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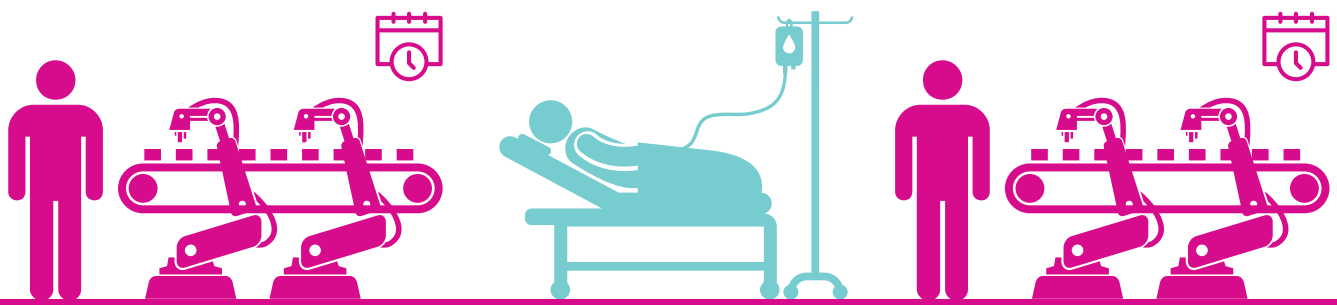
HEALTH – THE KEY TO PRODUCTIVITY?

SICKNESS ABSENCE SURVEY 2016



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1 INTRODUCTION

The UK's productivity performance is currently the subject of a major policy debate[1] in which the UK government is expressing concerns about the relative weakness of the UK economy.

Too often the discussion[2] around productivity improvement is narrowly focussed, centred on developing workforce talent, implementing lean initiatives, improving the supply chain or investing in research and development to bring about radical step changes in productivity improvement.

Few manufacturers seem to recognise that keeping people fit and in work, as well as accommodating an increasingly aging workforce, can hold the key to bigger productivity gains, especially where employers lose employees with key skills through ill-health or through sickness absence.

The health of employees is a major factor in an organisation's competitiveness. Employees in good health can be up to three times more productive than those in poor health; they can experience fewer motivational problems; they are more resilient to change, and they are more likely to be engaged with the priorities of the business.[3]

The UK's productivity performance matters because it is a key driver of long-term economic growth. The UK's growth prospects depend on people being fit, working and productive.[4]

Keeping people in work and helping employees return to work is enormously important for the manufacturing sector and the wider economy. It is also important for employers that the working-age population pool is made as large as possible through improvements in general health, fitness, wellbeing and capability.

This means boosting productivity by getting people back into work as early as possible and reducing unnecessary sickness absence. It means government investing in public health programmes to improve the health and well-being of both the general and the working-age population. It means designing workplaces so that the working population is exposed to safe and healthy work at any age.

This is our thirteenth national survey which looks at EEF member experiences of sickness absence. It is the third to be undertaken with Jelf, a leading UK provider of expert advice on matters relating to insurance, health care, employee benefits and financial planning.

Last year we concluded that the fit note, after five years of operation, was not fit for purpose. This year is our first opportunity to evaluate what impact the Fit for Work service has had on our member companies, including the payment of medical treatments recommended by the Fit for Work service and the utilisation of the £500 tax exemption (per year, per employee).

This year's survey introduced new questions. As well as questions about the Fit for Work service, we asked companies about the key factors they take into consideration when deciding whether an employee should leave the business as a consequence of sickness absence. We also asked what evidence companies require from employees as proof of sickness absence following self-certification, the extent to which businesses can accommodate individuals with temporary or permanent medical restrictions and whether they believe professionals other than GP's or doctors should be allowed to sign a fit note.

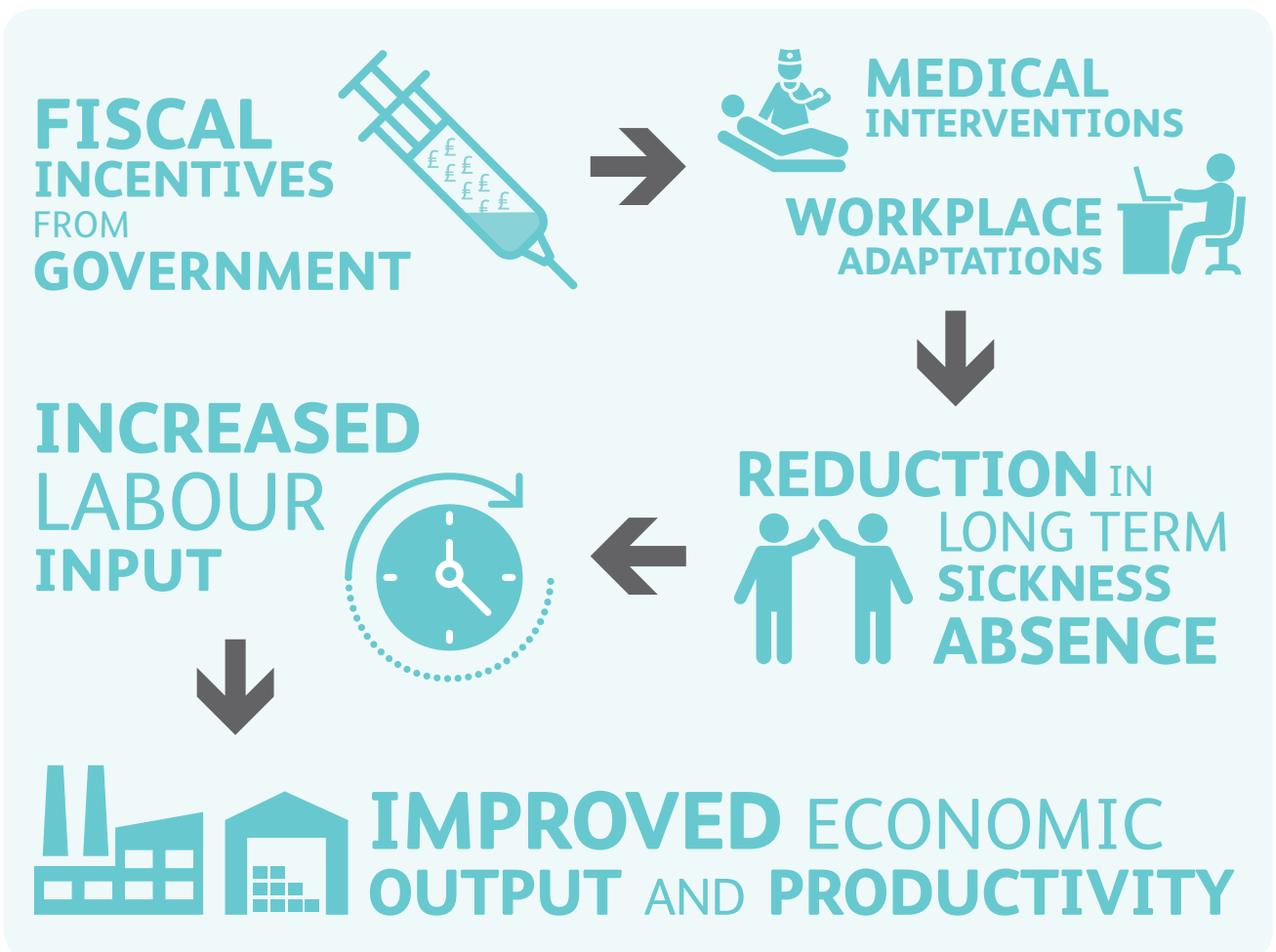
As well as the survey of members, we conducted follow-up telephone discussions in order to obtain more detailed member feedback and clarification on specific questions relating to the Fit for Work service.

The survey questionnaire was sent to manufacturers across the UK. We received 306 responses, covering 61,705 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 ten surveys. The responders are representative of the whole EEF membership by region and by manufacturing sub-sector.

[1]Fixing the Foundations: Creating a More Prosperous Nation, Cm 9098, HM Treasury, July 2015
[2]EEF's Productivity: The State of the Manufacturing Nation, Spring 2016.
[3]Vaughan-Jones, H. & Barham, L. (2010). Healthy work: Evidence into action. The Oxford Health Alliance, The Work Foundation and RAND Europe.
[4]EEF's '2015 EEF Manifesto: Securing a Manufacturing Renaissance', February 2015.

The government, through its new Health and Work Unit anticipate publishing a Green Paper in the middle of 2016 that will set out its plans for improving support for people with health conditions and disabilities at work. This Paper intends to identify the part that employers can play. We sincerely hope that, when formulating the Paper, the Government will seek the views of EEF and will remember that employers alone cannot be held responsible for resolving UK plc's societal ill health, well-being and public health issues.

We have consistently identified key sickness absence, health and wellbeing issues which need to be addressed in the manufacturing sector as well as in industry more broadly, and we firmly believe that there is a strong business case for the government to implement fiscal incentives which will help drive this agenda. It is important that the government does more to actively promote the issue of health and work in its Green Paper, bringing these options into mainstream policy debate.



2 KEY FINDINGS

The key findings arising from our survey are:

– Fit for Work service – a slow start, but high awareness amongst EEF members:

- Almost four-fifths (78%) of survey respondents are aware of the government's new Fit for Work service.
- Almost one fifth (18%) of those aware do not intend to use the 'service'.
- Out of 306 surveyed employers, only seventeen companies have used the 'service' and referred employees for assessment.
- Just one-fifth (20%) of companies are willing to pay for employee medical treatments recommended by the Fit for Work service.
- Three fifths (60%) of companies would pay for employee medical treatments if the cost were to be offset against allowable business expenses.

– Continuing concern about growing long-term sickness levels:

- One-twentieth (5%) of the workforce covered by this survey were absent from work for a continuous period of four weeks or more. This equates to at least 11,894 person-years of lost work for the whole manufacturing sector each year.
- Two-fifths (41%) of employers rely exclusively on the NHS to provide medical treatment for their employees.
- Just over a quarter (27%) of survey respondents do not have interventions in place to help employees with mental health related long-term sickness absence.
- Just under a third (32%) of companies measure the economic cost of sickness absence.
- The average sick pay cost per employee is £211 per annum. This equates to a total sick pay cost of ≈ £0.6 billion for the manufacturing sector.

– Fit note still failing:

- Just 13% of employers agree that the fit note has enabled those absent from work to return to work earlier, compared to 45% who said it has not helped.
- Almost four-fifths (79%) support a range of professionals (including GPs, physiotherapists, nurses) signing fit notes, compared to two- thirds (67%) before the fit note was introduced.

Absence trends

Our survey has uncovered a sickness absence rate of 2.3%, which translates to an average of 5.3 sickness absence days per employee per year. The average number of days lost to sickness absence has been fluctuating at around five days per employee (or a rate of 2.2%) for the past six years.

The reported average sick pay cost per employee from our latest survey is £211.

Half of all employees (50%) continue to have no absence because of sickness. This has also been consistent over the past five years.

Two-fifths (41%) of companies say that long-term sickness absence has increased over the past two years. This matches the reported increase from our 2015 survey when we saw the largest increase in long-term sickness absence in five years. The overall highest-ranked cause of long-term sickness are related to back problems and other musculoskeletal disorders (MSDs). This year, firms of **all sizes** ranked MSDs as the most common cause, whereas in last year's survey companies employing more than 500 employees ranked stress and other mental ill health disorders as the most common cause.

Just over half (54%) of companies report that they have an absence target, which is lower compared with previous recent surveys. Of those that set a target in 2015, just over half (53%) achieved it.

Fit for Work service

It is early days for the Fit for Work service. It has only been operating since July 2015, yet we found that four-fifths (78%) of respondents are aware of it. Relatively few employers have used it: just seventeen of our survey respondents. Of those who were aware of the service, just over half (54%) say that they would consider using the assessment service, but have not used it yet. A fifth (18%) said they would not use it at all.

Almost nine-tenths (87%) of the companies who say that they are aware of the service are also aware that they as employers can refer an employee who has been absent from work for four continuous weeks. In fact, all the interaction between the Fit for Work service and employers so far appears to have taken place as a result of employers

referring employees to the service. We are unaware of any situations where GPs have referred employees to the service.

Of the companies who have used the assessment service, almost all received return-to-work (RTW) plans in respect of the employees they referred. Although we have very limited user experience so far, of the seventeen companies who have used the service, fourteen have referred employees to the service. Seven of these fourteen say that it helped their employees make an early return to work.

At this stage only a fifth (19%) of employers said that they would definitely be willing to pay for medical treatments recommended by the Fit for Work service. Three-fifths (59%) of survey respondents are yet to make up their mind.

However, when it comes to the question of fiscal incentives, almost three-fifths (59%) of respondents support the introduction of some form of allowable business expense to help them pay for workplace adjustments or medical treatments.

Management of long-term sickness absence

The highest-ranked causes of long-term sickness absence are:

(i) back problems and musculoskeletal disorders,
(ii) absence as a result of medical tests, investigations and surgery; and
(iii) stress and mental health problems.

Three-quarters of companies (77%) say that their main approach for managing back problems and MSDs relies on modifying the task in some way. However, a significant proportion access professional occupational health advice/ rehabilitation (62%) or provide training (45%).

Just over half (54%) of companies rely on staff support mechanisms, systems and arrangements for managing mental-health-related long-term absence. Just under a third (33%) depend on the provision of talking therapies such as counselling or CBT, and a fifth (19%) rely on workforce stress risk assessments. Just over a quarter (27%) of companies indicate that they do not have support systems in place to help employees with mental-health-related long-term sickness absence. Employers across the board do not fare well in developing 'open' mental health policies to create cultures that encourage employees to disclose mental ill health as well as physical ill health.

Two-fifths (41%) of the survey respondents rely exclusively on NHS treatment in order to reduce long-term sickness absence and get employees back to work earlier. However, almost one-fifth (18%) pay for some aspect of private medical treatment (medical tests, consultations, appointments, surgery, etc.), and almost a third (31%) would pay for a medical treatment if there were to be a benefit to the company.

Almost three-fifths (59%) of companies say they would be most incentivised by some form of employer-allowable business expenses to pay for workplace adjustments or medical treatment for employees.

It is disappointing that only a third of companies measure the economic cost of sickness absence, only 6% of companies measure the return on investment of the well-being benefits and services they offer, and only 10% measure the impact of well-being benefits and services on levels of sickness absence. The sickness absence rate for those who do measure is 2.2% compared with 2.3% for all survey respondents.

The fit note six years on

The fit note medical certificate was first introduced in April 2010 to replace the sick note. It was introduced to allow medical professionals the option of indicating that an employee may be fit for work if certain criteria could be met by the employer.

In terms of progress over six years, we have seen very little. The fit note is still not delivering on its key objective to return employees to work earlier. In addition, employers are still reporting that the quality of the advice given by GPs is poor.

In our latest survey, two-fifths (45%) of employers report that the fit note is not helping employees to return to work earlier (up from 35% in 2010.) This compares with 13% (24% in 2010) who say that it has resulted in earlier returns to work. The balance or difference between those agreeing and disagreeing has increased from 11% in 2010 to -32% in 2015. If we look at the advice given by GPs about employees' fitness for work in 2015 more companies disagree (47%) than agree (13%) that this advice has improved. Again, the balance or difference between those agreeing and disagreeing has increased from -21% in 2010 to -35% in 2015.

3 KEY MESSAGES TO POLICYMAKERS

Resolving long-term sickness absence

Fit for Work service

We are supportive of the government's Fit for Work service as an important initiative to help reduce levels of long-term sickness absence, and in particular to tackle two of the most common causes of long-term sickness absence: MSDs and mental ill health.

The data from this year's survey so far show that there have been limited interactions between the Fit for Work service and EEF members. It is too early to assess whether the service is making a difference: i.e., are employees making an earlier return to work? What is clear so far is that only a fifth of companies say that they would be willing to pay for medical treatments recommended by the Fit for Work service, but more would pay if fiscal incentives were offered.

It is clear from our discussions with companies who have attended EEF Fit for Work seminars and companies who have interacted with the Fit for Work service that there are concerns and issues that need to be addressed by government if the service is going to be the success we all want it to be.

The concerns raised with EEF are:

- lack of fiscal incentives to encourage companies, particularly SMEs, to pay for medical treatments recommended by the Fit for Work service or company occupational health provider;
- whether the tax exemption being marketed by the government as a benefit for employers is really the case in practice;
- onerous HMRC record-keeping requirements associated with claiming the £500 tax exemption (including PMI exempt treatments) on behalf of employees;
- no clear picture on how the government is going to assess the success of the service and measure whether employees are making an earlier return to work;
- lack of engagement by government with both employers and GPs about the service;
- low numbers of GPs referring patients to the service, leading to a reliance on employers referring employees as the default option;
- requiring employers to wait four weeks to refer;
- GPs abandoning the fit note, no longer considering the 'may be fit for work' option and placing reliance on the Fit for Work service to manage all longer-term absences;
- the absence of discussions with the employer about any proposed RTW plan before it is agreed and finalised by the Fit for Work service and the employee;
- a lack of understanding about how the interaction between GP, Fit for Work service, company occupational health service, company and employee should work;
- restrictions on who, for how long and how many times individuals can use the Fit for Work service in any calendar year;
- no standard DWP specified format for written employee consents;
- few instances of medical treatments being specified in RTW plans, especially for MSD absences.

One of the main concerns is the **lack of fiscal incentives** to encourage companies to pay for medical treatments recommended by the Fit for Work service.

NHS dependencies

In six of our last seven surveys, companies have told us that the most common or the second most common cause of long-term sickness absence relates to employees with medical conditions who are waiting on the NHS for appointments, tests, investigations and surgery or who are recovering from medical treatment. Our latest survey shows that two-fifths of companies rely solely on the NHS for the medical treatment of its employees.

NHS waiting lists are not something that the Fit for Work service has been designed to address, but it is a major cause of absence from work which impacts business directly and which the government needs to tackle.

If employers cannot rely on the NHS, Health and Wellbeing Boards and Commissioning Groups to proactively support the working-age population and deliver effective rehabilitation and medical interventions within short time frames, then the government should offer employers appropriate fiscal incentives to go elsewhere. Employers should be provided with the flexibility to take advantage of non-NHS services and treatments in order to facilitate reductions in waiting times from diagnosis to treatment, reduce long-term sickness absence and help drive up productivity.

Employer incentives

There is an increasing tendency for governments, including the UK, to try to divert the responsibility for managing societal public health issues on to employers. This not only includes personal lifestyle factors such as exercise, obesity and smoking, but also covers wellness and mental health issues which more often than not stem from outside the workplace.

Most employers by and large understand the benefits of engaging with their employees about their health, their sense of well-being and sickness absence, but we should not assume that they alone are responsible for taking on more and more obligations for a range of societal and public health issues.

In a recent Work Foundation report, the Health at Work Policy Unit[5] it states, 'If the government wishes to see the wider societal benefits of improved workforce health, including improved productivity and lower spending on health and welfare benefits among working age people, then it must be prepared to … incentivise employers to act in their own interest, their employees' interests, and in the interests of society at large.'

EEF agrees that we need employers to become active investors in workforce health. For this to happen it is important that the government commits through its forthcoming Green Paper to assess the feasibility of different fiscal incentives which will:

(i) encourage the introduction of more employer-led workplace health and well-being interventions; and
(ii) lead to reductions in absence from work.

In particular, we would like the government to:

– review the current levels of employer taxation for employer-led health interventions where they are currently taxed as benefits in kind;
– carry out sensitivity analysis of different fiscal incentives (e.g. changes to allowable business expenses, tax credits, tax relief, matched funding, National Insurance changes, tiered VAT rates);
– look again at tax relief for private medical insurance (PMI). The £500 tax exemption for treatments recommended by the Fit for Work service raises the question why other treatments are not exempt. After all, the logic of the £500 tax exemption is that it encourages employers to get sick employees back to work more quickly. Extending the relief to all employer-provided private medical insurance, up to a reasonable ceiling, should have the same effect.
– consider tax relief on income protection insurance or group income protection (GIP) as a means of providing sick pay and rehabilitation support to employees through employers. This will allow the insurance market to take some pressure off the state. Many employees have this cover anyway as, increasingly, membership of a GIP scheme is a condition of participating in the workplace pension. Many insurers actually pay for the treatment required as part of the income protection package. The main issue is early notification of absence to allow for early intervention services to kick in,
– provide some form of fiscal incentive to companies who fund treatments as part of rehabilitation which would otherwise have to be provided by the NHS, or which prevent state Employment and Support Allowance (ESA) payments.

[5]Work Foundation Health at Work Policy Unit: Investing in a Workforce Fit for the Future – Challenges for the UK Government, September 2015.

4 JELF EMPLOYEE BENEFITS MARKET VIEW

Despite the understandable uncertainty in the UK business community over the UK's future in Europe, unemployment figures are at their lowest rate for 10 years according to the latest data from the Office of National Statistics[6]. A natural conclusion would be that the provision of traditional employee benefits would be at a corresponding high but this is not the case, even when there is a relatively soft premium market for benefits that are popular with both employers and employees such as private medical and income protection. Why is this?

In simple terms, the workforce is going through changes that have never before been experienced. An increasing ageing population is reflected in an ageing workforce which brings with it higher morbidity rates particularly for long term conditions and with these, a higher likelihood of both short and long term absences. This is compounded by an increase in normal retirement ages. In the next four years, one in three UK workers will be aged over 50[7] and there will be 60% more workers aged over 65 in the next decade[8].

Another aspect of the ageing population is the increasing number of workers who are also carers which is estimated to be at over 10%[9] of the working population of which circa 7% are caring for elderly relatives.

The challenges for younger sections of the population are can be equally pressurised with financial concerns increasingly featuring as a source of stress that impacts on working lives. The links between stress and the musculoskeletal and gastrointestinal health as the most common causes of short term absence are being increasingly understood. These conditions directly affect absence levels as well as creating additional costs for occupational health and health benefit plans.

This year's survey shows, absence rates are ticking up even in the EEF community that is rightly well regarded for notably leading productivity levels. It is a reasonable proposition that this increased absence trend is as a direct consequence of the workforce demographic changes outlined above and the resulting increased people risks of lowered engagement and increased absence which results in inhibited productivity.

In response, employers increasingly have to review and develop the benefits provided to ensure they remain engaging, fit for purpose and supportive of changed employee needs and expectations. Changes are focused on providing service based benefits that support the physical and financial wellbeing that are essential to engaged employees. Increasingly popular introductions to support and address these risks are workplace financial education, resources for caring workers and access to physical and psychological health education for managers and employees and that provide added value on an individualised basis.

As with traditional benefits which maintain their popularity, these developments need to be well communicated to ensure employees, and their families understand and engage with their benefits programme to maximise the value to them and their employer.

Iain Laws
Managing Director
UK Healthcare and Group Risk

[6]Office of National Statistics Statistical bulletin: UK Labour Market: May 2016 - Estimates of employment, unemployment, economic inactivity and other employment-related statistics for the UK.
[7]Managing A Health Ageing Workforce – A National Business Imperative CIPD, A guide for employers, March 2012.
[8]Employing Older Workers DWP 2012.
[9]The Positive Ageing Company http://positiveageing.co/carers-week-2015-2/, accessed on 08 June 2016.

5 INITIAL IMPRESSIONS: THE FIT FOR WORK SERVICE

The Fit for Work service – brief history

In 2011, Dame Carol Black[10] undertook a review of sickness absence to identify ways to minimise absence and to improve the sickness absence and benefits system. A lack of access to occupational health services, particularly for small and medium-sized businesses, was identified as a significant issue in preventing employees returning to work. Consequently, one of her key recommendations was the setting up of a state-funded health and work advisory and assessment service – or, as it is now known, the Fit for Work service.

The Fit for Work website and telephone advice line was launched with relatively little publicity on 16 December 2014. Assessment pilots also started across Sheffield. By March 2015 there was a further roll-out of the pilot GP referral and assessment service from the Sheffield area, extending initially to South Yorkshire and Bassetlaw in Nottinghamshire, then to Wales – Betsi Cadwaladr in Clywd and Abertawe Bro Morgannwg, Swansea.

In July 2015, the government announced that the roll-out of the GP referral service had been completed. It was not until September 2015 that employers were allowed to refer cases of long-term sickness absence to the Fit for Work service.

The service applies in England, Wales and Scotland, although it is run by a different service provider in Scotland. The service comprises three elements:

– a support website;
– a health and work telephone helpline and online support for employers, employees and GPs; and
– access to a telephone health assessment for employees on a period of sickness absence lasting four weeks or more.

The Fit for Work service – how does it work?

The normal referral route for the assessment component of the service is either via a GP or via the employer if the GP has not referred an individual after four weeks. The government expects GP referral to be the default option, although doctors are not compelled to refer patients. The service is also voluntary for employees – they are not obliged to participate or cooperate.

Employees who have, or in the GP's opinion are expected to reach, a four-week period of sickness absence can be referred to the Fit for Work service, although employees who are expected to return to work imminently without further assistance would not be suitable for referral.

The service is designed for employees who are unlikely to return to work within three months. GPs can refer earlier than four weeks if they expect the patient to be off work for more than four weeks and anticipate either a full or partial return to work.

The service adopts a case-managed approach. A case manager is assigned upon referral and is responsible for follow-up and continuity of care.

After talking to the individual via telephone (or, much more rarely, face to face), the case manager produces a return-to-work plan (RTW) which details any obstacles and recommended interventions, and a timetable when they anticipate the employee might return to work.

The case manager is expected to engage with the employer to understand the workplace and to discuss potential interventions to help a person return to work and identify whether access to an occupational health service is already available.

Although the assessment service is intended to be wide ranging, the core focus is on managing long-term musculoskeletal disorders and mental health conditions.

Fit for Work service – survey findings

Through our previous surveys we have seen trends in reported long-term sickness absence increase year on year. The Fit for Work service is an important initiative to help reduce levels of long-term sickness absence and, in particular, to tackle two of the most common causes of long-term sickness absence: MSDs and mental ill health conditions.

We said in our sickness absence survey last year that we had great hopes for the Fit for Work service but believed its ultimate success within SMEs would depend on how

[10]Dame Carol Black and David Frost, Health at work – an Independent Review of Sickness Absence, November 2011.

attractive the current government tax incentives are to employers, and that we would debate whether the current tax incentive is sufficient.

It is early days yet, but our 2016 survey has given us an opportunity to gauge the extent of awareness by companies of the Fit for Work service and discover whether or not employees are being referred.

Prevalence of long-term sickness absence

Periods of continuous absence of more than four weeks are generally considered to be long-term sickness absence. For the first time this year, we asked our survey respondents how many of their employees were absent from work for four weeks or more during 2015.

In our survey sample, 268 employees (5%) were absent from work for at least twenty continuous working days during 2015. As we did not ask respondents exactly how many days each of these employees took off from work, we do not know the true scale and can only calculate the minimum total number of long-term sickness absence days lost for the firms affected. A NICE study[11] on long-term sickness absence and incapacity to work examined a number of data sources and referenced one from the CIPD which reported that 20% of absences in 2007 lasted for four weeks (20 working days) or longer.

We know that most sickness absence is for short periods but that long-term sickness absence accounts for the major proportion of all working time lost. The CBI 2013 survey[12] reported that long-term absences lasting more than four weeks made up nearly a third (30%) of all total working time lost.

We do know that there are approximately 2.7 million employees working in the manufacturing sector. If the 5% long-term sickness absence rate found in our survey is reflected across the whole sector, we can estimate that 135,000 employees are off work per annum because of long-term sickness absence.

This means a minimum of **2.7 million working days**, or at least **11,894 person years** are lost to long-term Sickness Absence each year (based on 227 working days per year).

Our member companies either pay Statutory Sick Pay (SSP) at a rate of £88.45 per week for up to 28 weeks or Occupational Sick Pay (OSP), which in many companies can equate to full pay. Our 2015 EEF Fact Card gives the average annual pay in manufacturing as £30,900.[13]

At SSP levels of sick pay, 11,894 person years of lost work equates to approximately £30 million. **At average levels of pay for the manufacturing sector, 11,984 years of lost work equates to a cost of approximately £367.7 million.** Clearly the minimum cost to the manufacturing sector of lost work as a whole lies somewhere between these two figures.

In another survey[14] (referenced in the Frost–Black report[15]), it was calculated that out of a GB working population of 23.8 million, 4% (or approximately one million) of those workers would be absent from work for more than four weeks at any one time. The Fit for Work service will need to be prepared for a significant potential increase in the number of referrals they receive if the long-term sickness absence rate in the UK is hovering at around the 4–5% level.

Awareness

What was surprising was the high level of awareness about the Fit for Work service. Anecdotal evidence had suggested that the message was not getting out there. Clearly the new service has been actively promoted by EEF, but firms told us that they have seen very little information or publicity from government.

We found that although four-fifths (78%) of respondents are aware of the Fit for Work service, only just over a twentieth (6%) have used it. Of those who are aware, just over half (54%) say that they would consider using the assessment service but have not used it yet.

[11]NICE, PH19, Workplace Health: Long-term Sickness Absence and Incapacity to Work – Public Health Guideline, published 25 March 2009.
[12]CBI, Fit for Purpose: Absence and Workplace Health Survey 2013.
[13]2015 EEF Fact Card, available at https://www.eef.org.uk/campaigning/campaigns-and-issues/manufacturing-facts-and-figures (last accessed 19 May 2016).
[14]Young, V. and Bhaumik, C. (2011). Health and Well-being at Work: a Survey of Employees. DWP Research Report No. 751, and additional analyses by GfK NOP.
[15]Dame Carol Black and David Frost, Health at Work: an Independent Review of Sickness Absence, November 2011.

Of those, almost two-fifths (39%) of companies employ fewer than 50 employees.

One-fifth (22%) of our survey respondents were unaware of the service. When we look at the breakdown by company size in Chart 1 we can see that two-fifths of those unaware are firms employing fewer than 50 people – an audience that is difficult to reach.

Almost nine-tenths (87%) of the companies who say that they are aware of the service are also aware that they as employers can refer an employee who has been absent from work after four week of continuous absence. Strangely, only three-quarters (74%) of survey respondents are aware that a GP can refer if they believe the individual is likely to be absent from work for more than four weeks. The level of awareness is greatest in the larger employers, as can be seen in Chart 2.

Will all companies use the service?

Almost one-fifth (18%) of our survey respondents say that they do not intend to use the Fit for Work service.

This is a significant proportion. Almost three-quarters (74%) are mid-sized or large companies, which suggests that they either intend to continue using their own occupational health services or perhaps they do not clearly understand what is on offer from the Fit for Work service. If an employee's GP decides to refer an individual to the service, the company will have little choice but to engage, as the RTW plan produced by the service in effect becomes the fit note for sick pay purposes.

User experience so far

Of the seventeen employers who have used the service, fourteen have referred employees to the assessment part of the service. A total of thirty employees have been referred, all of whom gave their consent for referral. Thirteen of the fourteen companies say that they received RTW plans in respect of some or all of the employees who were referred.

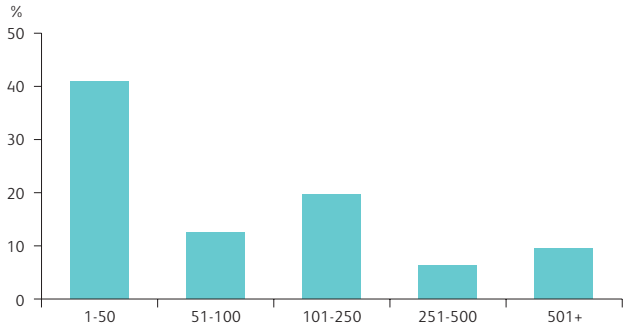
Of the RTW plans received, three specified a medical treatment, and a further seventeen recommended employee workplace adjustments. Where employers received a RTW plan specifying a medical treatment, one employer paid for the full cost of the medical treatment, one employer paid for between 41% and 60% of the medical treatment cost, and the remaining employer did not pay or was not willing to pay for the medical treatment.

Where workplace adjustments were recommended though a RTW plan, employers were able to fully accommodate six (50%) of the recommended adjustments. In only two cases were the employers unable or unwilling to accommodate. In three of the remaining four cases, employers were able accommodate some of the suggested workplace adjustments.

Chart 1

Micro companies unaware of Fit for Work service

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

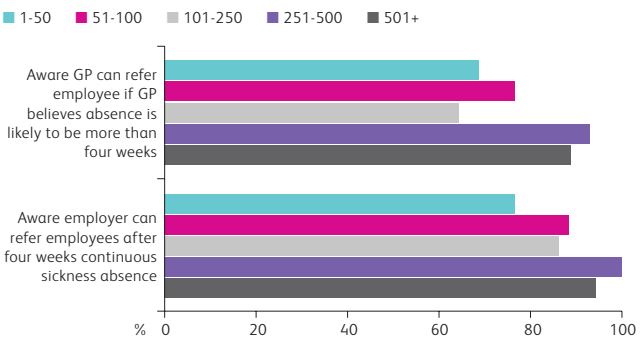


Source: EEF Sickness Absence Survey 2016

Chart 2

Knowledge of employer referral route high

% awareness of Fit for Work referral routes, by company size



Source: EEF Sickness Absence Survey 2016

Although we have very limited user experience so far, survey respondents were asked whether the service has helped their employees make an earlier return to work. From EEF's perspective this is the most important performance indicator for the Fit for Work service. Of the fourteen companies who referred employees to the service there was a mixed response: seven said that it helped their employees make an early return to work compared with six who said it had not.

Fit for Work tax exemption

Just over three-quarters (77%) of survey respondents 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. Lack of awareness was generally within SMEs.

Although the tax exemption is being marketed by the government as a benefit for employers, it is nothing of the sort. Under existing tax rules, the cost of any medical intervention funded or provided by an employer means that the employee is likely to be liable to tax and National Insurance contributions as either a benefit in kind or a payment of earnings. This tax exemption simply means that the employee will no longer be eligible for tax or National Insurance of up to £500 a year should they take advantage of a recommended medical treatment. The cost of the treatment still has to be borne by the employer, who will not realise any significant fiscal benefit apart from some potentially small savings in National Insurance contributions, which will be negated by the administrative costs of the paperwork involved.

Do companies currently pay for medical treatments?

Companies were asked whether they currently pay for medical treatments (such as medical tests, consultations, appointments, surgery) in order to reduce long-term sickness absence and get employees back to work earlier. Chart 3 shows that almost a fifth (18%) of employers currently pay for some form of medical treatment for all employees. Almost a further third (31%) of respondents say they would pay if there would be a benefit to the company of helping a particular individual. Just over two-fifths (41%) of survey respondents tell us they rely completely on NHS treatments. This is up from a third of all survey respondents last year. Most of the companies placing reliance on the NHS employ fewer than 250 employees.

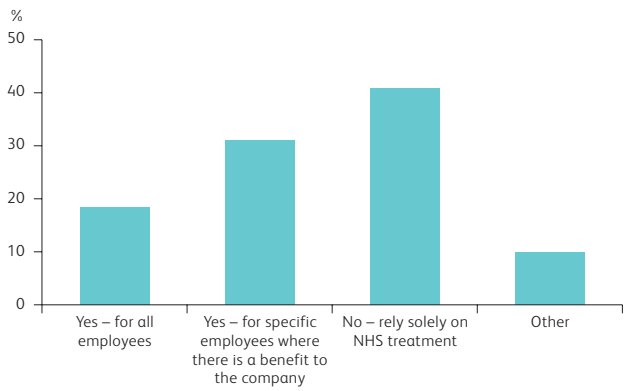
There is a problem for companies who depend solely on the NHS. We state elsewhere in this report that just under a third of our survey respondents say that waiting for employee treatment is the most common cause of long-term sickness absence. Clearly, the NHS is an extremely significant factor for employers in combating unnecessary long-term sickness absence, but this is not something that can currently be influenced by the Fit for Work service.

It is unacceptable that the duration of long-term sickness absence for many company employees is dictated by regional NHS waiting times and dependent on the type of health condition, individual circumstances and the ability of employers to pay for medical treatments.

Chart 3

Two-fifths 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

Will companies pay for medical treatments identified in RTW plans?

In our view, the success of the Fit for Work service relies heavily on employers paying for medical treatments that the service or the company occupational health providers recommend in the RTW plan. Only one fifth (19%) of our survey respondents tell us that they would be willing to pay (similar to the proportion of companies who already pay for some form of employee medical treatment), and a further fifth (21%) would not pay (similar to the proportion of respondents who say that they do not intend to use the service).

A large group, almost three-fifths (59%), of survey respondents say they are unsure whether they would pay for medical treatments or not. This suggests that employers are not yet ready to commit themselves because:

(i) they rely on the NHS for employee treatment;
(ii) they don't currently know enough about the types of medical treatment being recommended by RTW plans;
(iii) they don't know enough about the total cost of the treatment;
(iv) they might fear setting a precedent on paying for all treatments; and
(v) the decision would depend on whether paying the costs of treatment for a particular employee would be advantageous financially for the company.

Intriguingly, one might imagine that employers would give greater support to the payment of medical treatments recommended by their own occupational health services. Surprisingly, though, almost half (49%) say they don't know and a third (33%) say they would pay, but almost one fifth (18%) say they would not pay. One wonders in that case why some firms have specialist occupational health services at all for advising on long-term sickness absence cases.

Perhaps there is a greater need for employer GIP insurance. This usually encourages greater engagement by the employer in sickness absence issues at an earlier stage and helps fund RTW treatments. The cost of a GIP scheme can be offset if the cost of long-term sickness absence is taken into account against the benefits provided by the insurance. When we looked at the sickness absence rate for companies who pay for employee medical treatments, this is 2.3% compared with the 2.5% sickness absence rate for companies who do not pay. This 0.2% may not seem to be much, but it is equivalent to an extra half day at work for every employee in the company.

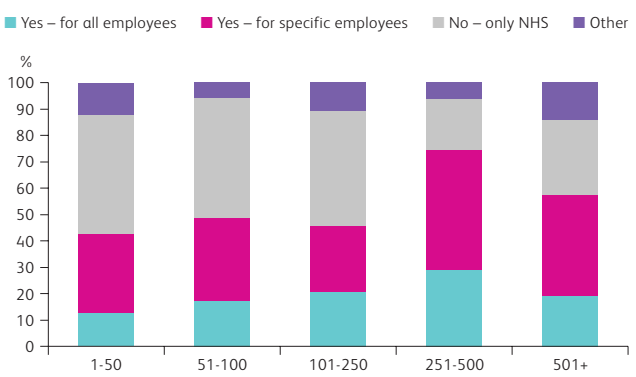
Fiscal incentives

We know that the Fit for Work service wants to target SMEs, but we also know that over 45% of employers employing fewer than 100 employees are currently heavily reliant on NHS services to deliver medical treatments for many longer-term ill-health conditions.

Chart 4

Smaller companies less likely to pay for medical treatments

% of companies paying for medical treatments, by size



Source: EEF Sickness Absence Survey 2016

Our survey this year shows that SMEs are much less likely to pay for medical treatments to get employees back to work. Chart 4 cuts the survey data by company size and demonstrates clearly that companies employing up to 250 place greatest reliance on use of the NHS, although 30% of companies employing up to 50 employees will pay for medical treatments if there is a perceived benefit to the company.

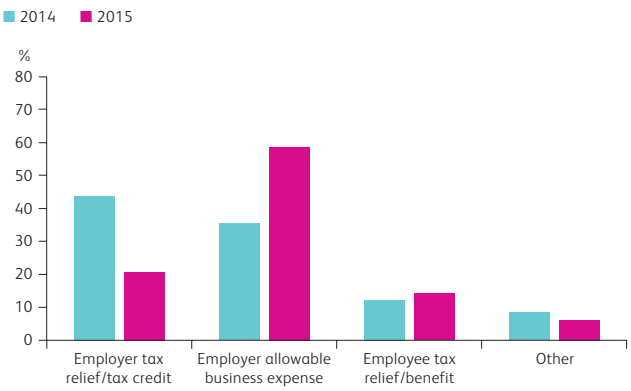
When it comes to fiscal incentives, Chart 5 demonstrates that almost three-fifths (59%) of respondents would support some form of allowable business expense as the most attractive mechanism to encourage them to pay for the cost of workplace adjustments or medical treatments. This contrasts with last year's survey where just over two-fifths (44%) told us that the most attractive incentive would be tax credits. It would appear that irrespective of the mechanism in place, employers would be more inclined to pay towards the cost of medical treatments or workplace adjustments if there were government incentives. However, treatment or insurance related to injuries or diseases that result from an employee's work is exempt from the need to report anything to HMRC[16] or pay tax and National Insurance.

[16]Expenses and Benefits: Medical or Dental Treatment and Insurance, available at https://www.gov.uk/expenses-and-benefits-medical-treatment/whats-exempt (last accessed 19 May 2016).

Chart 5

Three-fifths of companies would be incentivised by allowable business expenses

% of companies citing the main forms of tax incentivisation



Source: EEF Sickness Absence Survey 2015 & 2016

What should employers be doing now the Fit for Work service is here?

Employers should be reviewing and updating their sickness absence and attendance management policies.

Employers in particular need to:

- be aware that they can now refer an employee (with the employee's consent) to the Fit for Work service if they have been absent from work for four weeks or more;
- ensure that those within their business who are involved with the management of sickness absence are aware of the operation of the Fit for Work scheme and the possibility of being contacted by a Fit for Work case manager in relation to a RTW plan. Such employees should be aware of what they should do in these circumstances – e.g., channel all such contact centrally to HR or an internal occupational health department, as appropriate;
- review attendance management/sickness absence policies to ensure that there is nothing which is inconsistent with the operation of the Fit for Work service, in particular taking into account that a RTW plan can replace a fit note as evidence of sickness absence;
- consider developing a consent form in which the employee consents to be referred to the Fit for Work service and for the RTW plan to be shared with the employer;
- understand that company occupational health services can now recommend medical treatments which may be eligible for a £500 (per employee, per year) tax exemption;
- consider taking out group income protection.

The Fit for Work service – what next?

The role out of the Fit for Work service so far has been at a relatively gentle pace. This is largely a reflection of lack of awareness by both GPs and employers and has meant that the providers of the service have currently been able to meet demand.

We hope, with better communications, that more and more GPs and employers will start to refer employees to the service and that the providers will find themselves under more scrutiny to deliver a service which demonstrates that employees are making earlier returns to work.

We wish the service well, but would like to see the following points addressed to make it more effective going forward:

- make all GPs and employers aware of the service;
- publicise the performance indicators which are going to be used to assess whether employees are making an earlier return to work as a result of the Fit for Work service;
- expedite greater referral of employees to the service by GPs;
- allow employers to use the same referral criteria as GPs;
- ensure that the employer is consulted about the RTW plan before it is agreed and finalised by the Fit for Work service and employee;
- allow flexibility to the current restriction limiting availability of the Fit for Work service to employees likely to return within three months;
- remove the current restriction which limits referral of an individual to the service to only once a year.

We think that the service will only be successful if the government puts fiscal incentives in place to encourage companies, particularly SMEs, to pay for medical treatments recommended by the Fit for Work service or company occupational health provider. In the same way as companies invest in new machinery and research and development to help boost productivity, they must be given the same incentives to invest in the health of the working-age population. Keeping people fit and in work is a key to bigger productivity gains for the UK.

6 MANAGEMENT OF LONG-TERM SICKNESS ABSENCE

Last year was the first year we asked companies for specific information about the three main interventions they adopt to manage MSD-related and mental-health-related long-term sickness absence in their workplace. We also asked whether they had paid for employee medical tests, consultations, appointments, treatments, etc. to help reduce long-term sickness absence.

Musculoskeletal conditions

Chart 6 helps us understand how companies manage absence associated with back problems and other musculoskeletal disorders. Like last year, just over three-quarters (76%) of the respondents say their main intervention relies on task modification in some way (which can include rest periods, job rotation, force, duration, etc.), followed by access to professional occupational health advice, and/or provision of rehabilitation (67%) and training (40%).

Chart 7 indicates the degree of take-up for each of these intervention approaches. This shows that the larger the company, the more likely it is able to provide interventions such as task rotation, rest periods, rehabilitation services and occupational health advice. Smaller companies rely more heavily on interventions such as task alteration, equipment alteration, workload reductions and training. Smaller companies with finite numbers of staff do not always have the ability to rotate staff between different tasks.

Just over one-twentieth (5.3%) of employers, a decrease from 7% last year, indicate that they do not implement any specific approach for managing long-term sickness absence related to back problems and other musculoskeletal disorders. Unsurprisingly, many are companies employing fewer than 50 employees.

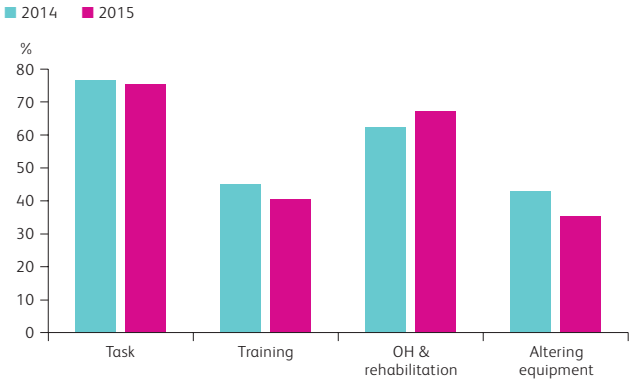
Mental ill health conditions

Chart 8 examines the main interventions adopted by companies for mental-health-related long-term absence. We found that most of the main approaches adopted are unchanged from last year's survey data, with the exception of wellness recovery action plans.

Chart 6

Three-quarters of respondents modify workplace tasks to manage MSDs

% of companies citing their main interventions in managing MSDs

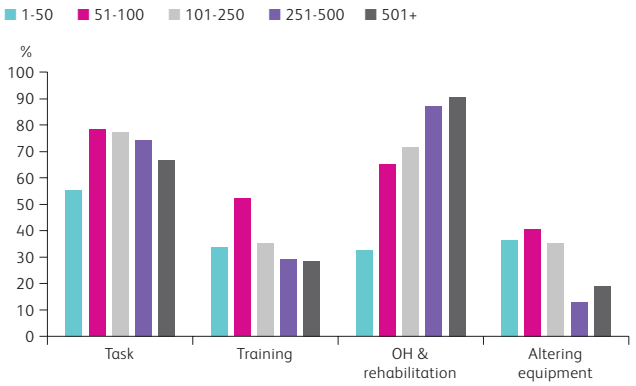


Source: EEF Sickness Absence Survey 2015 & 2016

Chart 7

Larger companies rely most heavily on occupational health and rehabilitation

% of companies citing the main approaches to managing MSDs, by size



Source: EEF Sickness Absence Survey 2016

In last year's survey, one-fifth (20%) said that they rely on the development and management of individual wellness recovery action plans. This is down to just over a tenth of respondents (12%) this year. Part of the reason may be because respondents were presented with an additional intervention option: the provision of workforce stress risk assessments. Almost one-fifth (19%) of companies say that they have stress risk assessments in place for their workforce, and it seems likely that wellness recovery action plans and workforce stress risk assessments are inextricably linked.

With very similar results to last year, just over a half (54%) of our survey respondents rely on staff support mechanisms to help employees, and a third (33%) provide talking therapies such as counselling or CBT. It would seem that companies value programmes that provide personal support as a vehicle for reducing depression levels and sickness absence.

There is a small increase in the number of respondents who say they provide mental health training for line managers and supervisors, from 10% to 13%, and a very small increase from 6% to 7% providing mental health awareness training for employees.

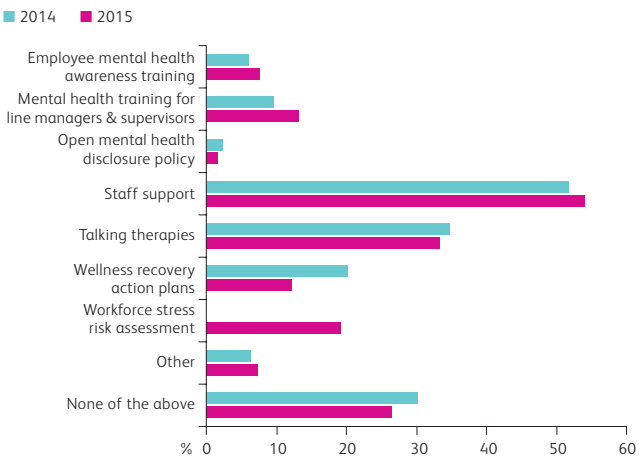
Are these interventions effective? At the first glance it would appear not, but this may be a reflection of the way in which the interventions were implemented in individual companies rather than the intervention itself. The sickness absence rate for companies utilising any of the mental health management interventions specified was 2.4% (5.5 days), compared with the general annual sickness rate of 2.3% (5.3 days) and compared with 2.2% (5.0 days), for companies who do not implement any of these interventions. It may be that those companies who have a higher sickness absence rate owing to mental health problems have decided to put interventions in place to reduce the higher sickness absence rate.

We were surprised in last year's survey to find that almost one-third (30%) of survey respondents did not have interventions in place to manage mental-health-related long-term sickness absence. This year has seen a marginal improvement. Just over a quarter (27.5%) do not have any provisions in place. If we look at company size, almost two-fifths (40%) of micro and a quarter (25%) of small companies do not have provision in place.

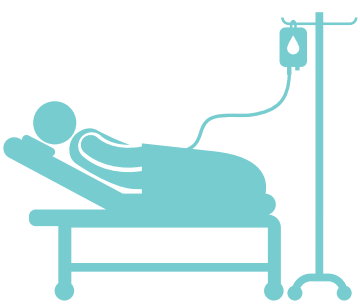
Chart 8

Half of respondents rely on staff support to manage mental health

% of companies citing their three main approaches to managing mental health



Source: EEF Sickness Absence Survey 2016



When we start to look at the types of intervention taken by company size, Chart 9 illustrates how the range of intervention tools used by employers is directly related to company size, with the notable exception of staff support, workforce stress risk assessments and open mental health disclosure policies. Staff support (whether formalised or not) is offered by roughly half of all employers irrespective of the size of the company. Workforce risk assessments are just as likely to be undertaken by SMEs as the largest employers. Employers across the board do not fare well in developing open mental health policies which create cultures that encourage employees to disclose mental ill health as well as physical ill health. We have a long way to go.

Medical restrictions

There is a subset of employees who are absent from work and who may have temporary medical restrictions which present 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. We asked employers what proportion of employees with medical restrictions they find difficult to accommodate. Chart 10 illustrates how almost two-thirds (61–65%) of employers can accommodate either temporary or permanent restrictions.

This is consistent with the results of our previous surveys, where more than 50% of employers said they were able to make all the workplace adjustments required for medical conditions specified on fit notes.

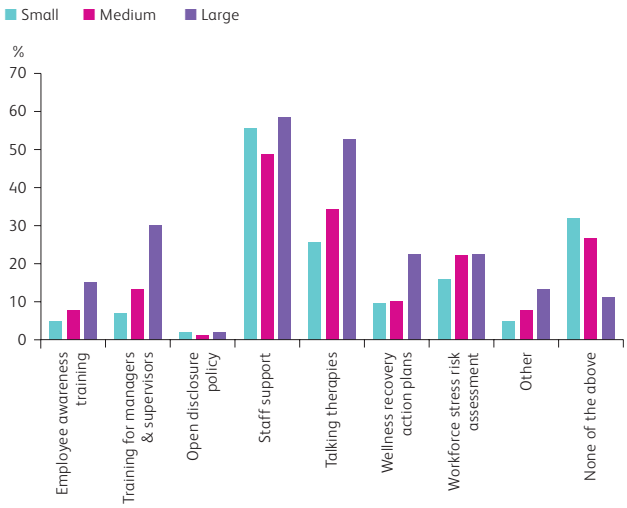
Employers are clearly willing to make workplace adjustments for their staff, but even so, we found that almost a third (29%) of companies have had at least one incidence of finding it difficult to accommodate an employee with a permanent medical restriction. For temporary medical restrictions, one-fifth (22%) find it difficult. It is not surprising that permanent restrictions are harder to accommodate than temporary ones, given the likely increased burden on other workers.

In terms of managing long-term sickness absence in the workplace, this is a welcome message, especially as Fit for Work service RTW plan recommendations are increasingly likely to specify workplace adaptations for employees to enable them to return to work.

Chart 9

Most companies do not have open mental health disclosure policies

% of companies citing the main approaches to managing mental health, by size

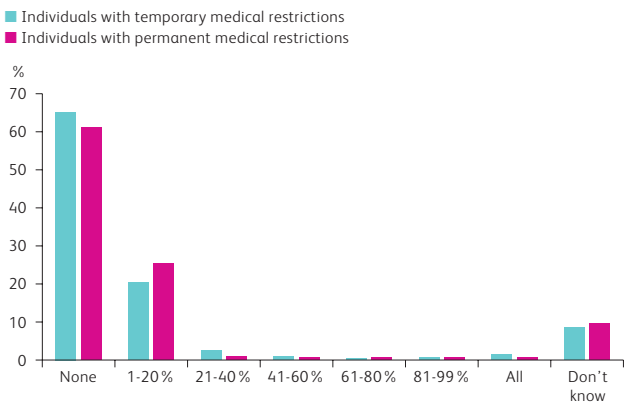


Source: EEF Sickness Absence Survey 2016

Chart 10

60% of firms do not find it difficult to accommodate medical restrictions

% of companies' accommodating medical restrictions



Source: EEF Sickness Absence Survey 2016

As well as implementing adjustments to accommodate both permanent and temporary medical restrictions, companies sometimes have to make decisions about whether employees should be asked to leave as a consequence of sickness absence. We asked our survey respondents about the key factors they take into consideration before making this difficult decision. Unsurprisingly, Chart 11 tells us that two-thirds (66%) of employers believe the most important factor they need to consider is the employee's actual fitness for work, closely followed, for almost two-thirds (65%) of survey respondents, by medical reports and levels of absence (53%).

In terms of fitness for work, more than 60% of our survey respondents told us that they accommodate both permanent and temporary medical restrictions. Clearly we cannot isolate an individual's fitness for work from the need by business to make all necessary workplace adjustments and/or to provide rehabilitation.

Cost of sickness absence

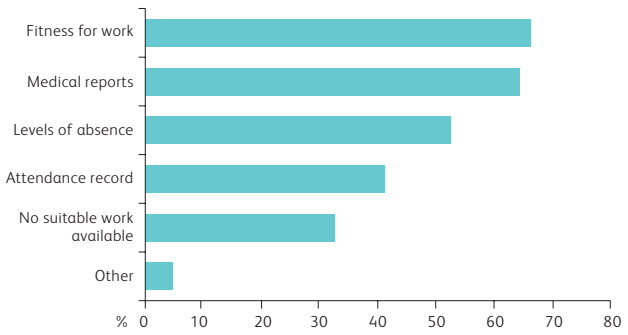
We asked companies whether or not they measure the economic cost of sickness absence. This year, respondents were only given the choice of a 'Yes' or 'No' answer, whereas in previous years they were given a 'Don't know' option. As a consequence, almost a third (32%) now say they do measure the economic cost, compared with a fifth (18%) in our 2015 survey. However, we still find it surprising that more than half (55%) of large companies employing more than 500 say that they do not measure the economic cost. See Chart 12.

The reported average sick pay cost per employee from our latest survey is £211, compared with £374 last year: a significant drop. The range in annual sick pay paid for any one individual varied between £0 and £1,579. This variation in sick pay can be accounted for by the fact that some companies just offer SSP, some pay specific rates of OSP and others pay normal salary costs.

Chart 11

Fitness for work is the key factor in maintaining employment status

% of companies citing the key factors in asking an employee to leave the business

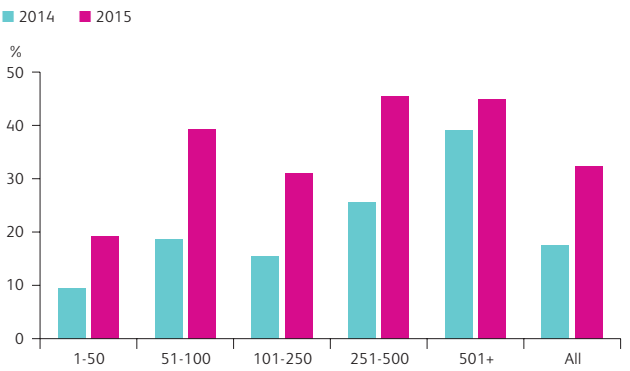


Source: EEF Sickness Absence Survey 2016

Chart 12

Just under half of large companies measure economic cost of sickness absence

% of companies measuring the economic cost of sickness absence



Source: EEF Sickness Absence Survey 2015 & 2016

If we look at the total sick pay bill from a company perspective, our survey uncovered a range between £0 and £1.6 million, which clearly is dependent on company size and number of employees. The mean sick pay cost per company in 2015 was £42,950.

We know that the true cost to a company of sickness absence is much higher than just sick pay costs. This figure does not reflect all the other direct costs, such as the replacement costs of absent individuals, additional overtime needed to cover absences, lost production costs, or the many indirect costs, such as reduced performance and productivity, missed business opportunities or impact on company image.

For the ≈2.7 million manufacturing sector employees who work in the UK,[17] this indicates a total sick pay cost for the sector of ≈ £0.6 billion, which is only a proportion of the direct costs which might be incurred. Clearly, companies should be helping themselves much more by starting to measure the total economic cost to their business by measuring at least the other direct costs mentioned above.

The CIPD in their 2015 survey[18] reported that the median cost of absence per year for the manufacturing and production sector was £557. This therefore equates to an estimated total absence cost for the sector of £1.5 billion.

Chart 13

Few companies evaluate their health and well-being spend

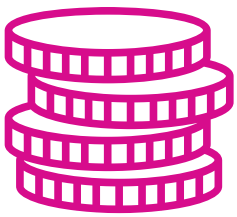
% of companies measuring the return on investment of health and well-being benefits and services or their impact on sickness absence

Source: EEF Sickness Absence Survey 2014, 2015 & 2016

Impact of investment in health and well-being benefits and services

Over the last three years of the survey we have asked whether or not companies measure the return on investment for the health and well-being benefits and services they offer, and the impact of those benefits and services on sickness absence levels.

The position shown in Chart 13 is still disappointing, although the situation does appear to have improved. A very high proportion of companies (94%) do not measure the return on investment for the well-being benefits or services they offer their employees. This is surprising if we consider that the average spend (or investment) per employee on well-being, health promotion and lifestyle advice is £84, not too dissimilar to last year's reported spend of £91.



For the **2.7 million** manufacturing sector employees who work in the UK, **total sick pay costs £0.6 billion.**

[17]Office for National Statistics, EMP14: EMP14: Employees and Self-employed by Industry, May 2015, Available at http://www.ons.gov.uk/ons/rel/lms/labour-market-statistics/may-2015/table-emp14.xls (last accessed 24 May 2015).
[18]CIPD Annual Survey Report 2015: Absence Management.

In addition, nine-tenths (90%) of companies are not able to say whether the money they spend and allocate to health and well-being results in a reduction in the level of sickness absence or in positive impacts on employee satisfaction surveys.

The responses from our past three surveys have shown a marginal improvement. Companies are not asking basic questions on why they spend money on health and well-being. It does seem astonishing, unless these services are offered principally to attract and retain employees or to be seen to be doing the right thing. Employers could readily evaluate their spend by copying what other companies have done (such as using the government's Responsibility Deal website, or well-being tools like the Business in the Community (BITC) Workwell model).[19]

Long-term sickness absence – what now?

In the management of mental health, we are reassured by the proportion of companies providing staff support mechanisms, counselling or CBT. Less reassuring are the low levels of mental health training provided for line managers and supervisors (13%, compared with 30% for all employment sectors in the 2015 CIPD survey) and employees (8%). Much more work needs to be done in our sector in establishing workforce stress risk assessments, in developing workplace cultures that support the implementation of open mental health disclosure policies and in tackling the hard-core 25% of companies who currently take no action at all in supporting employees with mental health problems.

We are finding that companies are much more actively involved with workplace interventions to reduce MSDs. There are 5% of companies doing nothing, but that figure is reducing. The key question is whether these interventions are effective. Our evidence does not yet suggest lower sickness absence rates for those companies who make these interventions. We need to do some work around the effectiveness of workplace interventions in reducing long-term sickness absence.

There is a significant subset of employees with long-term sickness absence who will not benefit from the Fit for Work service and whose employers are unlikely to pay for medical treatments in the current fiscal climate. For employees relying on the NHS for treatment, their length of absence from work is dictated by NHS waiting lists.

The current NHS eighteen weeks referral to treatment (RTT) pledge[20] means that some employees unnecessarily become a long-term sickness absence statistic.

Unless the NHS radically changes the response times it can offer the working-age population, we are only left with one tenable option – referral to the private medical sector. If the government is serious about reducing long-term sickness absence, it has to look outside the Fit for Work service and look more generally at the availability of rapid access to medical services. One way for the NHS to embrace work and health is to embed a target looking at a return to work for the patient.

Why do just over two-thirds of our survey respondents not measure the economic cost of sickness absence? Why do a third of businesses not have a sickness absence target? Why do most businesses in our survey who spend money on health and well-being benefits and services not know whether this spend is value for money in improving employee health and reducing sickness absence? These are clearly areas where businesses need to exercise greater scrutiny, and EEF has a role to play in developing tools that will help our member companies:

(i) reduce the costs associated with lost productivity and absenteeism; and
(ii) determine whether health and wellness programmes actually improve health, enhance well-being and incentivise attendance at work.

Plainly, employers need to do much more to assess the impact of the policies, benefits and services they introduce into the workplace and to target those that are most effective in helping to reduce the levels of long-term sickness absence. They also need to better appreciate the significant financial benefits associated with the successful management of long-term sickness absence.

[19]Public Reporting Guidelines on Employee Engagement and Wellbeing, available at http://wellbeing.bitc.org.uk/awards-benchmarking/public-reporting-guidelines (last accessed 19 May 2016).
[20]Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care, NHS England, October 2015.

7 THE FIT NOTE: PAST ITS SELL-BY DATE?

We are a little unsure about the nature of the relationship between the fit note and the Fit for Work service going forward. We are unconvinced of the extent to which GPs will bother to continue recording 'may be fit for work' on fit notes when they know they have a backstop in the Fit for Work service. Does it matter? Our view is that GPs should endeavour to continue assessing employees' functional capacity for work in order to minimise the number of individuals moving from short-term sickness absence into longer-term sickness absence.

Quality of GP advice and early return to work

In our 2015 survey we concluded that the fit note wasn't working on the basis of two key success measures we had evaluated over a five-year period. These were:

(i) whether employees return to work earlier; and
(ii) whether employers receive good advice from the GP.

We decided that there was still value in monitoring these key performance measures, and the results from our 2016 survey can be seen in Charts 14, 15 and 16.

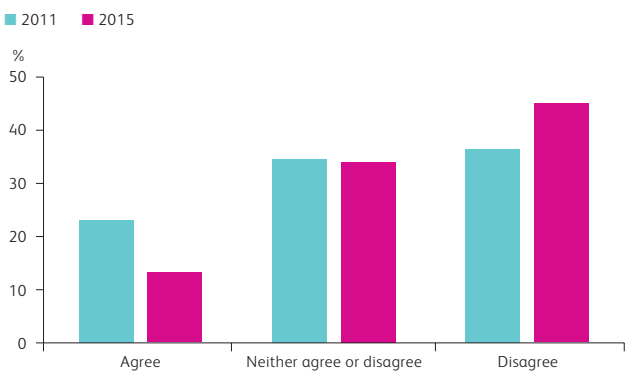
Our latest survey tells us (in Chart 14) that two-fifths (45%) of employers are reporting that the fit note is not helping employees to return to work earlier (up from 35% in 2010). This compares with 13% (24% in 2010) who say that it has resulted in earlier returns to work. The balance or difference between those agreeing and disagreeing has increased from -11% in 2010 to -32% in 2015.

If we look at the advice given by GPs about employees' fitness for work in 2015 in Chart 15, more companies disagree (47%) than agree (13%) that this advice has improved. Again, the balance or difference between those agreeing and disagreeing has increased from -21% in 2010 to -35% in 2015.

Chart 14

Fit note is still not helping employees make an early return to work

% of companies agreeing with statement that fit note has 'helped employees make an earlier return to work'

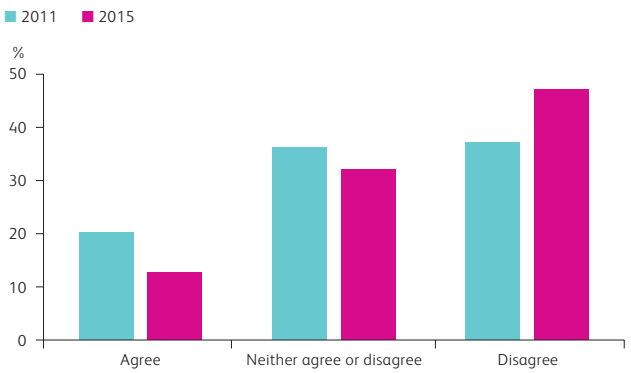


Source: EEF Sickness Absence Surveys 2011 & 2016

Chart 15

Fit note still not improving GP advice about employees' fitness for work

% of companies agreeing with statement that fit note has 'improved the advice given by GPs about employees' fitness for work'



Source: EEF Sickness Absence Surveys 2011 & 2016

Chart 16 shows how over the course of six years more companies have disagreed than agreed every year with the statements that the fit note has 'improved the advice given by GPs about employees' fitness for work' and the fit note has 'helped employees make an earlier return to work'.

Charts 14 and 15 also show that there is still a significant proportion of companies who neither agree nor disagree that GPs' advice is helpful, or that employees are being helped to make earlier returns to work. This would suggest to us that they are yet to be convinced that the perceived benefits of the fit note have or will ever be realised.

Fit note information

One of the biggest barriers for employers in accommodating medical restrictions is related to the information (or lack of) that GPs include on the fit note. We asked employers to what extent they agree that the advice included on the fit note by the GP has helped them make adjustments at work for their employees. Chart 17 shows that GPs still have a long way to go. More than half (52%) of employers disagree that the GPs' advice has helped.

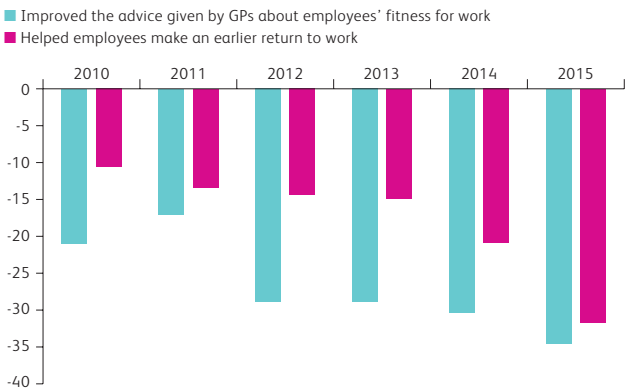
Fit note improvements

In our previous surveys we have expressed enormous concern about the low number of GPs who have been trained in the use of the fit note. Perhaps we need a change of tack. We have started to question whether only GPs or doctors should be able to sign the fit note. When it comes to occupational health and the functional capacity of employees, they may not be best placed to say whether someone is fit for work or not.

Chart 16

Employers' views about fit note have become increasingly negative

Balance of companies who agree or disagree with statements that fit note has 'helped employees make an earlier return to work' and 'improved advice given by GPs about employees' fitness for work'

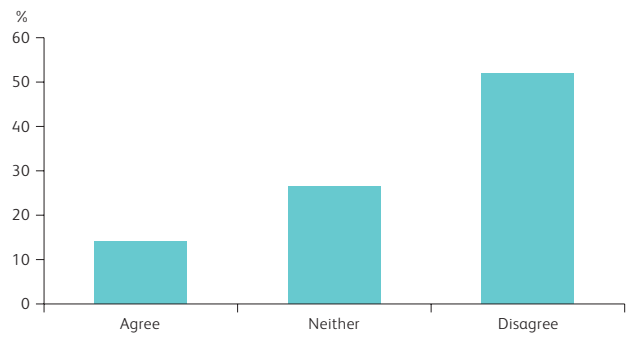


Source: EEF Sickness Absence Surveys 2011 to 2016

Chart 17

Fit notes contain insufficient advice on adjustments

% of companies agreeing with statement that fit note 'provided sufficient advice to help make adjustments at work for employees'



Source: EEF Sickness Absence Survey 2016

If we look at the RTW plans coming out of the Fit for Work service, these are effectively fit notes, but they do not necessarily require a GP or doctor to sign them off.

Who should sign the fit note

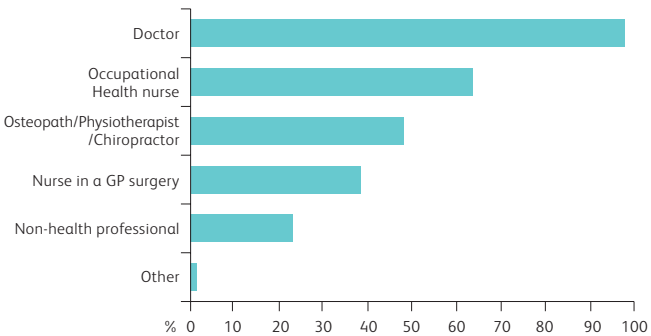
Because the fit note has not been considered to be a particular success in the eyes of our respondents, we decided to ask whether they would consider it acceptable for a range of medical professionals to sign off a fit note. Chart 18 shows the results.

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.

Chart 18

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 Survey 2016

If we compare our 2015 data with that gathered in our 2009 survey, before the fit note came into force, we can clearly see in Chart 19 that almost four-fifths (79%) of our company respondents would now accept a fit note signed by one of a whole variety of medical professionals.

Such a transformation would be welcome, but it will require legislative change and an appropriate level of training. It would change the nature of the traditional doctor–patient relationship, but perhaps it is something we should embrace if it makes the fit note work and improves the flow of employees back into the workplace before they become long-term sickness absence statistics.

Fit note future?

The fit note dynamic has changed with the introduction of the Fit for Work service and the introduction of RTW plans.

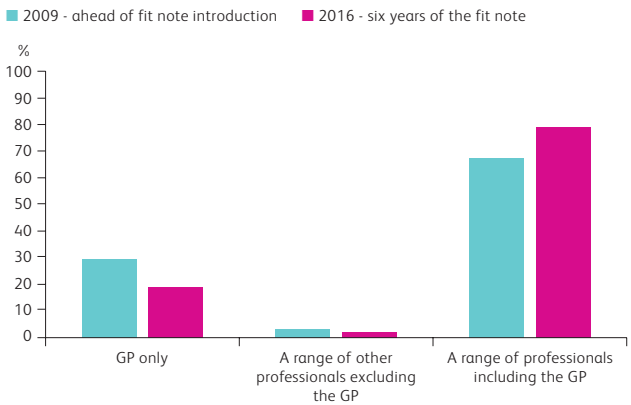
What is most important in the sickness absence debate is that we try to prevent individuals sliding into long-term sickness absence, no matter how it is achieved. Keeping people fit and healthy keeps people in work, which ultimately is good for their employer, productivity and the wider economy.

If we want to see more 'may be fit for work' fit notes, whatever the duration of the likely sickness absence, then perhaps it is time to let the most appropriate medical professionals sign fit notes. An obvious example is where an individual has been undergoing physiotherapy for a musculoskeletal condition. The physiotherapist might be better placed than the GP to advise employers on the work adaptations or modifications which could aid an earlier return to work. Maybe it is time to relieve GPs of some of their workload.

Chart 19

Signing fit notes should not be limited to GPs

% of companies citing which professionals should be able to sign fit notes, by year



Source: EEF Sickness Absence Surveys 2009 & 2016

8 ABSENCE TRENDS

Chart 20 shows that the average number of days lost to sickness absence in this year's survey stands at 5.3 days (an increase of 0.2 days from 2014, which is equivalent to an absence rate of 2.3%. This still compares favourably with the 2015 CIPD survey which shows overall absence levels per employee at 6.9 days: 8.7 days per employee for the public sector, 5.9 days for the manufacturing and production sector and 5.8 days per employee for private sector services.[21]

Manual workers, at 6.5 days (2.9%), continue to have higher levels of sickness absence than non-manual employees, at 3.6 days (1.6%). The absence rate for manual workers has increased by 0.4 days in 2015 from the lowest level previously recorded in 2014. We also saw a small increase of 0.1 days of sickness absence per non-manual employee in 2015 over that reported in 2014.

The average number of days lost to sickness absence has been fluctuating at or around five days (or a rate of 2.2%) for the past six years, but this has been slowly climbing from a low of 4.8 days in 2013 to 5.3 days in 2015. This is highly likely to be the result of improved economic growth in the general economy and greater job security leading to people feeling they can take time off work if unwell rather than turning up for work when ill (presenteeism).

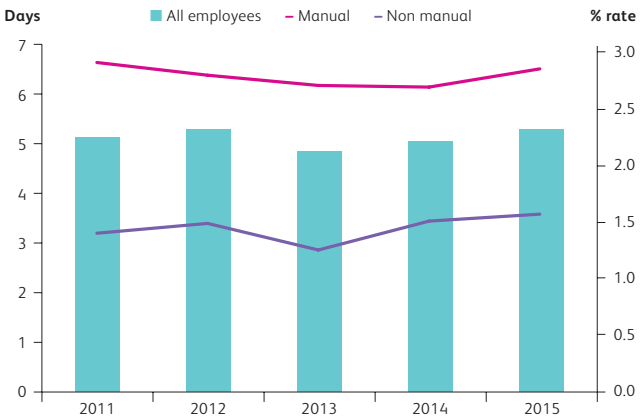
The average number of days lost to firms with 1–50 employees equates to 4.2 days (1.9%), a decrease of 0.2 days compared with 2014 data, while for all other sizes of companies, the average rate is more than 5.5 days (2.4%) – a jump from the 2014 level of 5.0 days (2.2%). Large companies with 501+ employees have the highest average number of days lost, at 6.1 days (2.7%). Companies employing between 50 and 500 employees show a significant increase in sickness absence from 2.2% in 2014 to 2.5% in 2015.

Just over half (54%) of companies report that they have an absence target. The data over a five-year period suggests that roughly a third of our survey respondents (34% in 2015) do not set a sickness absence target at all. See Chart 21. It may well be that they do not realise the benefits that can accrue from proactively managing sickness absence and reducing associated costs.

Chart 20

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

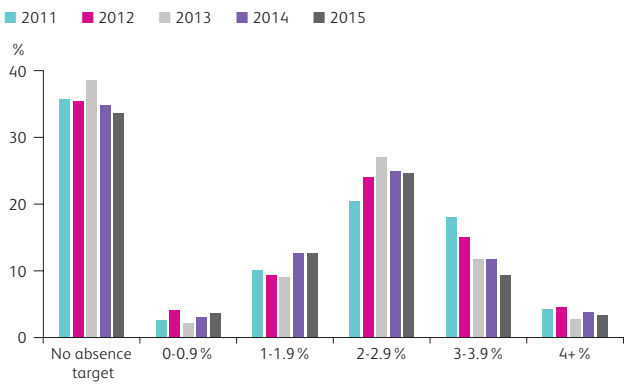


Source: EEF Sickness Absence Survey 2016

Chart 21

Two-thirds of firms have an absence target

% of companies setting absence target by year



Source: EEF Sickness Absence Survey 2012 to 2016

[21]CIPD Annual Survey Report 2015: Absence Management.

Just under half (48%) of companies with 1–50 employees did not set a target in 2015 compared with just over half (54%) in 2014 and almost two-thirds (63%) in 2013. This is still showing worthwhile improvements for SMEs.

Last year we found that only companies with fewer than 100 employees set very low sickness absence targets of 0–0.9% (0–2.1 days), but this year employers in the 101-250 bracket have also been setting tougher targets. Our survey tells us that in over three-quarters (78%) of cases, companies in these size brackets were able to achieve this very low target.

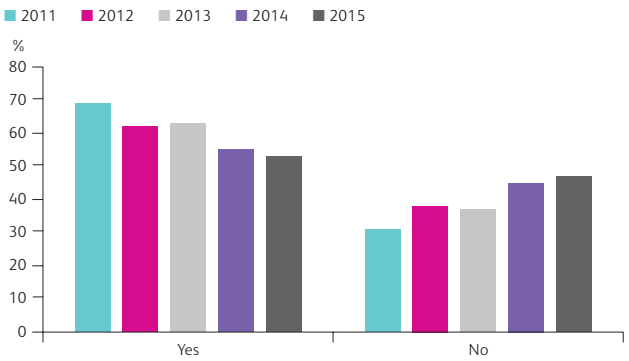
Overall in 2015 (for companies of all sizes) we see that just over three-fifths (63%) of respondents managed to achieve the sickness absence rate targets they had set of less than 2% (<4.6 days) (an improvement from 58% in 2014). Just over half (55%) (52% in 2014) achieved targets of 2–2.9% (4.6–6.6 days), 46% (55% in 2014) achieved targets of 3–3.9% (6.8–8.9 days) and almost 60% (69% in 2014) achieved targets of 4+% (9.1+ days). See Chart 22. Perversely, it would appear that those who set the least stretching sickness absence targets found them more difficult to meet.

Analysis of the data tells us that where absence rate targets were achieved, the average sickness absence rate was 2%; where they were not achieved, the average absence rate was 3.2%.

Chart 22

Just over half of companies achieved their absence target

% of companies and achievement of absence target



Source: EEF Sickness Absence Survey 2012 to 2016

Table 1 shows that a greater proportion of companies were unable to achieve the absence target they set themselves in 2015 (53%), compared with 2014 (55%) and 2013 (63%). This is a manifestation of many factors, including firms setting stretching absence targets, employees taking more sickness absence and fewer employees having zero sickness absence now that the economy has picked up and job security has improved.

Table 1

More companies achieved harder targets in 2015

% of companies setting and achieving absence target by year

	2015 % of firms setting target	2015 Achieved absence target	2014 % of firms setting target	2014 Achieved absence target	2013 % of firms setting target	2013 Achieved absence target
No absence target	33.6	0.0	34.9	0.0	38.6	0.0
0-0.9%	3.7	77.8	3.0	60.0	2.1	66.7
1-1.9%	12.6	47.4	12.7	55.8	9.0	65.5
2-2.9%	24.6	54.8	24.9	52.4	27.1	62.1
3-3.9%	9.3	46.4	11.8	55.0	11.7	57.9
4+%	3.3	60.0	3.8	69.2	2.7	77.8
All		53.2		55.3		62.7

Source: EEF Sickness Absence Survey 2014 to 2016

What we see in Table 1 over time is that more firms (albeit a small percentage) are meeting tougher sickness absence targets, but fewer companies are meeting the less-challenging targets. This may be contributing to higher sickness absence rates overall.

Just over a quarter of companies (27%) (16% in 2014) report that their short-term sickness absence (fewer than seven days) has increased in the past two years, while just over a fifth (22%) (28% in 2014) say it has fallen. See Chart 23. This clearly demonstrates a significant increase (18%) in reported short-term sickness absence over the past two years. This may partially explain the increase seen in overall sickness absence rates and the reduction in companies meeting their sickness absence targets.

Our data is telling us that short-term sickness absence is being managed most effectively by the largest companies, as the levels of reported short-term sickness absence are proportionally higher in all other sizes of company.

The picture for medium-term absence (more than seven days but less than four weeks) is a little different, with almost one-half (48%) saying that in the past two years the picture has not changed, one-fifth (20%) saying it has increased, balanced by a further one-fifth (20%) saying it has decreased.

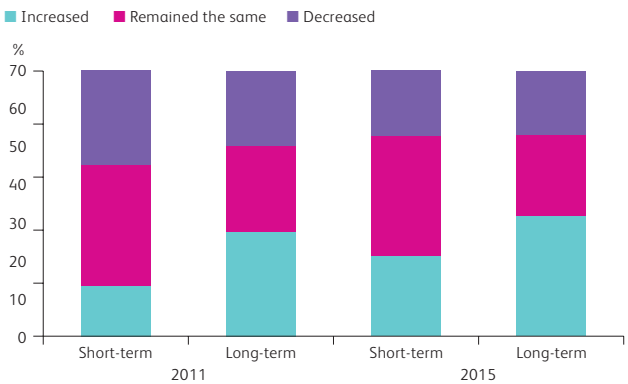
The biggest reported increase in long-term sickness absence over a five-year period was reported in our 2015 survey report (2014 data). This year's survey indicates that long-term sickness absence trends are at a similar level. Overall, two-fifths (41%) (40% in 2014) say that long-term absence has increased, and just over one-fifth (22%) (22% in 2014) say it has decreased, a difference of 19%.

Chart 24 gives an indication of long-term sickness absence trends by company size. Mid-sized companies are reporting the highest increases in long-term sickness absence compared with previous years.

Chart 23

Levels of short-term and long-term sickness absence rising

% of companies reporting change in type of absence in past two years by year

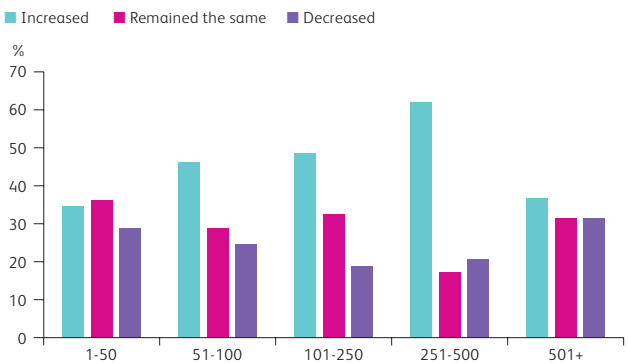


Source: EEF Sickness Absence Survey 2012 & 2016

Chart 24

Long-term sickness absence trends are still increasing

Companies reporting trends in long-term sickness absence by company size



Source: EEF Sickness Absence Survey 2016

For our 2015 data, the proportion of employees with zero sickness absence in Chart 25 is just under one-half (48%), a 3% decrease. Zero sickness absence has remained at more or less at the same 50% level for the past five years. Companies with fewer than 50 employees show a slightly higher proportion, with around 51% of employees on average taking no sickness absence, while medium and large companies show an average of around 47% of employees with zero sickness absence.

Non-manual workers continue to have higher levels (57%) of zero sickness absence than manual workers (47%).

Table 2 tells us that back problems and MSDs are ranked as the most common cause of long-term sickness absence by almost two-fifths (38%) of surveyed companies, the same as last year's survey. Back problems and MSDs scored a weighted ranking average of 4.7.

Surgery and medical investigations/tests are ranked as the second most common cause of long-term sickness absence by more than a quarter (29%) of companies, compared with just under a quarter (24%) in last year's survey. Recovery from surgery and time out for medical investigations/tests scored a weighted ranking average of 4.5.

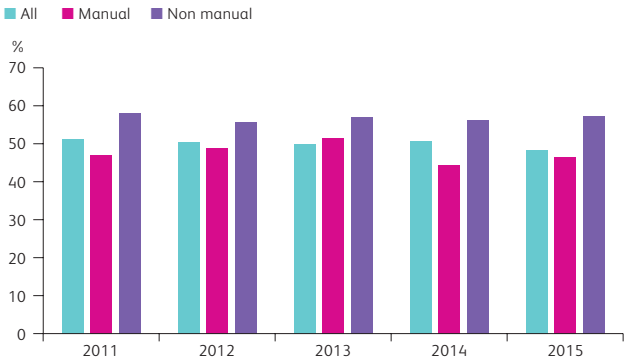
Stress and other mental ill health disorders are ranked as the third most common cause of long-term sickness absence by just over a tenth (12%) of surveyed companies, with a weighted ranking average of 4.0.

In this year's survey, firms of **all sizes** ranked MSDs as the most common cause, whereas in last year's survey companies employing more than 500 employees ranked stress and other mental ill health disorders as the most common cause.

Chart 25

Just under half of employees continue to have no absence from sickness

% of employees reported to have no sickness absence by year



Source: EEF Sickness Absence Survey 2012 to 2016

Table 2

Back problems and musculoskeletal disorders are ranked as the most common cause of long-term sickness absence

% of companies setting and achieving absence target by year

	2015 %	2015	2014
Ranked most common causes of long-term sickness absence %	**Ranked 1**	**Weighted ranking average***	**Weighted ranking average***
Back problems and MSDs	38.0	4.7	4.7
Surgery/medical investigations/tests	28.8	4.5	4.3
Stress/mental health problems	12.0	4.0	4.1
Cancer	10.4	2.9	2.8
Other	8.3	2.9	2.9
Heart problems	2.9	2.8	2.9

Source: EEF Sickness Absence Survey 2015 & 2016

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