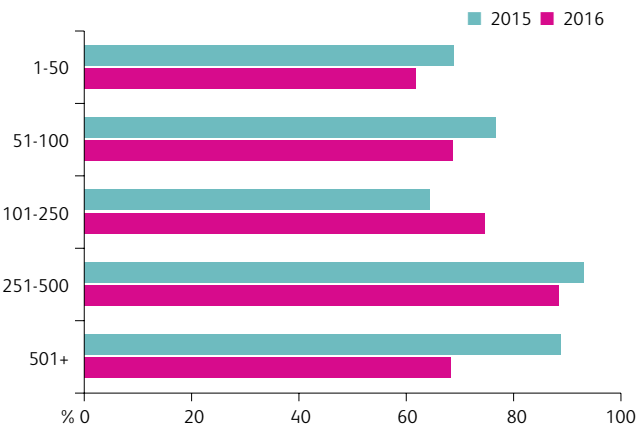


Source: EEF Sickness Absence Survey 2016 & 2017

Chart 5

Knowledge of GP route higher among larger companies

% awareness of Fit for Work GP referral route, by company size

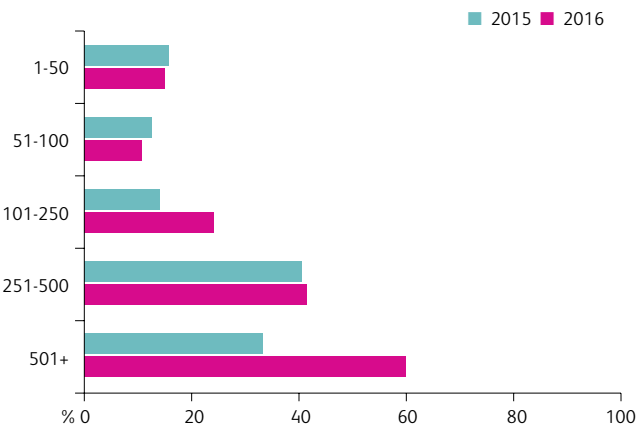


Source: EEF Sickness Absence Survey 2016 & 2017

Chart 6

Larger companies less likely to use Fit for Work service

% aware of Fit for Work service, but who do not intend to use it, by company size

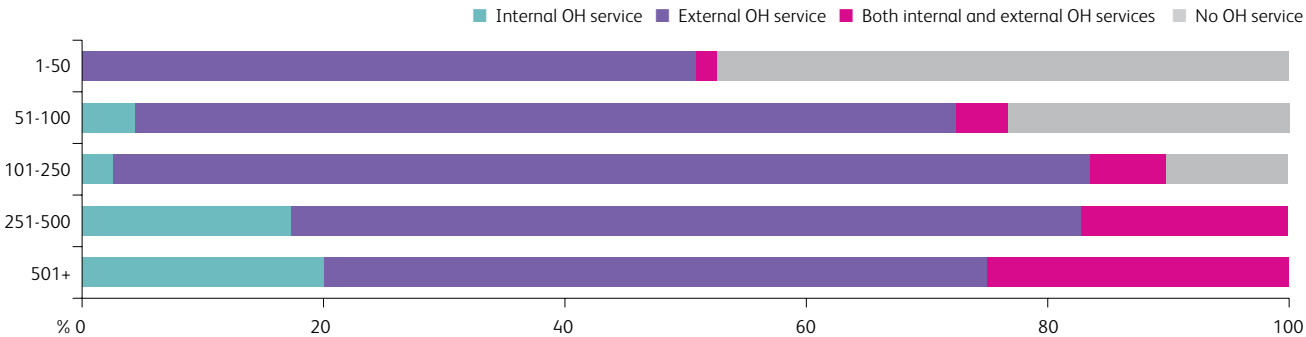


Source: EEF Sickness Absence Survey 2016 & 2017

Chart 7

Micro companies less likely to have access to occupational health (OH) services

% of companies with access to occupational health services, by company size



Source: EEF Sickness Absence Survey 2017

This is likely to reflect the fact that just over half (51%) of these companies (see Chart 7) already have satisfactory access to some form of occupational health service offer which meets their needs and which they wish to continue to use.

It is worth pointing out that although companies may not choose to refer individuals to the Fit for Work service voluntarily, they will have to become engaged with the service should they receive return-to-work plans instead of fit notes as a result of a GP referral.

User experience so far

During 2016, only fourteen companies (out of 264) said that they had referred employees to the Fit for Work assessment service. See Chart 8. A total of seventeen employees were referred. In all but one case the employer confirmed that the employee had given consent for referral.

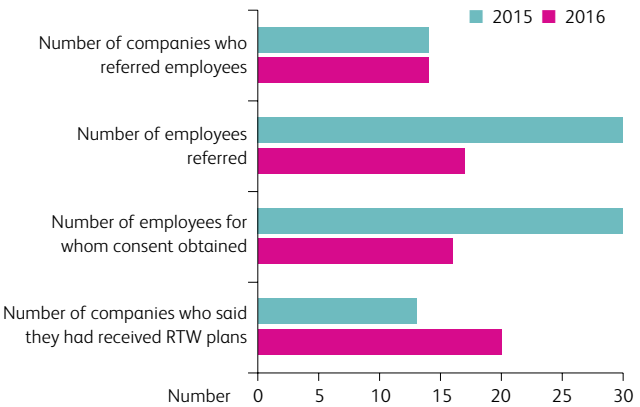
Twenty companies said that they had received RTW plans for employees. This suggests either that additional employee referrals were made by GPs or that some of the RTW plans related to 2015 employee referrals.

Of the RTW plans received, three specified a medical treatment and a further fifteen recommended employee workplace adjustments. Of the three employers who received a RTW plan specifying a medical treatment, one paid up to 20% of the medical treatment cost.

Chart 8

Very low referral rate to the Fit for Work service

Numbers of companies who had used the Fit for Work service



Source: EEF Sickness Absence Survey 2016 & 2017

of manufacturers had referred employees to the Fit for Work service

The remaining two employers did not pay or were not willing to pay for the medical treatment.

Of the fifteen employers who received a RTW plan specifying a workplace adjustment, twelve (80%) were fully able to accommodate the recommended adjustments. In only one case was the employer unable or unwilling to accommodate. In the remaining cases the employer was able accommodate some of the suggested workplace adjustments.

Survey respondents were asked whether the service has helped their employees make an earlier return to work – an important criteria. Of the thirteen companies who both referred employees to the service and answered this question, there was a mixed response. Only three said that it helped their employees make an early return to work.

Fit for Work tax exemption

Chart 9 illustrates how just over four-fifths (84%) of survey respondents in 2016 reported that they were unaware of the £500 tax exemption (per year, per employee) which is available for medical treatments recommended by either the Fit for Work service or by a company occupational health service.

It is perhaps not surprising that the level of awareness about the tax exemption is so low, especially as the overall number of employee referrals to the Fit for Work service is also low, coupled with the very small numbers of RTW plans specifying medical treatments.

As well as a lack of awareness, perhaps it is also the case that employers recognise that the cost of the treatment still has to be borne by the employer and that it is only the employee themselves who will benefit from the tax exemption.

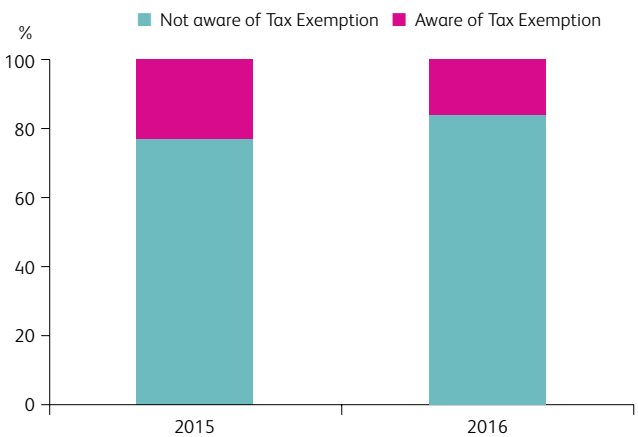
Evaluation of Year 2

Awareness of the Fit for Work service is high, but uptake and use of the service by our survey respondents is disappointingly low. The number of GP referrals are embarrassingly low, which suggests that GPs are leaving it to employers to make referrals. The problem there is that the employer has to wait four weeks before they can refer, whereas the GP can refer much earlier if they believe the individual is likely to be off for more than four weeks. This is important in getting people back to work earlier.

Chart 9

Little awareness of Fit for Work tax exemption

% of companies aware of £500 tax exemption



Source: EEF Sickness Absence Survey 2016 & 2017

It would appear that larger companies who already have access to occupational health services do not see any real benefit in using the Fit for Work service. Admittedly, they were not originally the target audience for the service. These companies believe they already have the mechanisms for managing individuals who are on long-term absence to get them back to work. Engaging the Fit for Work service could even be problematic for employers should judgements about an individual's capability for work differ between the service and the company's own OH provider.

Although SMEs stand to gain the most from the Fit for Work service, they are the least aware and engaged and the most likely to rely on NHS services to get their employees back to work.

It would appear that the service is not really being utilised by the manufacturing industry or by GPs. The £500 tax exemption is not being used. We found only fourteen employers who have referred employees to the service. Just three employers said that the service helped their employees make an early return to work. Not exactly a ringing endorsement.

There is also a large group of employers (roughly half) who are aware of the service and who would consider using it

but have not used it yet. Of those, almost one-fifth (18%) of companies employ fewer than 50 employees. Why have these employers not used the service, especially those who have had employees absent from work for more than four weeks?

The Fit for Work service – what next?

There is a clearly a high level of awareness about the Fit for Work service among manufacturers and HR departments. That is not the issue. The principal issue is around the low number of referrals to the service, and both Health Management Ltd (HML) and the DWP's low-key marketing and engagement about the service.

What needs to happen?

- HML/DWP need a high-profile and targeted media campaign to highlight the benefits for employers of using the Fit for Work service, especially towards SMEs. The Fit for Work marketing campaign needs to be ratcheted up several notches if this group are to be convinced of the benefits of using the service.
- HML and DWP need to expedite greater referral of employees to the service by GPs, rather than leaving it up to employers. Further engagement with the RCGP and the BMA is likely to be necessary.
- Employers (especially SMEs) need to refer their employees (with the employees' consent) to the Fit for Work service rather than rely on long NHS waiting lists.
- The referral criteria for employers should change to be identical to those of GPs, which would mean that if someone is likely to be off work for more than four weeks they can be referred at a very early stage.
- HML needs to demonstrate that it is providing a service which demonstrates that employees are making earlier returns to work. It should publicise its performance indicators to show that this is in fact the case. This will persuade more employers to engage with the Fit for Work service.
- The Fit for Work service should publicise what proportion of its fit notes make recommendations for medical treatments and the extent to which companies are taking advantage of the £500 tax exemption for their employees.
- Employers must be consulted about the RTW plan before it is agreed and finalised by the Fit for Work service and the employee.
- The current restriction limiting availability of the Fit for Work service to employees likely to return within three months should be removed.
- The current restriction which limits referral of an individual to the service to only once a year should be removed.
- The government should consider making use of the Fit for Work service mandatory rather than voluntary.
- Fiscal incentives should be provided for employers who pay for medical treatments recommended by the Fit for Work service or company occupational health provider.

To be successful, the service has to be well promoted, it needs GP buy-in and it needs to convince SMEs (its target market) about the benefits of referring employees and of being engaged with the implementation of return-to-work plans. Otherwise there is a danger that the government could pull the plug on funding what is potentially a hugely beneficial service to improving employee health and boosting UK productivity.

5 WORK, HEALTH AND DISABILITY: IMPROVING LIVES

In October 2016 the Government launched the Work, Health and Disability: Improving Lives Green Paper. The Green Paper posed a number of questions and started a national debate on what it would take to transform the employment prospects of both disabled people and people with long-term health conditions. EEF is a member of the DWP Green Paper Expert Advisory Group and provided input into the Green Paper and the consultation process. EEF will also be involved as part of this group as the government starts to develop its White Paper and recommendations arising out of the many consultation responses.

EEF consulted the Department for Work and Pensions (DWP) before launching our 2017 survey and agreed which questions would help inform the debate. The key questions were around:

- Barriers faced by employers in recruiting/retaining disabled people;
- Support for employers in recruiting/retaining disabled people;
- Experience of the Fit for Work service and how this should inform future provision;
- Views on impact/influence of the Fit for Work tax exemption on employer behaviour;
- Employer views on extending fit note certification to other healthcare professionals.

Key barriers preventing employers recruiting and retaining disabled people and people with health conditions?

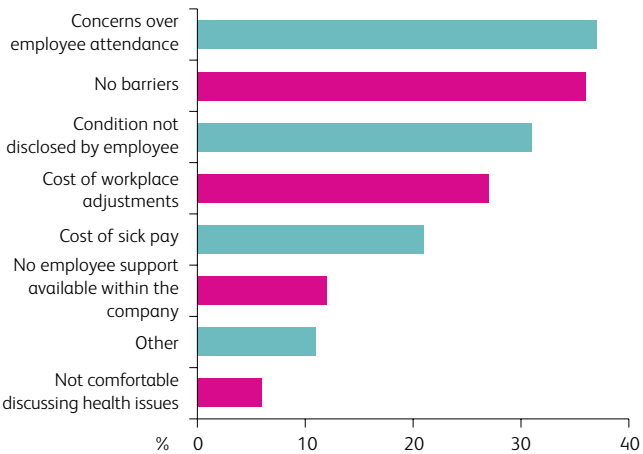
In relation to barriers faced by employers, Chart 10 shows that just over one-third (36%) of the firms we contacted in the manufacturing sector in January 2017 said that they had no barriers to the recruitment and retention of individuals with disabilities or long-term health conditions.

of manufacturers said there were no barriers in recruiting or retaining individuals with disabilities or long-term health conditions

Chart 10

One-third of respondents said that there were no barriers in recruiting/retaining individuals with disabilities or long-term health conditions

% of companies citing barriers faced in recruiting/retaining people with disabilities or long-term health conditions



Source: EEF Sickness Absence Survey 2017

For the remaining companies, the top four barriers expressed were:

- Concerns over employee attendance at work;
- Non-disclosure by employees of their disability or health condition;
- The cost of workplace adjustments;
- The cost of sick pay.

A significant concern for employers is in managing employees with long-term fluctuating health conditions, especially where this might have an impact on attendance at work and the potential disruption of not being able to carry out duties on a regular basis. If attendance is unpredictable, employers are concerned about the effect this can have on work scheduling, production, customer service and decision making, especially where the individuals hold key organisational positions.

Employers are restricted under Equalities Act legislation in terms of the circumstances in which they can ask job

applicants questions about disability or health. However, it is important that applicants do declare any disability or long-term health condition after a job offer has been made so that the employer can assess whether an impairment might affect their ability to do the job. It is important to assess at an early stage whether any necessary workplace adaptations can be made. In certain circumstances it might become clear that the applicant's impairment would have a substantial adverse impact on their ability to do the job and that no reasonable adjustment could be made to overcome that.

Employees do not always declare chronic or other ill-health conditions which may have an impact on their work. In these circumstances it is difficult for employers to take appropriate measures which would be of benefit to those individuals. As a consequence, EEF encourages employers to manage occupational safety and health in the context of an ageing workforce and to promote sustainable work and healthy ageing from the start of an employee's working life, irrespective of whether an individual has a disability or not.

Clearly, workplace adjustments are necessary in many circumstances. Employers can incur significant costs and it can sometimes be very difficult to make adjustments to machinery, jobs and tasks to meet specific individual requirements. In previous EEF Sickness Absence Surveys we have found a willingness by survey respondents to make workplace adjustments. Chart 11 from our 2015 survey report shows that two-fifths of employers say they are able to accommodate 'all' adjustments specified on 'may be fit for work' fit notes.

Understandably, there is a preference among employers to make ergonomic adaptations in the workplace which are beneficial not just for the individual with a disability or long-term health condition, but which would also benefit all employees by making their jobs easier to perform.

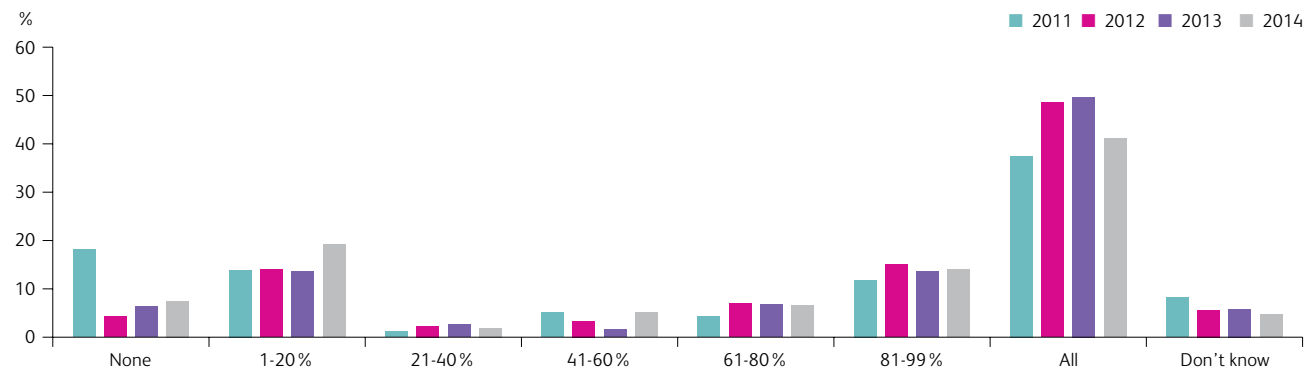
In our 2016 Sickness Absence Survey report we found that in tackling musculoskeletal disorders (MSDs), three-quarters of the companies made workplace adjustments or modified workplace tasks to manage MSD risk.

There is a subset of employees who are absent from work who may have temporary medical restrictions which prevent them carrying out their normal work. There is also a group with more permanent restrictions on the work they can do as a result of a chronic health condition. In our 2016 survey report we asked employers what proportion of employees with medical restrictions they find difficult to accommodate. Chart 12 illustrates that almost two-thirds (61–65%) of employers can accommodate either temporary or permanent restrictions.

Chart 11

Two-fifths of employers can make all workplace adjustments for employees

% of companies for which workplace adjustments could be made, by proportion of employees



Source: EEF Sickness Absence Surveys 2012–2015

Employers are clearly willing to make workplace adjustments for their staff, but even so, we found that almost a third (29%) of companies have had at least one incidence of finding it difficult to accommodate an employee with a permanent medical restriction.

There is a perception that individuals with disabilities or long-term health conditions will increase the cost of sick pay. It would be a useful exercise if the government were to compare sickness absence rates for individuals with disabilities or long-term health conditions against the general working population to see if there are in fact any significant differences. This would help dispel perceptions by some employers and would be a useful part of the business case to explain to companies how they might benefit from recruiting employees with disabilities and long-term health conditions.

If we look at responses by company size (see Chart 13) we can see that almost half (48%) of micro firms say that there are no barriers to the recruitment and retention of individuals with disabilities or long-term health conditions. Larger companies seem to perceive more barriers, which may be a reflection of the fact that smaller companies tend to look out for their employees in a more paternalistic way.

Some of the other barriers cited by survey respondents included limited alternative duties owing to the nature of work undertaken on the site, very limited availability of physically less-demanding manual roles, the issue of wheelchair access on the shop floor, the nature of the manual work making it very difficult/impossible to make workplace adjustments, etc. Heavy manual work is a recurring theme. One respondent said that the manual nature of shop-floor work may not be appropriate for some disabilities, but that there are no barriers for office work.

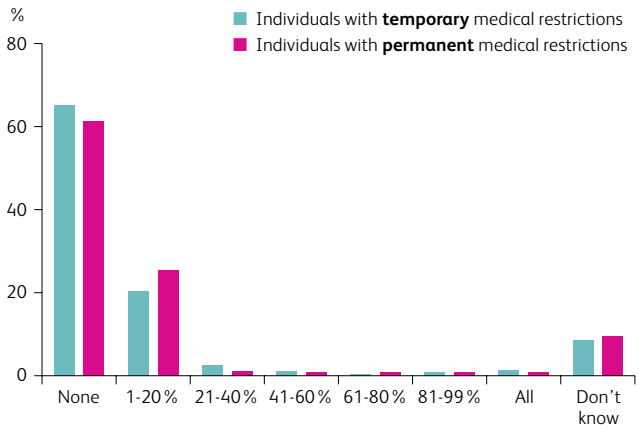
Measures which would best support employers to recruit and retain disabled people and people with health conditions

We asked our survey respondents what top five measures would best help employers recruit and retain disabled people and people with long-term health conditions. These are presented in Chart 14.

Chart 12

60% of firms can accommodate medical restrictions

% of companies accommodating medical restrictions

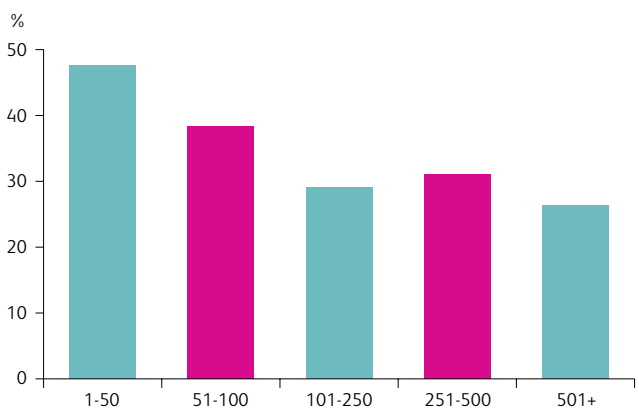


Source: EEF Sickness Absence Survey 2016

Chart 13

Almost half of all micro companies said that there were no barriers in recruiting/retaining individuals with disabilities or long-term health conditions

% of companies citing no barriers faced in recruiting/retaining people with disabilities or long-term health conditions by company size



Source: EEF Sickness Absence Survey 2017

The top five measures are:

- Access to practical information;
- Financial incentives;
- Statutory sick pay (SSP) reform to allow phased return to work;
- Access to occupational health services;
- Access to vocational rehabilitation services.

Access to practical information

Almost two-fifths (37%) of our respondents said that better access to practical information would make a difference in helping them recruit or retain individuals with disabilities or long-term health conditions. EEF supports the concept of a 'one-stop shop', which we think could have a pivotal role in overcoming barriers and providing practical information, so long as it is not a simple website signposting service. It should have either a physical or a telephone presence, but preferably both.

It needs to provide employers with practical help on recruiting and retaining individuals with disabilities or long-term health conditions and help employers to access support services in their local area.

As well as acting as an information hub, the one-stop shop should work closely with other groups and agencies, collaborating to understand and respond to the needs of both employers and those with disabilities seeking work.

It needs to be established on the understanding that each individual and employer faces unique challenges and requires varying levels of support. The one-stop-shop would need to provide information and advice that is meaningful.

Financial incentives

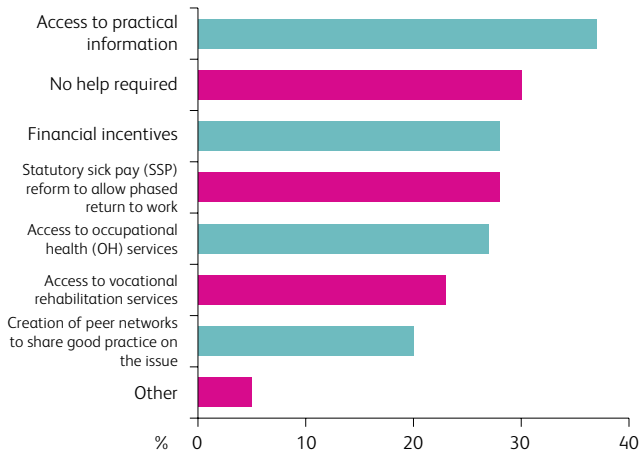
Just under a third (28%) of our respondents expressed the opinion that financial incentives would help them recruit or retain people with disabilities or long-term health conditions.

This one-third proportion is consistent with EEF's previous survey findings, when companies have been asked whether they would be willing to fund medical interventions for their employees to help reduce long-term sickness absence. The question of financial incentives is covered in more depth in Chapter 7 of this report.

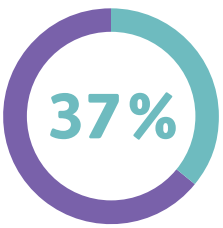
Chart 14

Almost two-fifths of respondents said that better access to practical information would help recruit/ retain individuals with disabilities or long-term health conditions

% of companies citing those measures which would help recruit/retain people with disabilities or long-term health conditions.



Source: EEF Sickness Absence Survey 2017



of manufacturers said that better access to practical information would make a difference in helping them recruit or retain individuals with disabilities or long-term health conditions

SSP reforms

Just over a quarter (28%) of our survey respondents said that they would support paying SSP if someone were to have a phased return to work, the caveat being that the total SSP paid out for the individual would be no greater as a consequence.

Our 2012 Sickness Absence Survey showed that only around a third of employers just pay SSP. Two-thirds said that they pay both SSP and some sort of occupational sick pay. We should not forget that many employers pay their employees occupational sick pay or normal salaried pay at rates significantly above SSP and continue to pay this during sickness absence, irrespective of whether someone has a phased return to work.

of manufacturers said that they had access to some sort of occupational health provision

OH access

Interestingly, just over a quarter (27%) of all our respondents (and almost a third of SMEs) said that better access to occupational health services would help remove barriers. In previous surveys we have demonstrated that the manufacturing sector generally has better provision in terms of occupational health than many other sectors. In our 2012 survey, we reported that three-quarters of respondents had some sort of occupational health provision, and companies recognised its importance in managing long-term sickness absence or those with long-term ill-health conditions. In our 2017 survey, four-fifths (80%) of companies said that they have some sort of occupational health provision. See Chart 15.The businesses who do not provide an OH service are all firms with fewer than 250 employees.

There is clearly a need for occupational health and related provision to be organised in such a way that it is accessible and tailored for all. The Fit for Work service is able to provide some elements of an occupational health service, although it is clear (see Chapter 4 that uptake of the service and GP referrals are very low, particularly among SMEs, which is the group most unlikely to have OH service provision.

The problem at the moment is one of capacity. There are insufficient occupational health practitioners to provide a service that is available to all employers. Expanding capacity should be one of the government's ambitions if they want all employers to have access to occupational health services.

There is no single solution, but one proposal is to have a national occupational health service as part of the NHS. This could be provided through primary care by mainstream healthcare provision being extended to include the integration of occupational health.

However, delivery of occupational health services could equally be undertaken by a combination of private-sector, public-sector and third-sector organisations, or even an expanded Fit for Work service. Occupational health providers would have to be able to meet minimum requirements of service level provision so that the needs of both employers and patients are met.

We would support general access and availability of occupational health services to employers, especially SMEs.

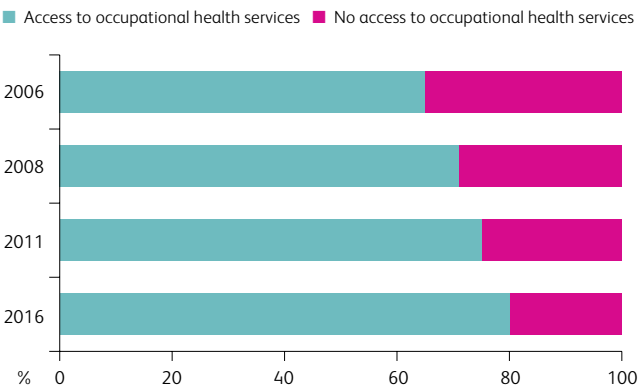
Creation of peer networks

One in five companies said they would support the introduction of peer networks to share good practice. These networks would help companies to understand various disabilities and health conditions and to manage their

Chart 15

Proportion of companies with access to occupational health services has increased from 65% in 2006 to 80% in 2016

% of survey respondents with access to occupational health services

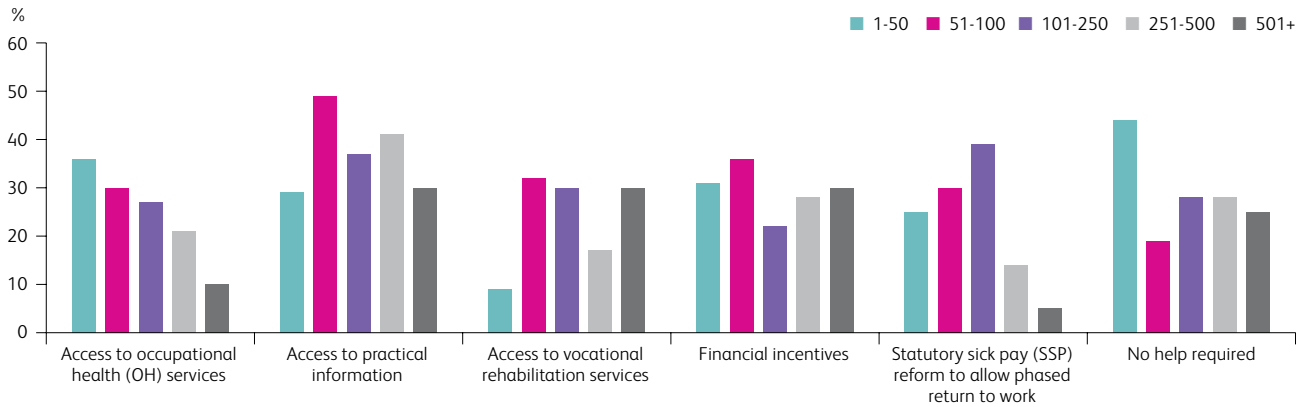


Source: EEF Sickness Absence Surveys 2007, 2009, 2012 & 2017

Chart 16

Almost half of micro companies do not require help to recruit and retain people with disabilities or long-term health conditions

% of companies citing those measures which would help recruit/retain people with disabilities or long-term health conditions, by company size



Source: EEF Sickness Absence Survey 2017

recruitment and retention programmes so they can explore ways to get people with disabilities and long-term health conditions into work and to remain there. In peer-to-peer networks, companies will be able to talk to others who face similar challenges, issues and problems. These networks will help companies to hear about the problems that have been solved and the mistakes that have been made as well as to gain access to best practice and innovative ideas. Rather than establish new networks, it might be more appropriate for the government to flag up existing peer networks through one-stop-shops.

Support measures by company size

If we look at the measures which would best support employers to recruit and retain disabled people and people with long-term health conditions by company size, just under half (44%) of the micro companies who employ fewer than 50 employees say that they do not need help in recruiting or retaining people with disabilities or long-term conditions. See Chart 16. We do not know whether this the same cohort of companies who told us that there are no barriers in recruiting or retaining people with disabilities or long-term health conditions or whether they do not want support because they do not recruit individuals with disabilities and long-term health conditions.

Experience of the Fit for Work service and how this should inform future provision

The DWP was interested in the manufacturing industry's experience of the Fit for Work service so far and how this might inform future provision for individuals with disabilities and long-term health conditions going forward. Chapter 4 gives a full analysis of the Fit for Work experience so far. From our viewpoint there is no reason why the remit of the Fit for Work service could not be extended to people with temporary or permanent disabilities or long-term health conditions.

Influence of the Fit for Work tax exemption on employer behaviour

The DWP wanted to ascertain what impact or influence the Fit for Work £500 tax exemption has had on employer behaviour. The simple answer is none. Very few RTW plans specified a medical intervention, and where they did, companies were not willing to pay for the cost of the treatment because there was no tax advantage or benefit in paying for the treatment if they could rely on the NHS.

Extending fit note certification to other healthcare professionals

There is a discussion in the Green Paper consultation as to whether fit note certification should be extended from doctors in primary care and other settings to other

healthcare professionals. EEF asked its members in our 2016 survey report the same question.

Chart 17 shows that in addition to accepting fit notes signed by doctors, almost two-thirds (64%) of employers would accept fit notes signed by occupational nurses, and almost half (48%) would accept fit notes signed by osteopaths, physiotherapists or chiropractors.

Before the fit note came into force, just over two-thirds of our 2009 survey respondents said that they would accept a fit note signed by one of a range of professionals, including the GP. This had increased to almost four-fifths (79%) in our 2015 survey data.

The fit note has not been considered to be a particular success in the eyes of our survey respondents over the past five or six years, largely because there is a view that when it comes to occupational health and the functional capacity of employees, GPs may not be best placed to say whether someone is fit for work or not.

Allowing other healthcare professionals to sign fit notes would change the nature of the traditional doctor–patient relationship, but should be implemented if it makes the fit note work and speeds up the flow of employees back into the workplace.

Line manager training

In the Green Paper is the suggestion that managers are not equipped to deal with conversations around disability, workplace health and well-being issues, in particular mental ill health. EEF decided to test this and determine how much training was given to line managers by our survey cohort.

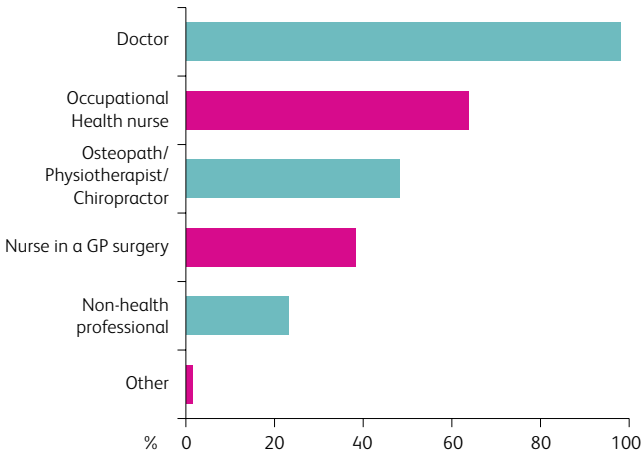
You will see in Chart 18 that two-fifths (40%) of the survey respondents said that their company does not provide training in the management of sickness absence, disability, mental ill health or MSDs. This proportion was higher, at almost two-thirds (62%), among micro companies.

On a more positive note, we can see that companies are investing in the management of both short-term (57%) and long-term (46%) sickness absence. In respect of long-term sickness absence management training, this has increased from almost two-fifths (38%) in 2008 to almost half (46%) in 2016. Management training for short-term

Chart 17

No need to limit fit notes to GPs

% of companies citing which medical professionals should be able to sign fit notes

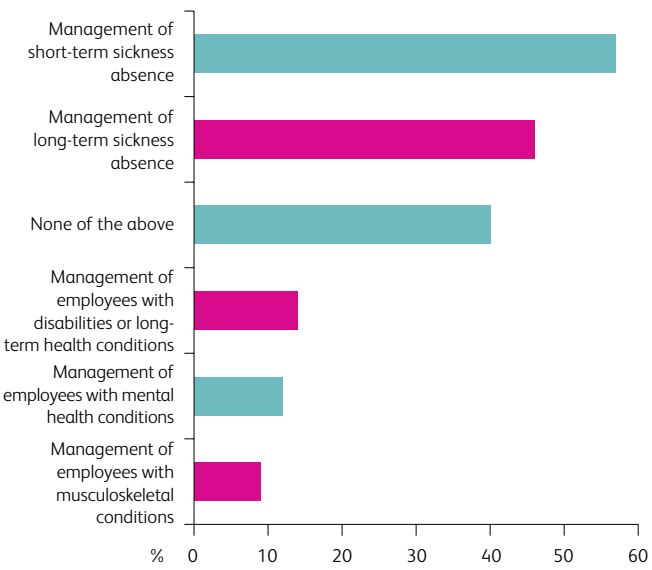


Source: EEF Sickness Absence Surveys 2016

Chart 18

One in eight managers receive training in mental health

% of companies that provide manager or supervisor training



Source: EEF Sickness Absence Surveys 2016

sickness absence has similarly increased from just over two-fifths (43%) to almost three-fifths (57%) in 2016.

So companies are in tune with the need for absence management line manager training, but have yet to pick up the mantle for disability manager training. It was clear from our most recent 2017 survey of manufacturers that, whereas one in two managers has received training in the management of sickness absence, only one in six managers has received training in managing employees with disabilities or long-term health conditions. One in eight managers received training in mental health.

We know from our 2016 survey report that stress and mental health issues are ranked as the third most common cause of long-term sickness absence. In the management of mental health, we are not reassured by the low levels of training provided for line managers and supervisors (12%, compared with 30% for all employment sectors in the 2015 CIPD survey).

We also know that line managers play a crucial role in promoting positive employee well-being. If we want line managers to make a greater positive impact on employee well-being, they need to be equipped with the tools to do this. HR departments should ensure that management training covers all aspects of the well-being role, for example, how to identify symptoms of mental ill health and to respond sensitively to concerns employees may raise.

Another tool is to provide all line managers with mental health first aid or disability awareness training so they become able and confident in supporting employees who may be experiencing mental health issues or who have disabilities in the workplace. If managers are able to have open and supportive conversations about disabilities and health conditions, this should help both employees and employers work together to enable individuals to fulfil their potential at work and to remain in work if a condition fluctuates or develops.

More generally, we believe that effective performance management and line management training is essential to develop cultural norms which look at capability rather than disability.

Health and work – what next?

We would expect employers to both recruit and retain individuals with disabilities and individuals with long-term health conditions without discrimination. We agree that it is important for employers to consider capability, not disability, i.e. what individuals can do rather than what they cannot.

The Equalities Act already ensures that people with disabilities are not unjustifiably screened out of job opportunities on health/disability grounds before they have had the opportunity to demonstrate that they qualify for the job because they have the required skills and experience. The Act restricts the circumstances in which employers can ask job applicants questions about disability or health.

We need to recognise that in some industry sectors there is limited availability of physically less-demanding manual roles, which might limit the job pool for certain types of disability or long-term health conditions.

The question for employers is more around when an individual's disability or condition has a substantial adverse impact on their ability to do the job. The decision the employer has to face is what amount of 'reasonable adjustment' needs to be considered in these circumstances. Employers would welcome more concrete information and guidance on what are reasonable adjustments in specific circumstances.

There should be a recognition that smaller organisations may not have the resource capacity, knowledge and ability to consider the most appropriate options or to introduce the correct workplace adaptations or work modifications for individuals with disabilities and long-term health conditions. SMEs may have a more limited number of available job roles, which can limit their flexibility to match jobs with specific intrinsic features to individuals with particular types of disabilities or long-term health conditions.

6 THE AGEING WORKER

In common with many developed countries, the UK population is ageing rapidly. The old-age dependency ratio (people aged 65 or above relative to those aged 15–64) is projected to increase significantly. This is having inevitable consequences on the labour market and creates health, safety and well-being challenges in managing an older workforce.

Declining labour market participation by the over-50s, together with fewer younger workers entering the labour market, raises the spectre of labour shortages. These shortages, coupled with expensive pension provision, make imperative the retention of older workers.

We believe it is important for employers to support a vision of a sustainable working life centring on facilitating people being in work and remaining healthier and in employment longer.

As age management is emerging as an important factor in enhancing the likelihood of older workers staying in work, we felt it was important to find out what steps EEF members are taking to maintain or enhance the health and well-being of workers over the age of 50. See Chart 19.

The manufacturing sector is not alone in facing the problems of an ageing workforce, but it does have a disproportionately high number of workers in the age range 35 to 55 and sometimes struggles to attract young people into the sector.

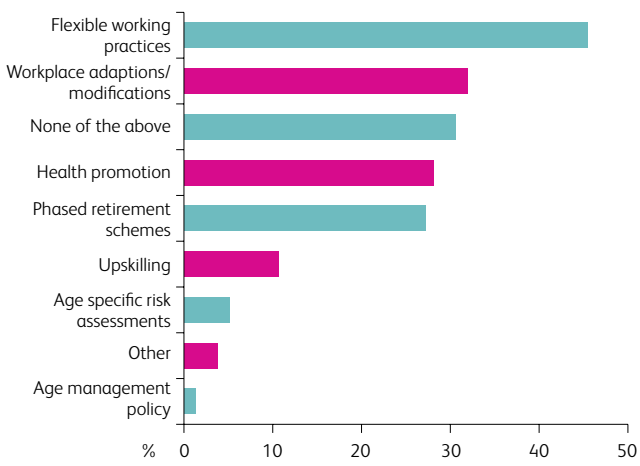
Considering the current debate around UK skills shortages as well as access to skills post-BREXIT, it was surprising that almost a third (31%) of our survey respondents said that they are not taking any of the steps listed in the survey question to maintain or enhance the health and well-being of workers over 50.

Of the companies taking active steps in respect of workers over the age of 50, almost half (46%) are promoting flexible working practices, almost a third (32%) are implementing workplace adaptations or modifications, just over a quarter (27%) have phased retirement schemes and just over a quarter (28%) arrange health promotion activities.

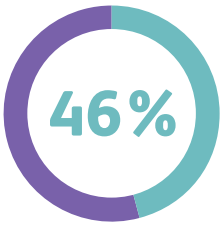
Chart 19

Older workers benefit from flexible working arrangements

% of companies taking steps to enhance or maintain the health and well-being of workers over the age of 50



Source: EEF Sickness Absence Survey 2017



of manufacturers said that they promoted flexible working practices for workers over the age of 50

How do the survey findings in Chart 19 compare to data collected by EEF in its 2008 report[4] on the ageing workforce, shown in Table 2?

We can see in Table 2 that relatively few firms were redesigning jobs or the workplace to account for the needs of older workers back in 2007, but that by 2016 (Chart 19), almost a third of survey respondents said that they are making workplace adaptations/modifications. This is likely to be a reflection of the fact that more firms now see the ageing of their workforce as impacting significantly on the ability of the workforce to undertake physically demanding tasks.

We can also see that just under half (46%) of companies offered flexible working arrangements (including flexible hours) in 2016 compared with just under two-fifths (38%) of firms in 2007. This increase may be a reflection of changes in Employment Law, which require employers to consider applications for flexible working arrangements (FWAs) from their employees.

Flexible working arrangements (FWAs)

Employers have different options when introducing flexibility through FWAs in the workplace. These relate primarily to:

- When work is done (temporal flexibility);
- Where it is done (geographical flexibility);
- How and by whom it is done (functional flexibility).

In the UK, under the Employment Rights Act 1996 and regulations made under it, all employees have a statutory right to ask their employer for a change to their contractual terms and conditions of employment to work flexibly, provided they have worked for their employer for 26 weeks continuously at the date the application is made. Before June 2014 the right only applied to the parents of children under 17, or 18 in the case of parents of disabled children, or to those caring for an adult. Now any eligible employee can apply to work flexibly for any reason.

There is growing recognition that FWAs may support the extension of working lives (CIPD, 2012;[5] Loretto et al., 2009[6]), and it is therefore important that employers consider flexible working requests from older workers in a formal, structured way.

Table 2

Return-to-work and rehabilitation are most common strategies

% of companies implementing measures for older workers

	Already standard practice	Implemented or considering implementing
Return-to-work/rehabilitation policies	58	12
Offer flexible working hours	38	20
Strategies to ensure a broad age demographic	33	19
Winding-down programmes for those close to retirement	20	25
Redesigning jobs	15	13
Redesigning the workplace	15	8

Source: EEF Ageing Workforce Survey 2008

Temporal FWAs offer variation in how long people work (number of hours) and/or when people work (arrangement of hours), typically through practices such as part-time and term-time working, job sharing and flexitime. Temporal flexibility can help retain older workers who want to reduce their work commitments or who find it more difficult to work full-time or do shift-work. Shacklock et al. (2009)[7] found that many retired workers said that they would have worked longer had they been offered temporal FWAs. The Equal Opportunities Commission (2005)[8] reported that many older workers expressed a preference to remain with their existing employer and scale down their working commitments.

One specific type of temporal flexibility is partial or phased retirement. Our survey showed that this was offered to employees in just over a quarter of the surveyed companies. The success of these schemes often depends on factors such

[4]An Ageing Workforce – How Are Manufacturers Preparing? EEF, 2008.
[5]Managing a Healthy Ageing Workforce, London: CIPD (2012).
[6]Loretto, W., Vickerstaff, S. and White, P. 'Flexible work and older workers', in W. Loretto, S. Vickerstaff and P. White (eds), *The Future for Older Workers*, Bristol: The Policy Press (2009).
[7]Shacklock, K., Brunetto, Y. and Nelson, S. 'The different variables that affect older males' and females' intentions to continue working'. *Asia Pacific Journal of Human Resources*, 47: 1, 79–101 (2009).
[8]'Older workers and flexible work', EOC Working Paper Series, Manchester: EOC (2005

as pensions, as older workers can sometimes be reluctant to reduce working hours if this will affect the pension benefits they will receive upon retirement. Flexible retirement can offer a smooth transition from work into retirement or from employment into self-employment.

Geographical FWAs offer variation in work location and include homeworking, mobile working and teleworking. These FWAs can assist in the retention of older workers by making work activities more satisfying, reducing travel time and allowing individuals to work at from different locations.

Some older workers may no longer be able or willing to continue in their previous occupation as they reach retirement age. This can be the case for physically or psychologically demanding work. Functional FWAs, where work-roles change can be a solution. It includes role variation to reduce physical strain, changes in responsibilities and/or reduced workload, etc.

Older workers value FWAs, and they can help to sustain their working lives. They can be of benefit for both employers and older workers. Some problems have been recognised especially where reductions in working hours leads to work intensification. FWAs are sometimes viewed as costly and are unpopular with some employers.

FWAs for older workers can be formal or informal. Detailed working arrangements are often negotiated between the individual employee and their manager, which may or may not ensure that the needs of both business and the individual older worker are accommodated. Rousseau et al. (2006)[9] called these 'voluntary, personalized agreements of a non-standard nature negotiated between individual employees and their employers regarding terms that benefit each party'. There may be a danger that individualised agreements discriminate by attracting only targeted workers with a particular value or those with the ability to negotiate their own FWAs.

Workplace adaptions/modifications

Few workplaces are designed with the needs of the older worker in mind.

Ideally, workplaces would be ergonomically designed at the outset to be safe and healthy for workers at any age through the application of 'inclusive' design principles. The British Standards Institute (2005)[10] defines inclusive design as 'the design of mainstream products and/or services that are accessible to, and usable by, as many people as reasonably possible ... without the need for special adaptation or specialised design'.

Workplace adaptations and work process modifications through workplace redesign have key roles to play in allowing older workers to be able to continue existing job roles, whether they be physical or cognitive. When considering how to accommodate the ageing workforce, it is important to match job demands to worker capabilities. The focus should be about designing the job to fit the person, rather than forcing the person to fit the job. A systematic ergonomics improvement process will also help manage risk factors that lead to musculoskeletal injuries and allow for improved human performance and productivity.

By making improvements to the work process through job redesign, it is possible to maximise safe work performance for older workers and to provide workers with a job that is within their capabilities and limitations. This will help contribute to the company's bottom line.

Health promotion

Regular health checks are generally viewed positively by older workers.

Mini health checks, health condition tests, rehabilitation and mental health support can be important for older workers. Health promotion activities may not directly improve work capability but can help identify health risks so that older workers can increase their fitness levels and improve their mental well-being, enabling them to stay healthier and in work longer.

[9]Rousseau, D., Ho, V. and Greenberg, J. (2006), 'I-Deals: idiosyncratic terms in employment relationships', *Academy of Management Review*, 31: 4, 977–994.
[10]The British Standards Institute BS 7000-6:2005: 'Design management systems – Managing inclusive design – Guide' (2005).

However, stress and mental ill health may be less of a health issue for older workers than chronic musculoskeletal problems. In our 2013 survey report[11] we found that stress and mental ill health issues are more prevalent where the average age of the workforce is 40 years or younger (24%) compared with those over 40 (13%).

Are age-specific risk assessments necessary?

Risk assessments should take into consideration the large individual differences in functional capacities and health of all individuals, irrespective of age. Bearing in mind that employees of all age groups are vulnerable to harmful work exposures, it is important that the assessment of an individual's abilities, skills and state of health is a continuous and dynamic process, based on adequate risk assessment. However, the redesign of individual tasks for older workers will no doubt need to consider the loss of auditory and visual acuity, reduction in grip strength and loss of agility and mobility more commonplace in older workers.

Age-management policies

A tiny percentage (1%) of our survey respondents said they have a 'formal' age-management policy. This is probably because most companies deal with the issue of age under their more HR-related generic health, equality, recruitment, discrimination and flexible working policies. We do, however, think it is beneficial for age-management strategies to be established at company level to make clear, for example, what types of flexible working are on offer (to avoid discrimination) and what forms part of an overall strategic approach to general recruitment. It is important that age-management strategies support employer recruitment and retention priorities.

What next?

Demographic change and its likely impact on a company's talent pool is a persuasive motivation for businesses to implement active age-management strategies. It is important that employers understand their current and potential future workforce requirements. To do this they need a clear picture of the age structure within their organisation, the skills and experience present and how this maps against future demands and changing requirements. Only then will they be in a position to decide which are the most appropriate measures they need to take to maintain or enhance the health and well-being of workers over 50. It is clear that the payback for ergonomic workplace design improvements is of benefit not only to employees over the age of 50, but also to employees who are just starting out in their working lives.

[11] EEF Sickness Absence and Rehabilitation Survey, June 2013.

7 FISCAL INCENTIVES

EEF has repeatedly stated in many of its Sickness Absence Survey reports over the years that reductions in long-term sickness absence will only be achieved once the government recognises that fiscal incentives are likely to be the route which will secure SME engagement in the funding of medical interventions, rehabilitation or workplace adaptations without reliance on the NHS.

The government Green Paper on 'Work, Health and Disability: Improving Lives' asked whether financial or other incentives would encourage employers to try new and creative things to support more people with disabilities and with long-term health conditions in work.

Just under one-third (28%) of our survey respondents thought that financial incentives would help recruit or retain people with disabilities or long-term health conditions. Fiscal incentives were more popular with SMEs with up to 100 employees. See Chart 20.

We also asked our survey respondents what would most incentivise their companies to pay for employee health (including people with longer-term health conditions) and well-being programmes. The top six measures expressed by employers in order of importance (see Chart 21) were:

- Employer/government matched funding;
- Health tax credits for employers;
- Lower National Insurance rates;
- Income protection and private medical insurance incentives;
- Employer allowable business expenses;
- Lower VAT rates on health and well-being expenditure.

Barriers

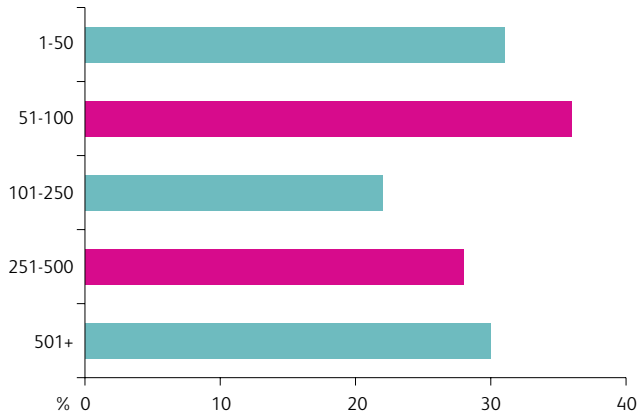
A crucial barrier to the implementation of workplace health and well-being programmes is the limited funding that employers are able to make available for such programmes. Our 2016 Sickness Absence report found that the average spend per employee on well-being, health promotion and lifestyle advice was £84. However, almost two-thirds (64%) of companies who gave us details of their spend stated it as £0.

Many employers question whether the tax system discourages them from investing in early interventions, especially as, at present, many employer-sponsored health interventions are taxed as benefits in kind.

Chart 20

Almost one-third of all companies support financial incentives

% of companies that believe financial incentives would help them recruit/retain people with disabilities or long-term health conditions, by size of company

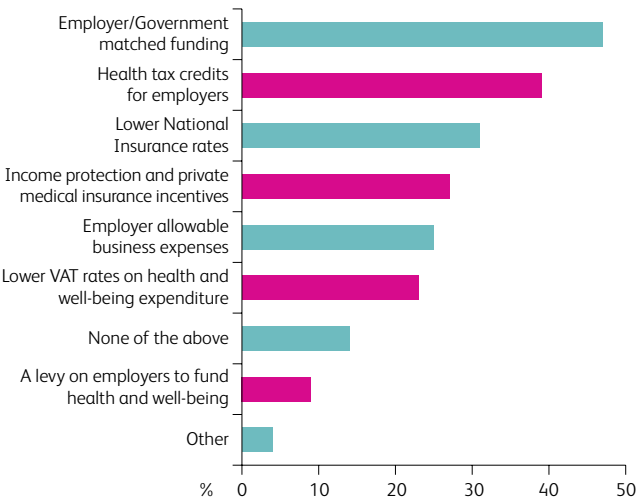


Source: EEF Sickness Absence Survey 2017

Chart 21

Half support matched funding financial incentives

% of companies supporting financial incentives to pay for employee health and well-being programmes



Source: EEF Sickness Absence Survey 2017

The argument for providing tax incentives for health and well-being programmes suggests that if such initiatives become tax free, demand for them will rise. The other argument is that is we put more effort into prevention, then everyone could benefit.

Simon Stevens (CEO of NHS England) has suggested[12] that employers could receive tax breaks for a variety of reasons, including setting up jogging clubs, group weigh-ins and slimming clubs to help combat obesity, and also that incentives be offered to employers 'who provide effective Nice-recommended workplace health programmes for employees'.

He also spoke at the Institute of Directors Annual Convention on 6 October 2015[13] at the Royal Albert Hall in London, where, on the role of employers in workplace health, he said:

> Because we have a tax-funded National Health Service in this country, rather than employer-based health insurance like the French or Germans or Americans, we don't saddle business with the costs of health care. But one by-product is that we tend to neglect workplace health. Yet the NHS spends over £40 billion a year on treating working age adults, much of which could be prevented. That's on top of the estimated £32 billion cost of sickness absence caused by 130 million days off work. Some larger employers are now – as the *Financial Times* put it – 'waking up to the cost of ill employees'. But for small business this is harder. The NHS will therefore now work with the Institute of Directors and other employers and staff organisations to explore whether there is a case for suggesting to government consideration of fiscal incentives – perhaps an employer's national insurance rebate – for those small employers who provide their employees with credentialed health and well-being programmes proven to cut long-term costs to the NHS.

If the government wants employers to implement initiatives that have a wider societal and public health benefit, it can be argued that the deal has to involve some sort of 'nudge' in the form of fiscal incentives from the government itself. This is likely to persuade companies who might not have considered health and well-being interventions to do so.

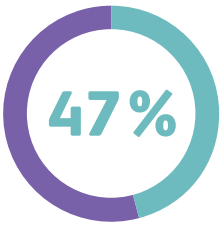
There are pros and cons to using different sorts of fiscal incentive. Any incentive that is made available has to be administratively simple for both the government and the employer to operate and to strike a balance between setting precise eligibility rules and discouraging companies to apply. We discuss the options below.

Matched funding

Matched funding is where a government grant is equally matched by employer investment, although a ratio other than 50:50 could be used. This type of financial incentive appealed to just under half (47%) of our survey respondents.

The government would be able to apply precise eligibility criteria for employers to obtain funding. It needs to be acknowledged that the task of administering matching funds is likely to be much more bureaucratic than that of monitoring tax deductions or tax credits both for the government and for employers.

Previous UK social care reviews have suggested a funding system based on matched contributions between the government and the individual so that people would be incentivised to save more for their health.



of manufacturers said that 'matched funding' between government and employer would most incentivise them to pay for the cost of employee health and well-being programmes.

[12] 'Employers could get tax breaks for helping to tackle obesity', *The Telegraph*, available at http://www.telegraph.co.uk/news/health/news/11102821/Employers-could-get-tax-breaks-for-helping-to-tackle-obesity.html (accessed 19 July 2017); 'Why a tax break for employers is the smart way to improve mental health' *The Guardian*, available at https://www.theguardian.com/commentisfree/2017/feb/01/mental-ill-health-business-prevention-norman-lamb (accessed 19 July 2017).
[13] Institute of Directors Annual Convention, 6 October 2015.

Health tax credits

Tax incentives are commonly used to attract investments or to incentivise savings. One area where tax incentives are used in the UK, and in many other countries, is to tackle problems of under-investment in Research and Development (R&D). It was also introduced to facilitate international competitiveness and attract more mobile investment to the UK.

An R&D tax credit for SMEs was introduced in the UK in 2000, and a large company credit was introduced in 2002. The UK R&D tax credit allows companies to claim 130% of eligible R&D expenditures in the calculation of profits subject to corporation tax (or 230% for SME companies), thus reducing the corporation tax bill and in effect reducing the overall cost of R&D carried out.

Tax incentives can be effective in tackling the problem of under-investment. Almost two-fifths (39%) of our survey respondents supported the concept of introducing a health tax credit which would help tackle under-investment in employee health and well-being in the workplace with a view to reducing workplace absences and boosting productivity. The health tax credit could also be used as a vehicle for tackling the employment and retention of individuals with disabilities and long-term health conditions in the workplace. A two-tier system for SMEs and for large companies could provide a suitable model.

Lower National Insurance rates

Almost one third (31%) of our survey respondents supported the concept of lower National Insurance rates as an incentive to pay for employee health and well-being programmes. This could take the form of tax credits (in the form of tax relief on employer National Insurance contributions) or tax relief in the same way as HMRC permits tax relief on employer contributions to registered pension schemes by allowing pension contributions to be deducted as an expense, reducing the employer's taxable profit.

Any employer National Insurance Contributions (NICs) relief would have to be set at a level where the fiscal incentive allows employers to invest in workplace health interventions, because the benefits would exceed the costs. This would offer immediate support and would be a more direct way for employers to take advantage of the incentive.

It is also important that any savings to the NHS achieved through reductions in long-term health costs and savings through reductions in numbers of Employment and Support Allowance (ESA) claimants are considered when calculating the overall cost benefit and net benefit to society from encouraging workplace health interventions.

Income protection and private medical insurance (PMI) incentives

We found that just over a quarter (27%) of our survey respondents supported financial incentives associated with the provision of income protection and private medical insurance (PMI). This reflects a finding in our 2015 Sickness Absence Survey report which showed that PMI was the most popular benefit offered to almost two-thirds of employees. Group income protection (GIP) was offered to a quarter of employees.

Both PMI and GIP schemes allow employees early access to medical treatments and rehabilitation services and can remove from the NHS some of the burden and cost of treating working-age adults.

Analysis by the Centre for Economics and Business Research[14] indicates that employees who have access to and use early intervention and rehabilitation services tend to have long-term absences of shorter duration compared to those who do not have access to or use such services. On average, the duration is shorter by 17%.

The government's Work, Health and Disability: Improving Lives Green Paper stated that GIP insurance policies should have a much greater role to play in supporting employers who wish to invest in their employees' health and well-being, while also recognising that research is necessary to demonstrate the return on investment for employers who purchase income protection insurance. The Green Paper also wanted to explore why larger employers are not making better use of group income protection products and whether group income insurance products could be made more viable for smaller employers.

[14]Centre for Economics and Business Research. 'The benefits of early intervention and rehabilitation. Supporting employees when they need it the most', London (2015).

Although employers can currently claim corporation tax relief on their premiums when they purchase income protection insurance products for their employees, the insurance industry has said[15] that if the government wants to bring about a step change in GIP take-up it should introduce a reduction of £30 per employee in National Insurance contributions for those employers that provide GIP. A tax incentive would encourage employers to extend GIP to more employees so that many more get the support they need to stay in work.

We believe that a tax break for employers, or perhaps some form of capped basic rate tax relief in corporate PMI schemes, would encourage greater take-up of private healthcare. There is no doubt that increased use of private medical facilities would potentially ease the pressure on the NHS by freeing public spending that would otherwise have gone on those who could receive treatment though PMI schemes.

Use of private care and PMI could help boost industry productivity by giving workers prompt access to medical treatment. The private health sector takes pressure off the NHS and supports the NHS by providing additional beds and treatment to reduce long waiting lists. It gives access to prompt treatment for key staff in industry for a quicker return to work and allows the NHS to boost its income with much more private work.

The case for introducing PMI tax relief is based on the proposition that it would encourage substantial new take-up of private medical insurance and eventually be self-financing in terms of the overall costs to society and the economy. It is certainly one tool which should be considered if we want to reduce the cost of sickness absence to both industry and the UK economy.

Polling for ComRes in 2016 found that organisations would be more likely to offer private medical insurance if reductions in business rates or tax relief were provided to employers offering private medical insurance, or if relief were given to employees who receive it.[16]

Employer allowable business expenses

A quarter (25%) of our survey respondents supported the introduction of further allowable business expenses for companies who pay for health and well-being programmes or interventions.

Currently, counselling services for welfare issues, such as bereavement, ill health or stress, problems at work, sexual abuse or personal relationship difficulties do not attract tax, National Insurance or reporting commitments to HMRC. It is also the case that if employers provide equipment or services for disabled employees so they can do their work, it doesn't count as a taxable expense or benefit, which strengthens the argument for employers using the government's Access to Work scheme.

However, if employers provide medical or dental treatment or insurance for their employees, they currently have specific tax, National Insurance and HMRC reporting requirements (P11D returns for each eligible employee), with the exception of:

- Annual medical checks or health screening;
- Eye tests required by health and safety legislation for employees who use a computer monitor or other screen;
- Glasses or contact lenses where employers have to provide them for monitor or screen work;
- Medical treatment outside the UK if employees are working overseas and need treatment;
- Medical treatment or insurance for injuries or diseases resulting from employee work activities.

There is clearly scope for the government to do much more in this area by allowing employer expenditure on specific disability, health and well-being programmes to be exempt or partially exempt from tax and National Insurance. This would encourage employers to introduce programmes which recruit and retain people with disabilities or long-term health conditions, and to promote return-to-work programmes which minimise long-term sickness absence and which allow employers to help the government to tackle public health issues, such as obesity in the workplace.

[15]'What next for health at work? Five years on from the Black/Frost review of sickness absence', UNUM (2017).
[16]ComRes interviewed 2077 GB adults online and 251 HR decision makers in UK companies employing 10+ people online (September 2016).

An alternative approach would be for the government to reintroduce some sort of threshold for individual liability for tax on benefits in kind, which it abolished in 2014.

Tiered VAT rates

There was some support by almost a quarter (23%) of our survey respondents for tiered VAT rates. Certain goods and services are either exempt from VAT or VAT is charged at a lower rate. In the health arena, the care or medical treatment provided by a qualifying institution like a hospital, hospice or nursing home, and health services provided by registered doctors, dentists, opticians, pharmacists and other health professionals are VAT exempt.

We would also like to see lower VAT rates or VAT exemptions applied to include expenditure by employers on health and well-being initiatives designed to improve both mental and physical employee fitness.

Health levy

The idea of a levy on employers to fund health and well-being programmes was considered a possible option by just under one tenth (9%) of our survey respondents.

The government has recently introduced an apprenticeship levy, and the implementation of that scheme is proving to be both costly and bureaucratic. It is also seen as a direct tax on business. In addition, it has proved to be very complicated to decide how the levy money is spent or distributed. When the apprenticeship levy was announced, the government argued that it was required because there had been a significant reduction in employer investment in training.

The relationship with NHS budgets and other public health programmes is potentially more complex. EEF would not want to see industry burdened with the costs of workplace healthcare or healthcare associated with issues which do not arise out of work – for example, individual lifestyle choices such as smoking.

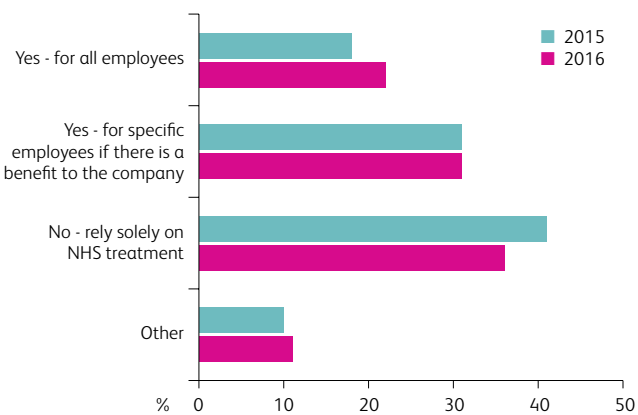
Do companies pay for employee medical treatment?

In our annual Sickness Absence Survey we always ask companies whether they currently pay for medical treatments (such as medical tests, consultations, appointments, surgery) as a means of reducing long-term sickness absence to get employees back to work sooner. Chart 22 shows that just over a fifth (22%) of employers currently pay for some form of medical treatment for all employees; this is a 4% increase over 2015. Almost a third (31%) of respondents (as in 2015) say they would pay if there would be a particular benefit to the company in helping a specific individual. This is consistent with EEF's previous survey findings when companies have been asked whether they would be willing to fund medical interventions for their employees to help reduce long-term sickness absence. Just over a third (36%) of survey respondents tell us they rely completely on NHS treatments for their employees, down from a high of 41% in 2015.

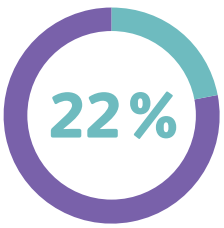
Chart 22

A third of companies rely on the NHS to treat employee medical conditions

% of companies citing whether they pay for medical treatments to reduce long- term sickness absence and get employees back to work sooner



Source: EEF Sickness Absence Survey 2016 & 2017



of manufacturers said that they pay for some form of medical intervention/treatment for their employees.

of manufacturers said that they rely completely on NHS treatment to reduce long-term sickness absence and get employees back to work

Most of the companies placing reliance on the NHS employ fewer than 250 employees. See Chart 23.

There is a problem for companies that depend solely on the NHS to treat their employees. In our 2016 Sickness Absence report and in our previous reports we have found that around a third of employers say that waiting for employee treatment is the most common cause of long-term sickness absence in the workplace. We know that NHS waiting times are a major factor for SMEs in combating unnecessary long-term sickness absence. We know that the duration of long-term sickness absence for many company employees is dictated by the ability or willingness of employers to pay for medical treatments.

Financial incentives for employers – overview

EEF believes that there is a strong business case to support the provision of financial incentives by government which has as its objectives the management and reduction of long-term sickness absence, greater recruitment and retention of individuals with disabilities and long-term health conditions, the promotion of work as a clinical outcome, the reduction of the government's overall benefit payment bill, the improvement of the nation's health and the increase in UK plc productivity. All options need to be fully costed at a macro-economic level. If the UK wants to maintain its economic prosperity post-Brexit, then good workplace health should definitely be one of the important foundations of our future industrial strategy.

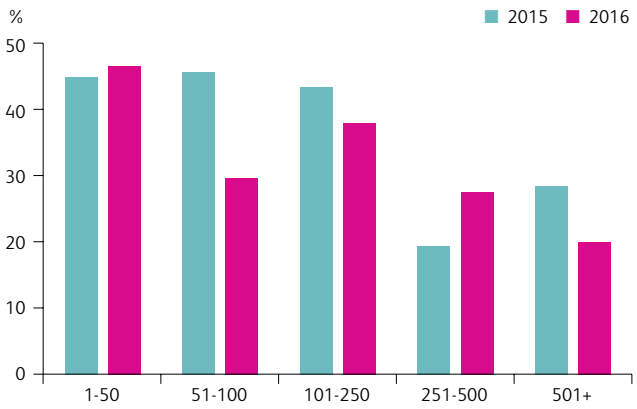
Such a macro-economic analysis will allow the government to determine which financial incentive would provide the greatest return in terms of disability employment, improvements in health, reduced welfare payments, increased productivity and economic output.

We know from our 2016 Sickness Absence Survey Report that only around one-third of companies measure the economic cost of sickness absence, and we know that roughly one-third of firms do not set sickness absence

Chart 23

SMEs place greatest reliance on NHS

% of companies that rely solely on NHS for medical treatments, by size



Source: EEF Sickness Absence Survey 2016 & 2017

targets. We know too that the cost of sickness absence to employers is approximately £9 billion per year.[17] The average sick pay cost for each of our 2016 Sickness Absence Survey respondents is around £43,000, which does not include all the other direct costs associated with sickness absence.

If the government wishes to realise the wider societal benefits of improved workforce health, including improved productivity and lower spending on health and welfare benefits among working-age people (including individuals with disabilities and long-term health conditions), then it must be prepared to incentivise employers to act in their own interest, in their employees' interests and in the interests of society at large.

[17]Dame Carol Black and David Frost, 'Health at Work: an Independent Review of Sickness Absence' (November 2011).

8 ABSENCE TRENDS

The 2016 absence rate is 2.3%, unchanged from the previous year. This represents an average of 5.2 days lost to sickness absence per employee – down slightly on 2015. The latest data shows that there has been little change in absence over the past eight years.

If we compare our data with the 2016 CIPD survey, this showed a not too dissimilar average absence level of 5.4 days for the manufacturing and production sector. Overall absence levels per employee for all sectors in the CIPD survey were 6.3 days and 8.5 days for the public sector.

The members who took part in this survey lost a total of 249,555 days owing to sickness absence during 2016.

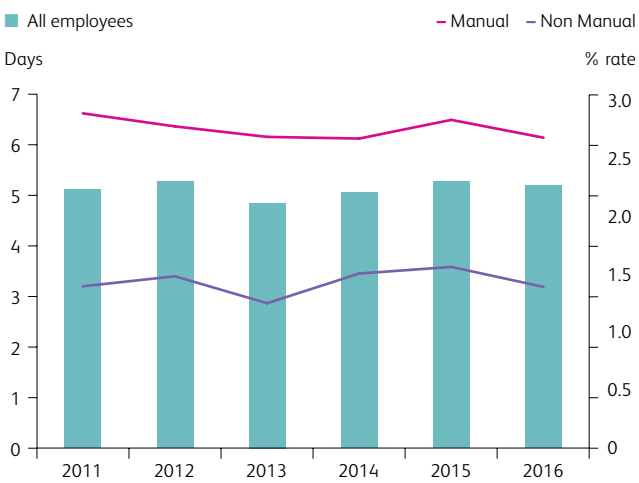
Manual workers, at 6.1 days (2.7%), continue to have higher levels of sickness absence than non-manual employees, at 3.1 days (1.4%). The number of days of sickness absence per manual employee reduced by 0.4 days in 2016 to match the lowest level previously recorded in 2014. We also saw a reduction of 0.5 days of sickness absence per non-manual employee in 2016 over that reported in 2015.

The average number of days lost to firms with 1–50 employees equates to 4.2 days, the same as for the 2015 data, while for all other sizes of companies the average rate is more than 5.1 days (2.2%) – a small decrease from the 2015 level of 5.5 days (2.4%). There is a significant differential between micro companies employing fewer than 51 employees and the rest. See Chart 25.

Chart 24

Sickness absence continues to fluctuate at around five days per employee, or 2.3% absence rate

Average number of days lost to sickness absence (left-hand axis) and equivalent absence rate (right-hand axis) by type of employee

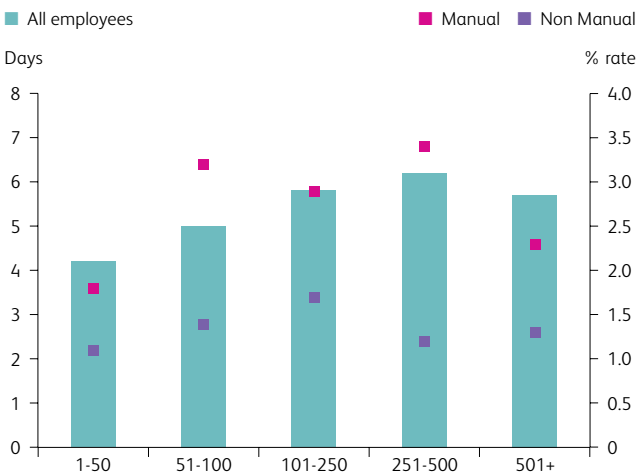


Source: EEF Sickness Absence Surveys 2012 to 2017

Chart 25

Micro companies consistently have lower sickness absence rates for both manual and non-manual employees

Average number of days lost to sickness absence and absence rates by company size



Source: EEF Sickness Absence Survey 2017

Absence rates – gender and nightshift working

Gender

We did not find any significant differences in sickness absence rates between male and female employees.

Shift work

When we looked at companies who operate shifts between 10pm and 6am (night shifts), we found that the sickness absence rate was higher for these companies. See Table 3. Higher sickness absence rates could be a significant cost for companies who have large numbers of night-shift workers.

The Health and Safety Executive (HSE) in its guidance on Managing shift work[19] points out that that there can be undesirable consequences for those working shifts outside standard daytime hours, particularly those covering the night or early morning starts, which might have a negative effect on health. The same guidance refers to research evidence associating long-term exposure to shift work and ill health effects, such as:

- Gastrointestinal problems such as indigestion, abdominal pain, constipation, chronic gastritis and peptic ulcers;
- Cardiovascular problems such as hypertension and coronary heart disease;
- Increased susceptibility to minor illnesses such as colds, flu and gastroenteritis.

We believe it is important that companies manage the risks associated with shift work in order to financially benefit the business by lowering sickness absence and absenteeism, increasing work efficiency, improving product quality and reducing staff turnover.

It may be worthwhile for employers to review their shift patterns to see which patterns cause the greatest sickness absence. We know that permanent night workers and early morning workers run a greater risk of chronic sleep debt, fatigue, ill health and disruption of family and social life. Fast forward rotating shift patterns every two to three days can help reduce sleep loss and the risk of fatigue and ill health.

For more detail on absence trends please refer to the EEF 2017 Absence Benchmark Report.[20]

[19]Managing shift work: Health and safety guidance, HS(G)256, HSE, 2006
[20]EEF Absence Benchmark report, 2017.

Table 3

Higher sickness absence rates for companies operating night shifts

Sickness absence rates for companies which operate and do not operate night shifts

	Sickness absence rate	Average days lost
No, do not operate night shift	2.1	4.9
Yes, operate a night shift	2.5	5.7
Average sickness absence rate	2.3	5.2

Source: EEF Sickness Absence Survey 2017

ABOUT US

EEF is dedicated to the future of manufacturing. Everything we do, from business support to championing manufacturing and engineering, is designed to help our industry thrive, innovate and compete locally and globally.

We are the voice of UK manufacturing and engineering and a leading provider of business support. We work with the UK's manufacturers from the largest to the smallest and because we understand manufacturing so well, policy-makers trust our advice and welcome our involvement. We work with them to create policies that are in the best interests of the sector, that encourage a high growth industry and boost the manufacturing sector's ability to make a positive contribution to the UK's economy.

Our policy work delivers real business value for our members, giving them a unique insight into the way changing legislation will affect their business. This insight, complemented by intelligence gathered through our ongoing member research and networking programmes, informs our broad portfolio of business support services which include HR & employment law, health, safety and sustainability and productivity improvement.

We also provide a wide range of training, from engineering apprenticeships to management and leadership development.

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