June/2015

SICKNESS ABSENCE SURVEY 2015

"EEF stated in its 2015 EEF Manifesto that the UK's growth prospects depend on people being fit, working and productive. Keeping people in work and helping people return to work is very important for the manufacturing sector. It means boosting productivity by getting people back into work as early as is possible, as well as fostering workplace cultures and environments which proactively manage individuals' health conditions so that all can benefit from lower sickness absence outcomes."

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1 Introduction

EEF stated in its '2015 EEF Manifesto: Securing a manufacturing renaissance' that the UK's growth prospects depend on people being fit, working and productive.[1]

So, keeping people in work and helping people return to work is very important for the manufacturing sector. It means boosting productivity by getting people back into work as early as is possible, as well as fostering workplace cultures and environments which proactively manage individuals' health conditions so that all can benefit from lower sickness absence outcomes.

However, the big challenge faced by employers continues to be the management of long-term sickness associated with musculoskeletal disorders (MSDs), waiting times for diagnosis, treatment and recovery from surgery, and mental ill health. We are hoping that the flagship Fit for Work service will start to bring down levels of long-term sickness absence for MSDs and mental ill-health related conditions, but believe that its ultimate success within SMEs will depend on how attractive the current government tax incentives are to employers. As the service becomes established, we will review the take-up by employers of paying for medical treatments as recommended by the Fit for Work service or by employer-based occupational health services, and we will debate whether the current tax incentive is sufficient.

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

After five years of operation, this survey is an important opportunity to assess the success of the fit note and discuss its role going forward as more and more GPs start to interface with return-to-work plans being produced by the Fit for Work service.

In this survey, we asked companies whether or not they measure the economic cost of sickness absence, their average employee sick pay costs and the average investment they make per employee in wellbeing, health promotion and lifestyle initiatives. We also asked whether companies measure the return on investment and changes in the levels of sickness absence as a result of introducing wellbeing benefits and services.

The survey questionnaire was sent to manufacturers across the UK. We received 345 responses, covering 83,654 employees. As in previous surveys, there was a high response rate from SMEs with up to 250 employees; like last year, they accounted for four-fifths (82%) of the respondents, and the sample was representative of the whole EEF membership.

As well as the survey of members, we conducted follow-up telephone interviews in order to obtain more detailed member feedback and clarification on specific questions relating to:

- economic costs of sickness absence;
- return on investment of health and wellbeing benefits;
- impact on sickness absence levels of wellbeing benefits and services;
- average sick pay costs per employee;
- average wellbeing, health promotion and lifestyle advice spend per employee;
- approaches for managing mental ill health long-term sickness absence.

We have consistently identified key sickness absence, health and wellbeing issues which employers in the manufacturing sector as well as in industry more broadly need to address. Employers cannot resolve these issues by themselves. Governments need to set frameworks that incentivise employers and bring about lasting change if we want to be serious about helping to further reduce levels of unnecessary long-term sickness absence.

[1] EEF's '2015 EEF Manifesto: Securing a manufacturing renaissance', February 2015.

2 Key findings

The key messages arising from our survey are:

- Five years on – the government's fit note isn't working:
  - Just over two-fifths (43%) of employers disagree that it has enabled those absent from work to return to work earlier. In addition, just under a third (29%) of employers say that it has made no difference in enabling earlier returns to work.
  - There are still insufficient GP and medical professionals trained (approx. 12% of GPs; negligible numbers of hospital doctors) in the use of the fit note.
  - GPs and medical professionals are still issuing low numbers of 'may be fit for work' fit notes. Just over a quarter (26%) of companies did not receive any.
  - GPs and medical professionals are not working closely with employers to help people return to work earlier, although just under a quarter (23%) of employers provided GPs with information about work adjustments they can provide.
- Increasing concern about growing long-term sickness levels:
  - Musculoskeletal disorders (MSDs), NHS waiting lists, recovering from treatments and mental ill health top the list of long-term sickness absence issues.
  - One-third (33%) of employers rely exclusively on the NHS to manage long-term employee sickness absence arising from medical investigations, tests and recovery from surgery.
  - Almost a third (30%) of survey respondents indicate that they do not have support systems in place to help employees with mental-health-related long-term sickness absence.
- Managing long-term sickness absence:
  - Fewer than a fifth (18%) of companies measure the economic cost of sickness absence.
  - The average sick pay cost per employee is £374. This equates to a total cost of £1 billion for the manufacturing sector.
  - The average spend per employee on wellbeing, health promotion and lifestyle advice is £91, but employers do not measure its impact on sickness absence.
  - 3% of companies measure the return on investment and 5% of companies measure the impact on wellbeing or sickness of the health and wellbeing benefits and services they offer.
  - Almost four fifths (79%) of employers would be incentivised to pay for employee workplace adjustments, rehabilitation or medical treatment through the introduction of health tax credits or allowable business expenses.

Absence trends

Our survey has revealed a sickness absence rate of 2.2%, which translates to an average of 5.1 sickness absence days per employee per year. The average days lost to sickness absence has been fluctuating at around five days per employee (or a rate of 2.2%) for the past five years.

Half of employees (51%) continue to have no absence because of sickness, which has also been consistent over the past four years.

Two-fifths of companies say that long-term sickness absence has increased over the past two years. This is the largest reported increase in long-term sickness absence in the past five years. The overall highest-ranked cause of long-term sickness is back problems and other musculoskeletal disorders. Firms employing less than 50 employees ranked MSDs as the most common cause whereas companies employing more than 500 employees ranked stress and other mental ill health disorders as the most common cause.

Almost two-thirds (65%) of companies report that they have an absence target, which is an improvement over previous recent surveys. Of those that set a target in 2014, just over half (55%) achieved it.

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.

A third of companies say that these are the most difficult to make workplace adjustments for.

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 (52%) of companies rely on staff support mechanisms, systems and arrangements for managing mental-health-related long-term absence. Just over a third (35%) depend on the provision of talking therapies such as counselling or CBT, and a fifth (20%) rely on the development and management of individual wellness recovery action plans. Almost one-third (30%) of companies indicate that they do not have support systems in place to help employees with mental-health-related long-term sickness absence.

Almost half (46%) of companies say that their main approach for managing long-term sickness absence associated with medical tests, investigations and surgery is to contact the employee's GP, consultant or specialist. More than a quarter (27%) pay for private appointments or consultations, 17% pay for some form of private treatment, 12% for private medical investigations and 11% for private medical tests. A third of the survey respondents rely exclusively on NHS treatment.

Just over two-fifths (44%) of companies say they would be most incentivised by tax relief in the form of tax credits to pay for the cost of workplace adjustments or medical treatment for employees.

Five years on: Fit note verdict

The fit note medical certificate was first introduced in April 2010 and replaced 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 five years, we have seen very little. The fit note has not delivered 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.

Our latest survey tells us that two-fifths (43%) 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 22% (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 -21% in 2014. If we look at the advice given by GPs about employees' fitness for work in 2014, more companies disagree (47%) than agree (17%) that this advice has improved. Again, the balance or difference between those agreeing and disagreeing has increased from -21% in 2010 to -30% in 2014.

A slightly more positive note is that there has been a small reduction in the number of companies who did not receive 'may be fit for work' fit notes. Overall, just over a quarter (26%) of companies report that they did not receive any 'may be fit for work' fit notes in 2014, compared with 35% in 2010. Two-fifths (40%) of employers say that in 2014 between 1% and 5% of their fit notes were signed 'may be fit for work', compared with 30% in 2010. The movement is slow, but there is some progress.

This is discouraging for employers because just over two-fifths of employers (41%) say that they are able to make all the required workplace adjustments for employees with fit notes signed 'may be fit for work' (an increase from 38% in 2011). Only 8% of employers say they are not able to make any adjustments (a decrease from 18% in 2011).

We assume that the computer-generated fit note is now fully functional in all GP surgeries. We think it is time for the government to publish its anonymised monitoring data to demonstrate whether or not there are inconsistencies in the issuing of 'may be fit for work' fit notes by GPs, by GP practices, by geographical region or by receipt or not of fit note training.

Focus groups in our 2014 survey told us that they believe there to be insufficient GP and medical professional training in the use of the fit note and that there is little evidence of hospitals issuing fit notes. Little has changed.

Health and wellbeing benefits and services

This is the third year we have asked companies about the health and wellbeing benefits they provide to their employees. We were also interested in finding out whether there are benefits and services which companies are considering offering to enhance employee health and wellbeing and why.

We found that private medical insurance (63%) is the most commonly offered benefit/service for all employees. Provision of exercise advice or programmes is the least commonly offered benefit/service at 20%.

The most significant benefit offered to attract employees (67%) is private medical insurance, and to retain employees (68%) is income protection insurance. The most significant benefit offered to reduce absence (71%) is online counselling, and to improve health (91%) is smoking cessation advice or programmes.

The benefit least likely to be offered to attract (15%) or retain (15%) employees is the implementation of smoking cessation advice or programmes. The benefit least likely to be offered to reduce sickness absence (16%) and improve health (19%) is income protection insurance, a consistent finding from our 2014 survey.

What is disappointing is that only 3% of companies say they measure the return on investment of the wellbeing benefits and services they offer, and only 5% measure the impact of wellbeing benefits and services on levels of sickness absence.

3 Key messages to policymakers

Resolving long-term sickness absence

Fit for Work service

We are very 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 – i.e. MSDs and mental ill health conditions. We have seen trends in reported long-term sickness absence increase year on year.

To achieve credibility, the Fit for Work service is more likely to find success if the following conditions are created:

- resourced with health-care professionals with the right level of occupational health competence and knowledge of different industries so that the most appropriate adjustments and interventions are recommended for that work environment;
- return-to-work plans are discussed by all stakeholders – i.e. patient, GP, Fit for Work service, company and company occupational health provider, before they are agreed and finalised;
- a discussion with the employer about any proposed return-to-work plan before it is agreed by the Fit for Work service and employee;
- in the same way as companies invest in new machinery and research, they must have the right incentives to invest in the health of their employees to help prevent long-term ill health and subsequent sickness absence from work. The Fit for Work service should introduce health tax credits or allowable business expenses to incentivise employers to pay for the cost of medical treatments recommended by the Fit for Work service or occupational health provider;
- mandatory referral to the Fit for Work service by GPs of employees who have been absent or are likely to be absent from work for more than four weeks (subject to exceptions);
- Statutory Sick Pay (SSP) or Occupational Sick Pay (OSP) only paid on the condition that employees cooperate with the Fit for Work service;
- restriction on GPs from signing off a patient for more than four weeks unless the patient engages with the Fit for Work service.

Diagnosis and treatment

We must not forget that in five of our last six surveys, companies have told us that waiting times for medical tests, medical investigations, surgery and post-operative recovery are the most significant causes of long-term sickness absence. Long periods of absence can clearly impact company productivity and growth, especially for the third of companies (often SMEs) who say that they rely solely on the NHS to treat their employees and get them back to work. Again it is necessary to repeat our message from last year, that Clinical Commissioning Groups and Health and Wellbeing Boards should be tasked with facilitating reductions in waiting times from diagnosis to treatment to support both business and the public at large. If employers are to rely on the NHS it needs to be able to deliver effective rehabilitation and medical interventions within short time frames.

Perhaps we need an integrated approach to cater for the needs of employees as a separate community, bringing together Clinical Commissioning Groups and councils to develop a shared understanding of the health and wellbeing needs of the employment community and how these needs can best be addressed. This could include recommendations for joint commissioning and integrating services for health, care and wellbeing across the employment community.

Incentives for employers

As people remain in the workforce for longer, there is more that can be done to support employers in providing healthy workplaces. Incentives for companies funding medical treatments or rehabilitation should be improved and could be expanded to cover additional wellbeing and lifestyle issues if employers are to take on more responsibility for societal and public health issues.

If companies fund treatments as part of rehabilitation which would otherwise have to be provided by the NHS, or in doing so prevent state Employment and Support Allowance (ESA) payments, then tax relief should be available. Tax relief for private medical interventions (PMI) that aid return to work should

also be considered if it improves productivity by getting people back to work more quickly.

Fit-note blues – can we make the fit note work as intended?

The results of the survey show that the concerns about the fit note that have been expressed over five consecutive years are still pertinent in 2015. Employers are not seeing employees returning to work earlier, nor are they seeing improvements in the quality of GP advice to the employer. There are insufficient numbers of 'may be fit for work' fit notes being issued, even though two-fifths of employers are able to make appropriate workplace adjustments. There is almost no engagement by medical professionals in hospitals in the fit note process.

We make no apologies for reiterating what we said in our 2014 report. We asked the question, how can we move the debate further forward on the fit note to make it work better and bring about change? We held a joint summit with the Department for Work and Pensions (DWP); we brought together 24 stakeholders; we secured commitments from the DWP, the British Medical Association (BMA) and the Royal College of GPs (RCGP); and the stakeholder group identified a number of actions to make the fit note more effective.

If we really want the fit note to work and not be permanently discredited in the eyes of employers, then the following actions must be implemented:

- Set a date by which all GPs and hospital medical professionals who are required to issue fit notes have been trained in completion of the fit note.
- Link evidence of fit note training to GP and medical professional CPD and appraisal systems.
- Create e-communities to allow more effective interaction and communication between GPs, employers and employer occupational health services in the fit note process.
- Provide targeted advice for SMEs who may come across a fit note infrequently.
- Target training of line managers about awareness of the fit note process.
- Target employee awareness and training of the fit note process at induction.
- Analyse and publish GP performance in using the fit note and issuing 'may be fit for work' fit notes.
- Modify the fit note to include a referral to the Fit for Work service.
- Produce clear guidance to show the interaction between the Fit for Work service and the fit note.

We realise that the new Fit for Work paradigm could be a bit of a game changer and that in some respects this may change the way the fit note is currently utilised. We imagine that it will be business as usual for the fit note for absences of less than four weeks, where the employee does not cooperate with the Fit for Work service or where the employee or employer does not accept the return-to-work plan.

The Fit for Work service may potentially change the way in which GPs and medical professionals consider issuing fit notes for absences of short duration. There may no longer be any incentive for GPs to record 'may be fit for work' on the fit note, to specify the employee's functional capacity or to make suggestions about any workplace adjustments, amended duties, altered hours or phased return to work, any of which would allow the employee to return to work earlier.

When faced with assessing the occupational health needs of their patient, the new GP default position may be that the employee is unfit for work. This is on the basis that should absences last or be likely to last more than four weeks, the GP can simply refer the individual to the Fit for Work service, which has resource capacity and occupational health expertise. The fit note would once more in effect become a 'sick' note.

Effectiveness of health and wellbeing benefits and services

This year's survey has clearly shown (as it did last year) that fewer than 5% of companies measure the impact on sickness absence or the return on investment of the health and wellbeing benefits and services they provide.

What is the key motivation for companies offering these benefits and services if they do not measure their impact? Is it about offering a feel-good factor for employees? Is it about reducing absence or improving health? Is it about attracting or retaining staff? Are these benefits and services proven? Are they really effective?

There are any number of examples of case studies on the internet which purport to show the health and absence benefits of various types of health and wellbeing benefits and services. However, many of the measured impacts are qualitative rather than quantitative. There is little knowledge among companies about the true value of these benefits and services in improving the productivity, engagement and health of employees.

We would like to see a government research initiative which develops a 'simple' model which is able to quantify both the costs and benefits of intangible and tangible outcomes which employers can use to make informed decisions about the provision of health and wellbeing benefits in the workplace.

4 Jelf Employee Benefits market view

The survey results continue to reflect the ongoing importance of employee benefits to organisations and in support of effective employee health management. In respect of health benefits, most notably private medical insurance, costs continue to increase as these benefits are increasingly used in replacement for the NHS. The NHS continues to provide excellent care and support but has to do this with finite resources against a similarly increased demand from an ageing and less healthy population.

A direct result of this in the employee benefits market has been the development of virtual GP services which enables quicker and more convenient access via telephone, tablet or PDA technology. This has been in direct response to the growing shortage of GPs and the often significant waiting times for an appointment. Current GP retirement forecasts mean the additional GPs committed to by the government will still see a significant net drop in numbers, compounding the current problems without additional action. We expect these and other digitally provided health services to be an increasing feature of employee benefits programmes and workplace health management.

Meanwhile, there has been a return to growth in the number of people covered by company PMI plans with organisations extending the range of employees for whom this benefit is provided. This is typically to all staff or extending beyond management and supervisory into essential workers. Health Cash Plans continue to be increasingly taken up as their low cost and provision of cover for areas that the NHS has finite resources and which contribute to absence such as physiotherapy, specialist consultations in response to growth in musculoskeletal (MSK) workplace issues.

The importance of Occupational Health (OH) and growth in health benefit provision resonates with employers who are increasingly recognising the productivity impact of ill health. It is therefore a little surprising that so many organisations still do not have formalised systems to identify absences at an early stage so these can be managed through effective interventions. Reliable, easy to use absence recording systems empower employers and managers to provide the support to employees to minimise absence and manage longer term or complex cases. This in turn can have a positive impact on benefit costs as early detection and action often means lower treatment costs as well.

The growth in long-term and stress related absences can be reasonably attributed in part to this under provision of absence recording and management. With lives becoming increasingly pressured, the sources of stress are often not work related but nearly always exhibit in the workplace and contribute or cause absence. Promotion of Employee Assistance Programmes, management training in identifying signs of stress, resilience training for employees (including physical and financial wellbeing) are increasingly seen as a natural extension of employee benefits programmes.

Income protection benefits continue to be evolved to provide lower cost entry points and the inclusion of comprehensive rehabilitation programmes. While the Government has started to address the pension savings gap through the Automatic Enrolment legislation, the protection gap, particularly in the workplace, remains both a risk and an opportunity for employers.

Finally, employee benefits programmes are starting to be considered against the changing workforce demographic which is increasingly diverse with increasing diverse expectations and desires. Services specifically aimed at longer working lives, carers and working families will continue to be launched and provide practical support for the everyday issues that are unrelated to work but can impact on the workplace.

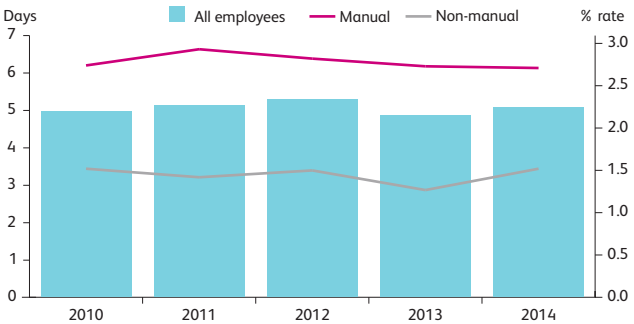
Iain Laws
Managing Director,
UK Healthcare and Group Risk

5 Absence trends

Chart 1

Sickness absence continues to fluctuate at around five days per employee or 2.2% 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 2015

The average number of days lost to sickness absence in this year's survey stands at 5.1 days (a small increase of 0.2 days from 2014), which is equivalent to an absence rate of 2.2%. This compares favourably with the 2014 CIPD survey which showed overall absence levels per employee at 6.6 days, 7.9 days per employee for the public sector, 6.2 days for the manufacturing and production sector and 5.5 days per employee for the whole private sector.[2]

Manual workers, at 6.1 days (2.7%), continue to have higher levels of sickness absence than non-manual employees at 3.5 days (1.5%). The absence rate for manual workers is at its lowest level recorded, whereas we are seeing an increase of 0.6 days sickness absence per non-manual employee over that reported in 2013.

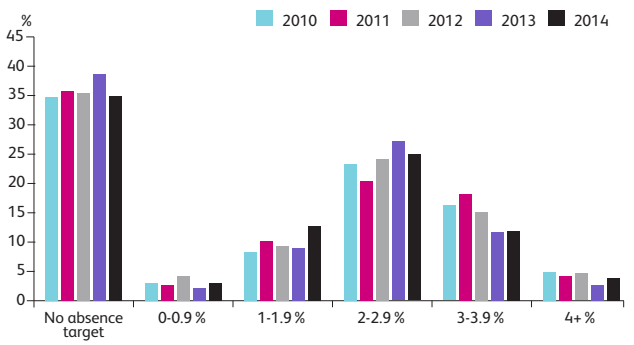
The average number of days lost to sickness absence has been fluctuating at or around an average of five days (or a rate of 2.2%) for the past five years.

The average number of days lost to firms with 1–50 employees equates to 4.4 days (1.9%), while for all other sizes of companies (apart from mid-sized companies), the average rate is more than 5.0 days (2.2%). Large companies with 501+ employees have the highest average number of days lost, at 6.3 days (2.8%). This is a similar picture to the average number of days seen in previous surveys.

Chart 2

Two-thirds of firms have an absence target

% of companies setting an absence target by year



Source: EEF Sickness Absence Survey 2011 to 2015

Almost two-thirds (65%) of companies report that they have an absence target. This is a small improvement on the 61% of companies who set an absence target in 2013. The data over a five-year period suggests that roughly a third of our survey respondents (35% in 2014) do not set a sickness absence target and are not realising the benefits that can accrue from proactively managing sickness absence and reducing associated costs.

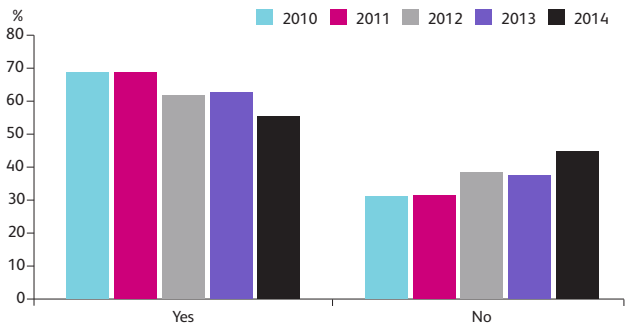
Just over half (54%) of companies with 1–50 employees did not set a target in 2014, compared with almost two-thirds (63%) in 2013. This is a significant improvement. What is surprising is that almost one-third (30%) of larger companies (501+ employees) did not set a target in 2014, compared with one-tenth (13%) in 2013. It is still only companies with fewer than 100 employees who set very low sickness absence targets of 0–0.9% (0–2.1 days), and our survey revealed that in almost two-thirds of cases these companies achieved that target.

[2] CIPD Annual survey report 2014 – Absence management.

Chart 3

Just over half of companies achieved their absence target

% of companies and achievement of absence target



Source: EEF Sickness Absence Survey 2011–2015

Overall in 2014 we saw that almost three-fifths (58%) of respondents managed to achieve the sickness absence rate targets they had set of less than 2% (<4.6 days), 52% achieved targets of 2–2.9% (4.6–6.6 days), 55% of 3–3.9% (6.8–8.9 days) and almost 69% achieved targets of 4+% (9.1+ days).

Analysis of the data tells us that where absence rate targets were achieved, the average absence rate was 2% (4.6 days), and where they were not achieved, the average absence rate was 3% (6.8 days).

Table 1

Fewer companies achieved absence target in 2014

% of companies setting and achieving absence target by year

	2014		2013	
	% of firms setting target	Achieved absence target	% of firms setting target	Achieved absence target
No absence target	34.9	0.0	38.6	0.0
0-0.9%	3.0	60.0	2.1	66.7
1-1.9%	12.7	55.8	9.0	65.5
2-2.9%	24.9	52.4	27.1	62.1
3-3.9%	11.8	55.0	11.7	57.9
4+%	3.8	69.2	2.7	77.8

Source: EEF Sickness Absence Survey 2014 & 2015

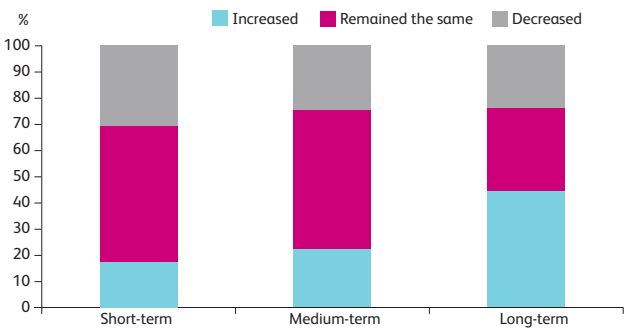
Table 1 shows that a greater proportion of companies were unable to achieve the absence target they set themselves in 2014 (55%) compared with 2013 (67%). This is likely to be a reflection of a number of factors, including more firms setting absence targets for the first time, employees taking longer periods of sickness absence and fewer manual employees having zero sickness absence as we come out of a recession.

It is difficult to define an achievable sickness absence rate without incurring sickness presenteeism. From the evidence we have, most companies with fewer than 100 employees could achieve a rate of around 0.44%–1.32% (1–3 days), and larger companies around 1.32%–2.2% (3–5 days). An ageing workforce will inevitably push up the sickness absence rate.

Chart 4

Changes in sickness absence

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



Source: EEF Sickness Absence Survey 2015

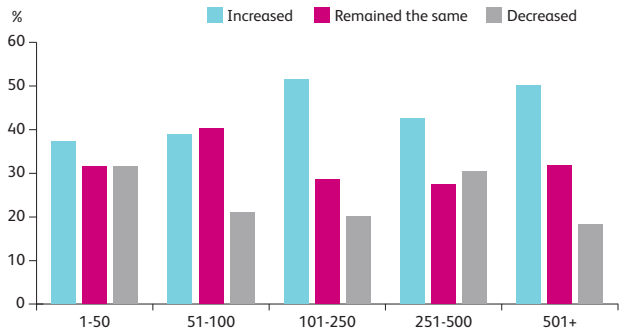
A little more than a sixth (16%) of companies report that their short-term sickness absence (fewer than seven days) has increased in the past two years, while just under a third (28%) say it has fallen. The picture for medium-term absence (more than seven days but less than four weeks) is a little different, with almost one-half (45%) saying that in the past two years the picture has not changed, and around one-fifth (19%) saying it has increased, balanced by a further one-fifth (21%) saying it has decreased.

There is a marked difference when companies report what has happened with long-term sickness absence, with overall two-fifths (40%) saying it has increased and just over one-fifth (22%) saying it has decreased, a difference of 18%. Increases in long-term sickness absence have been reported in previous surveys, but this is the largest increase in the last five years.

Chart 5

Long-term sickness absence trends are rising for medium and larger companies

% of companies reporting change in long-term sickness absence in past two years, by size of company



Source: EEF Sickness Absence Survey 2015

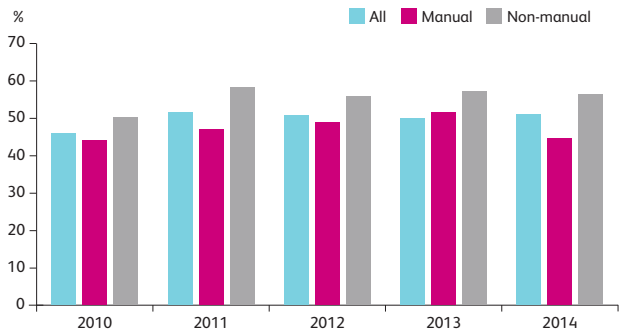
Chart 5 gives an indication of the reported long-term sickness absence trends by company size. This shows that medium to large companies are reporting much higher increases in long-term sickness absence than in previous years.

It would appear from our data that short-term sickness absence is being better managed overall. As a consequence, we are finding that long-term sickness absence is proportionally higher.

Chart 6

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 2015

For our 2014 data, the proportion of employees with zero sickness absence was just over one-half (51%). This has flattened out and has remained at more or less at the same level for the past four years. Companies with fewer than 50 employees show a slightly higher proportion, with around 57% of employees on average taking no sickness absence, while medium and large companies show an average of around 48% of employees with zero sickness absence.

Non-manual workers continue to have higher levels (56%) of zero sickness absence than manual workers. Companies also report that fewer manual employees had zero sickness absence (45%), the first drop in five years. We wonder whether this is a post-recession effect.

Table 2

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

% of companies ranking most common causes of long-term sickness absence

Ranked commonest causes of long-term sickness absence	Ranked 1	Ranked 2	Ranked 3	Ranked 4	Ranked 5	Ranked 6	Ranking average*	Weighted ranking average*
Back problems & MSDs	38.0%	24.3%	16.3%	11.3%	6.7%	3.3%	2.3	4.7
Surgery/medical investigations/tests	24.1%	26.1%	24.9%	10.0%	9.1%	5.8%	3.1	4.3
Stress/mental health problems	23.3%	25.4%	16.8%	17.2%	9.5%	7.8%	2.9	4.1
Heart problems	6.0%	9.0%	16.9%	24.9%	24.4%	18.9%	4.1	2.9
Other	14.5%	7.5%	17.2%	10.2%	13.4%	37.0%	4.1	2.9
Cancer	13.7%	7.1%	9.1%	16.2%	24.9%	28.9%	4.2	2.8

Source: EEF Sickness Absence Survey 2015
* See appendix 1 for ranking average and weighted ranking average calculation methodology.

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, compared with one-fifth (19.5%) in last year's survey. Back problems and MSDs scored an average ranking of 2.3 (1 = most common cause and 6 = least common cause) and a weighted ranking average of 4.7 (6 = most common cause and 1 = least common cause).

Surgery and medical investigations/tests are ranked as the second most common cause of long-term sickness absence by almost a quarter (24%) of companies, compared with just under a third (31%) in last year's survey. Recovery from surgery and time out for medical investigations/tests scored an average ranking of 3.1 and a weighted ranking average of 4.3.

Stress and other mental ill health disorders are ranked as the third most common cause of long-term sickness absence again by almost a quarter (23%) of surveyed companies, broadly comparable with just over a fifth (21%) in last year's survey. Stress and mental health problems scored an average ranking of 2.9 and a weighted ranking average of 4.1.

Firms employing fewer than 50 employees were more likely to rank MSDs (50%) as the most common cause of long-term sickness, whereas companies employing more than 500 employees were more likely to rank stress and other mental ill health disorders (38%) as the most common cause of long-term sickness.

6 Management of long-term sickness absence

Our last five annual surveys have told us that more companies are experiencing increases in long-term sickness absence (more than four weeks). The most common 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.

Survey respondents have consistently told us that the most difficult types of long-term sickness absences for which to make workplace adjustments are stress and mental health problems. Chart 7 shows, as also reported last year, that almost a third of respondents (32%) find that to be the case. Furthermore, GPs find it difficult to advise on mental health: a recent study on GP certification for work-related ill health found that workplace adjustments were less likely to be recommended for cases of mental ill health and concluded that GPs need further training in this area.[3]

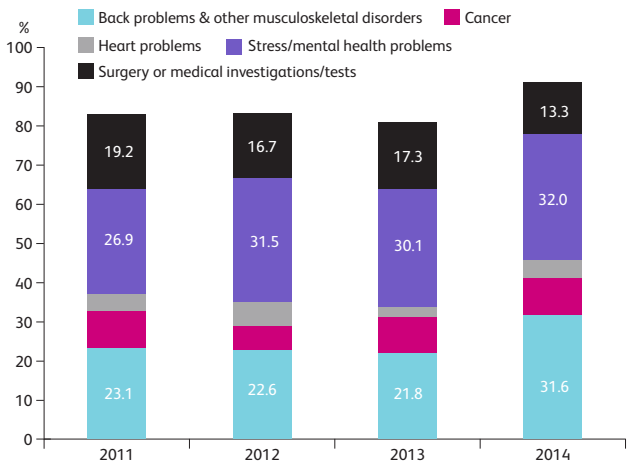
A further third (32%) of respondents report back problems and other musculoskeletal disorders as the most difficult cause, a sharp rise of 10% from last year. Surgery and medical investigation/tests are reported as the third most difficult cause, at 13%.

There are no real surprises here. This trend is reported in much of the sickness absence and wellbeing literature.

Chart 7

Mental-health and MSD-related absence most problematic

% of companies citing the most common cause of long-term sickness absence for which to make adjustments



Source: EEF Sickness Absence Survey 2012 to 2015

This year we decided to ask companies about the three main approaches they currently adopt to manage MSD-related and mental-health-related long-term sickness absence. We also asked about any approach they adopt to reduce long-term sickness absence associated with medical tests/investigations and surgical recovery.

Chart 8 gives us an insight into how companies manage absence related to back problems and other musculoskeletal disorders. Just over three-quarters (77%) of the respondents say their main approach relies on modifying the task in some way, followed by accessing professional occupational health advice and/or provision of rehabilitation (62%) and provision of training (45%).

Chart 9 indicates the degree of take-up for each of these approaches. With the exception of altering equipment or provision of mechanical aids, the approach taken is directly related to company size. As you would expect, larger companies are in a stronger position to be able to implement a greater proportion of these approaches.

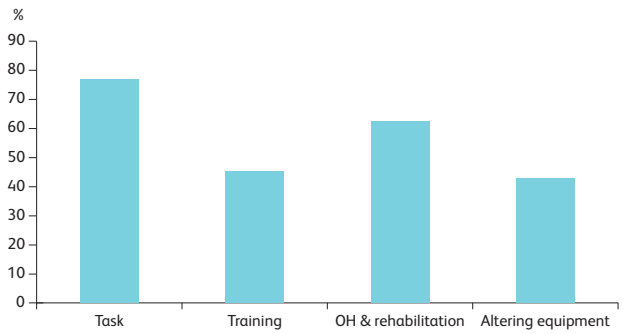
Just under one-tenth (7%) of employers indicate that they do not implement any specific approach for managing long-term sickness absence related to back problems and other musculoskeletal disorders.

[3] Hussey, L. et al. (2015) 'Has the fit note reduced general practice sickness certification rates?' *Occupational Medicine*, 65 (3), pp.182-189.

Chart 8

Three-quarters of respondents modify workplace tasks to manage MSDs

% of companies citing their main approaches to managing MSDs

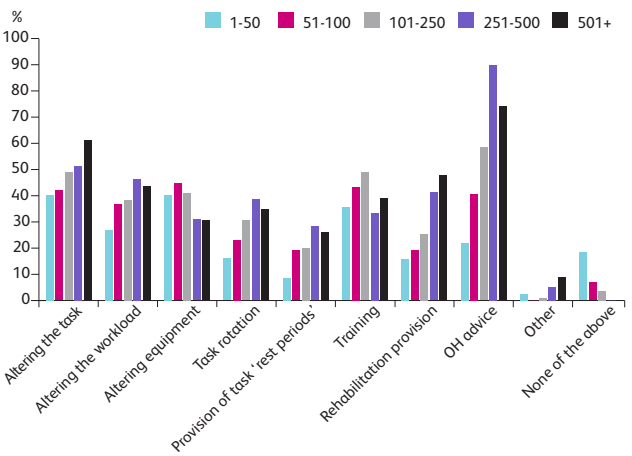


Source: EEF Sickness Absence Survey 2015

Chart 9

Larger companies adopt more MSD management approaches

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



Source: EEF Sickness Absence Survey 2015

Chart 10 examines the main approaches adopted by companies for mental-health-related long-term absence. Just over half (52%) of our survey respondents say that they rely on staff support mechanisms, systems and arrangements; just over a third (35%) on the provision of talking therapies such as counselling or CBT; and a further fifth (20%) on the development and management of individual wellness recovery action plans (20%).

Only a tenth of our respondents say that they provide mental health training for line managers and supervisors, and 6% of our respondents provide mental health awareness training for employees.

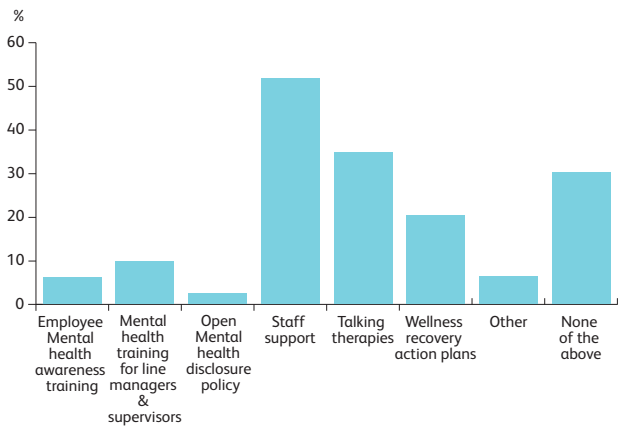
The absence rate for companies utilising any of these different mental health management approaches is 2.2% (five days), equivalent to the average sickness absence rate for all our survey respondents.

Somewhat perturbingly, almost one-third (30%) of survey respondents indicate that they do not currently have approaches for managing mental-health-related long-term sickness absence. Almost half (45%) and just over a third (36%) are respectively from micro or small companies. Their absence rate is just 2.3% (5.2 days).

Chart 10

Half of respondents rely on staff support to manage Mental health

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



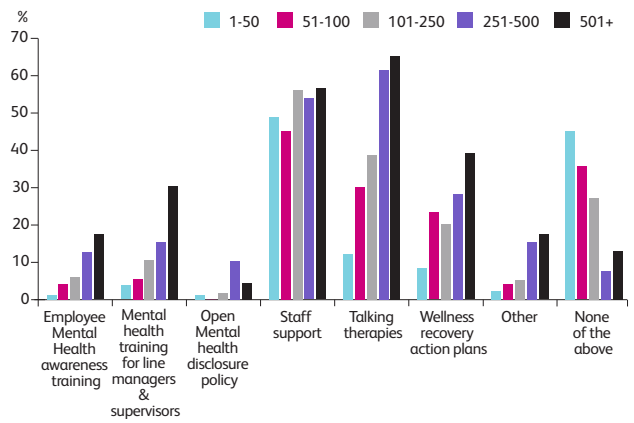
Source: EEF Sickness Absence Survey 2015

When we start to look at the approaches taken in relation to company size, Chart 11 clearly illustrates that the level of intervention is directly related to company size, with the exception of staff support. This is offered by roughly half of all employers irrespective of the size of the company.

Chart 11

Staff support offered by companies of all sizes

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



Source: EEF Sickness Absence Survey 2015

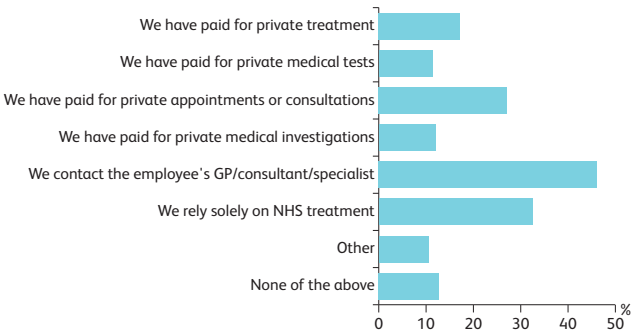
The remaining health matter which regularly results in high levels of reported long-term sickness absence is absence associated with medical tests, investigations and recovery from surgery.

Chart 12 shows that almost half (46%) of all employers will proactively contact an employee's GP, consultant or specialist to help reduce long-term sickness absence associated with medical tests, investigations and surgery. Significant proportions of employers have paid for some form of private treatment for their employees (17%), private medical tests (11%), private medical investigations (12%) and private appointments or consultations (27%) to help reduce the length of sickness absence. A third of the survey respondents also told us that they rely exclusively on NHS treatment, which effectively means that the duration of long-term sickness absence in these cases is dictated by regional NHS waiting times, the type of health condition and individual circumstances.

Chart 12

Half of companies contact employee's GP, consultant or specialist directly

% of companies citing their main approaches to managing absence as a result of long-term sickness absence associated with medical tests, investigations and surgery



Source: EEF Sickness Absence Survey 2015

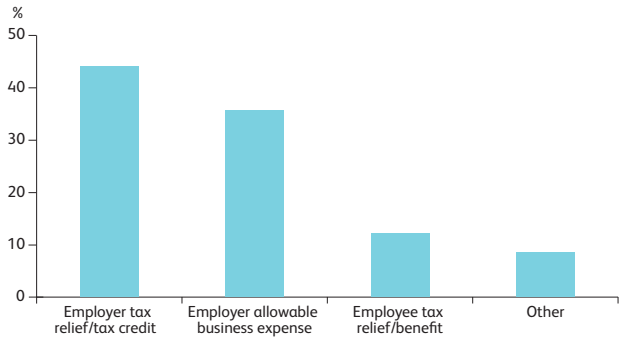
We are hopeful that the flagship Fit for Work service will start to bring down levels of long-term sickness absence for MSDs and mental-health-related conditions. However, we believe its ultimate success within SMEs will depend on how attractive employers find the current government tax incentives.

Chart 13 shows the extent to which companies would be incentivised to pay for the cost of workplace adjustments or medical treatment for employees. Just over two-fifths (44%) of our respondents say they would be most incentivised by tax relief in the form of tax credits.

Chart 13

Two-fifths of companies would be incentivised by tax credits

% of companies citing the main forms of tax incentivisation



Source: EEF Sickness Absence Survey 2015

Cost of sickness absence

Our survey established that less than a fifth (18%) of companies measure the true economic cost of sickness absence, which is not too dissimilar to our findings (22%) in our 2012 survey. What is surprising is that almost half (48%) of the largest companies who took part in the survey say that they do not measure this cost.

We also wanted to find out the three biggest key costs to companies arising out of employee health-related issues, a question we last asked in our 2013 survey. Chart 14 predictably portrays the three biggest costs: of lost production (81%), of sick pay (61%) and of customer service image (24%). These were the costs of most concern when we asked a very similar question in our 2013 survey.

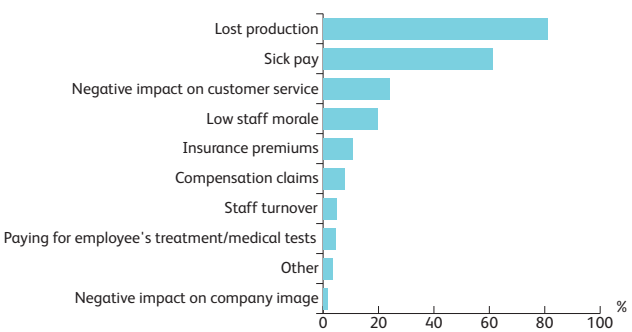
MEASURING ECONOMIC COST OF SICKNESS ABSENCE – CASE STUDY

One survey respondent told us that they monitored, at a senior management level, the cost of sick pay on a monthly basis and also logged the additional overtime required to cover sickness absence. Additional overtime was a big issue for them because they operated in the specialised engineering market where they couldn't just get a temp in to cover for short term absence. When an employee was off on long-term sickness absence, they would provide specialist training for a temporary worker in these circumstances as it was cost-effective. All these costs including training are measured and recorded by the company.

Chart 14

Lost production is biggest health-related cost for four-fifths of companies

% of companies citing the main costs of health-related issues



Source: EEF Sickness Absence Survey 2015

We have asked companies in previous surveys to quantify the total direct costs of sickness absence, but have always concluded the survey data we received to be of limited value because of the many different ways in which companies assess these costs. On the basis that most organisations will pay out some sort of Statutory Sick Pay (SSP) or Occupational Sick Pay (OSP), we set out to obtain robust data by ascertaining the average sick pay cost per employee in each company.

The reported average sick pay cost per employee from our survey was £374. The variation in the responses we received was accounted for by the fact that some companies simply offered SSP, some paid specific rates of OSP and others simply paid normal salary costs when someone was absent from work.

Clearly 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 and lost production costs or the many indirect costs such as reduced performance and productivity, missed business opportunities or impact on company image.

There are approximately 2.7 million manufacturing sector employees in the UK[4] which suggests a total sick pay cost for the sector of £1 billion. It is not difficult therefore to calculate the huge financial benefits of sickness absence management if the number of sickness absence days are reduced. One company told us that the economic cost of lost production associated with sickness absence is translated into the number of products that are unable to be produced on a weekly or monthly basis. This is advertised around the workplace and made known to all employees, i.e. 41,000 widgets is equal to two weeks lost production as a consequence of sickness absence.

If we look at the 2014 CIPD survey this gives an overall absence levels per employee at 7.9 days per employee for the public sector, compared with 5.1 days per employee in the EEF surveyed manufacturing sector. The 2.8 days per employee sickness absence difference between the public sector and manufacturing sector means that an additional ≈ 15 million working days are lost each year in the public sector than the manufacturing sector. This equates to 66,000 people who would be attending work in the public sector if it had the same sickness absence rate as the manufacturing sector.

There are approximately 5.3 million public sector employees in the UK.[5] OSP is much more favourable in the public sector and the median duration of OSP at full pay in the public sector is 26 weeks[6]. If the public sector sickness absence performance matched the manufacturing sector, there are potentially some very large cost savings to be made through effective sickness absence management.

If we extrapolate the average sick pay cost per employee of £374 for the manufacturing sector to the current UK workforce of 30.8 million this equates to a total sick pay cost of ≈ £11.5 billion, which is of the same order of magnitude to the £9 billion estimated in the Frost/Black Report.[6]

Long-term sickness absence – next steps

It is reassuring that many companies are using a multiplicity of different strategies to help them manage the most common causes of long-term sickness absence.

In the area of mental health management, it is encouraging that so many companies are providing staff support mechanisms, counselling or CBT and wellness recovery action plans. Less encouraging are the low levels of mental health training provided for line managers and supervisors (10%, compared with 21% for the manufacturing and production sector in the 2014 CIPD survey) and employees (6%). It is not surprising therefore that only 2% of our survey respondents have an open mental health disclosure policy.

Elsewhere, the same survey respondents tell us that they are seeing increasing levels of long-term sickness absence, while short-term sickness absence is decreasing. They also tell us that absences related to mental health and MSDs are the most problematic to manage and for which to make adjustments in the workplace. In addition, we have been told that less than a fifth of companies measure the economic cost of sickness absence, only 3% measure the return on investment for the wellbeing benefits and services they offer, and only 5% measure the impact on sickness absence of the wellbeing benefits and services offered.

What we do not have is robust data on the effectiveness of these approaches on reducing long-term sickness absence. Long-term absence should be becoming a much more important

[4] 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 (accessed 24 May 2015)

[5] Office for National Statistics, Statistical bulletin: Public Sector Employment, Q2 2014. Available at http://www.ons.gov.uk/ons/rel/pse/public-sector-employment/q2-2014/stb-pse-2014-q2.html (accessed 19 May 2015)

[6] Dame Carol Black and David Frost, 'Health at work – an independent review of sickness absence', November 2011

management issue, driven by concern at the cost of this type of sick leave and the fact that it is rising as a proportion of total absence. In our previous surveys we have demonstrated how line managers have become much better equipped at managing short-term sickness absence. Perhaps managing long-term sickness absence requires a different skill set, particularly in the area of mental ill health. It requires much more effective counselling skills with an emphasis on providing the appropriate balance between absence, disciplinary, capability and rehabilitation policies.

Clearly, 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 that there are potentially significant financial benefits associated with the successful management of long-term sickness absence.

7 Five years on: Fit note verdict

The fit note – or Medical Statement of Fitness to Work – was introduced in 2010 following the Black report into ill health among working-age people.[7] The aim was for GPs to give advice concerning how a patient might return to work depending on workplace adjustments and support, rather than simply stating that they were too sick to work.

Before its introduction, in a DWP-funded research trial of the fit note, 583 volunteer GPs completed either the existing sick note or a new style fit note for back pain, depression, and combined back pain and depression.[8] GPs using the trial fit note assessed 70% of back pain cases as 'fit for some work', whereas 76% of the same back pain cases were advised by GPs using the sick note to refrain from work. 'Fit for some work' was used least often in the cases of depression (19%), the majority being considered 'not fit for work'. GPs using the sick note assessed 88% of cases with combined back pain and depression as 'not fit for work', compared to 58% of cases assessed this way by GPs using the trial fit note. GPs using the trial fit note were less likely to advise patients to refrain from work, although a small proportion of cases were deemed 'fit for work'. When the study took into account the reduction in cases that were 'fit for work' and the decrease in cases that were 'not fit for work', a net increase of 15 to 44 percentage points remained across the health conditions considered 'fit for (some) work'.

The results of this study suggested that a 'fit note' could increase the numbers of patients discussing returning to modified work with their employers and that GPs would be much more likely to issue 'may be fit for work' fit notes.

In our last five sickness absence surveys we have expressed our continued support for the potential benefits the fit note can bring. We have also said that it would be necessary to judge its level of success after a five-year gestation period to allow it to become embedded in GP practices and within employer sickness absence policies.

The main benefit of the fit note is its potential to enable individuals to return to work earlier by helping them with a phased return to work as part of their rehabilitation. However, this does rely on GPs recording an assessment on the fit note that the individual 'may be fit for work'. The fit note allows discussions with the individual about their functional capacity to do some work. We also think that enabling an earlier return to work is a key factor in promoting economic growth.

The fit note has been in place for five years. What is the verdict of our survey respondents? Unfortunately, our surveys over a five-year period tell us that an increasing number of employers do not believe that the fit note has resulted in employees making earlier returns to work. Over the same five-year period, employers have also reported increases in the levels of long-term sickness absence.

The fit note summit held by EEF in December 2013 secured some key stakeholder commitments to allow better use to be made of the fit note by employers, medical professionals and employees. Unfortunately, the commitments made by EEF, the RCGP, the BMA and the DWP do not appear to have changed the views of our survey respondents about the fit note.

We reluctantly have to conclude that, on the basis of the evidence, the original aspirations for the fit note have not been met.

Quality of GP advice and early return to work by employees

We believe that the main two key success measures for the fit note are:

(i) whether employees return to work earlier, and

(ii) whether employers receive good advice from the GP.

These are covered by Charts 15 and 16.

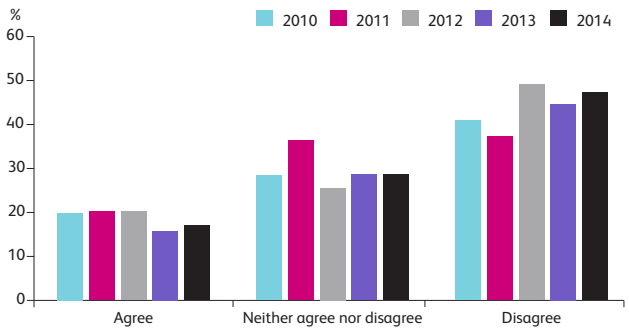
[7] Black, C. (2008) 'Working for a healthier tomorrow: review of the health of Britain's working age population', London: TSO.

[8] Sallis, A., Birkin, R. and Munir, F. (2010) 'Working towards a "fit note": an experimental vignette survey of GPs', *British Journal of General Practice*, 60 (4) pp.245–250.

Chart 15

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

% of companies agreeing with statement 'Improved the advice given by GPs about employees' fitness for work'

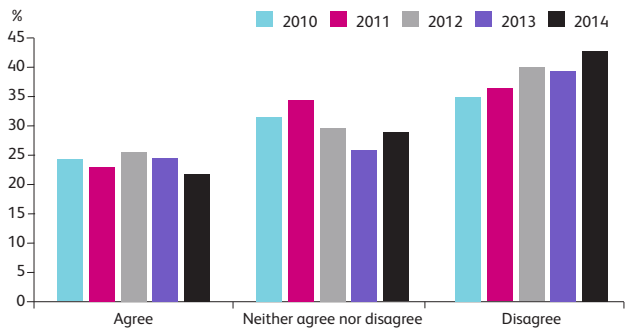


Source: EEF Sickness Absence Surveys 2011–2015

Chart 16

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

% of companies agreeing with statement 'Helped employees make an earlier return to work'



Source: EEF Sickness Absence Surveys 2011–2015

Our latest survey tells us in Chart 16 that two-fifths (43%) 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 22% (24% in 2010) saying 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 -21% in 2014.

If we look at the advice given by GPs about employees' fitness for work in 2014 in Chart 15, more companies disagree (47%) than agree (17%) that this advice has improved. Again, the balance or difference between those agreeing and disagreeing has increased from -21% in 2010 to -30% in 2014.

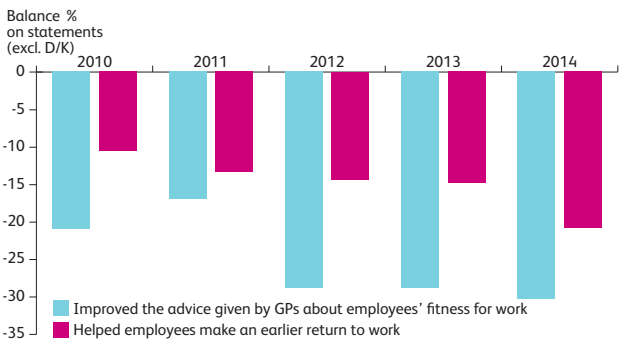
Chart 17 shows how over the course of five years more companies disagree than agree with the statements, fit notes have 'improved the advice given by GPs about employees' fitness for work' and fit notes have 'helped employees make an earlier return to work'.

Charts 15 and 16 also show that there is still a large 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. Many of our EEF members have told us that they do not see any real differences between the fit note and the previous sick note certification system.

Chart 17

Employers' views about fit note have become more negative

Balance of companies who agree or disagree with statements 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 2015

Why isn't the fit note working? As we have stated in previous sickness absence reports, there are still too many GPs who are either not trained or are poorly trained in the use of the fit note. Of the 40 584 GPs in the UK[9] no more than 12% have received either

[9] NHS Workforce: Summary of staff in the NHS: Results from September 2014 Census; HSCIC, March 2015. Available at http://www.hscic.gov.uk/catalogue/PUB16931/nhs-staf-2004-2014-over-rep.pdf, accessed 24 May 2015

face-to-face training or completed the online e-learning modules.

Previous EEF member focus groups told us that they saw regional differences (particularly in the West Midlands) in the way different GPs use the fit note and the extent to which they consider that a patient 'may be fit for work'. We have previously heard views expressed that GPs are not trained to understand workplace hazards, that it is up to the employer to take the responsibility for any action. There seems to be a myth that GPs are not allowed to state someone is fit for work, that GPs can only say they are not fit, or they might be fit, that only occupational physicians or nurses can determine if someone is fit for work.

We believe the absence of training of medical professionals in the use of the fit note to be a real issue. A recent study indicated that GPs who had undertaken training in occupational medicine or had received some form of work and health training had significantly more positive attitudes to patients' returning to work and to the fit note.[10] The study revealed evidence of differences between trained and non-trained GPs in their attitude to the fit note, and to work and health generally.

May be fit for work

Chart 18 illustrates generally that employers see a very low proportion of 'may be fit for work' fit notes. This does not fit comfortably with numbers anticipated by employers and does not compare favourably with the outcomes of the original pilot fit note study.6 Chart 15 also shows that just over a quarter (26%) of respondents did not receive any 'may be fit for work' fit notes in 2014, compared with 35% in 2010. Although this is the lowest figure since the fit note scheme was introduced, and a small step in the right direction, it is still unacceptably high.

Two-fifths (40%) of employers in 2014 said that between 1% and 5% of their fit notes were signed 'may be fit for work', compared with 30% in 2010. The movement of travel is slow, but there is some progress.

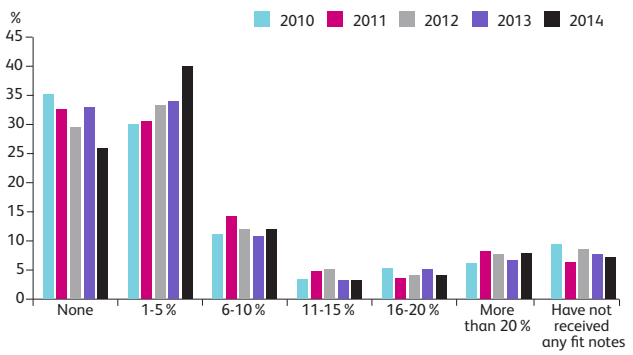
[10]Money, A. *et al*, (2015), 'The influence of prior training on GPs' attitudes to sickness absence certification post-fit note', *Primary Health Care Research & Development*, 6 January 2015, pp.1-12.

All our previous surveys have shown a range of somewhere between 30% and 35% of respondents not receiving 'may be fit for work' fit notes. The reduction this year may be attributable to the greater use of the computer-generated fit note, which is easier and quicker for medical professionals to complete.

Chart 18

Spread of responses regarding 'may be fit for work' fit notes

% of fit notes received by companies that were signed 'may be fit for work'



Source: EEF Sickness Absence Surveys 2011–2015

The expectation from industry is that GPs should be making much more use of the 'may be fit for work' option, especially if an individual is fit to do some form of work. It would be helpful to employers if OH providers were able to have a direct discussion with GPs about an individual's fitness for work, especially where differences of opinion exist as to the validity of a fit note.

Why aren't GPs issuing more 'may be fit for work' fit notes? It would seem to be a combination of factors:

(i) not following DWP guidance;

(ii) lack of understanding or training about purpose of fit note;

(iii) lack of knowledge about employers' ability to make work adjustments; and

(iv) pressure from patients to issue sick notes.

We think government should by now (through the computer-generated fit note) be actively monitoring and reporting on the inconsistencies between both trained and untrained GPs who issue 'may be fit for work' fit notes.

Workplace adjustments

It is clear that action can be taken by employers if they receive 'may be fit for work' fit notes, typified by Chart 19.

Although there was a surprise fall of 9% from last year (the first decline since the fit note scheme was introduced), two-fifths (41%) of companies still say that they are able to accommodate 'all' adjustments specified on 'may be fit for work' fit notes. A further 14% of survey respondents are able to accommodate between 80% and 99% of 'may be fit for work' fit notes. Almost one-fifth (19%) of companies report that they are able to make workplace adjustments for '1–20%' of their 'may be fit for work' employees, a climb of 5% from figure of the last three years.

Only 8% of employers say they are not able to make any adjustments, compared with 18% in 2011. This demonstrates that there is an appetite among employers to engage with employees and involve them in some form of productive work and should encourage GPs to reconsider carefully before they sign patients off as 'not fit for work'.

In our 2012 survey, the most common interventions companies implemented as a result of receiving fit notes were changing an employee's work duties, reducing working hours or altering the pattern of an individual's working hours. The most difficult interventions to implement were changing the physical layout of the workplace, which is also reflected in the 2014 survey results. It will be interesting to see what recommendations are made by the Fit for Work service when it becomes established. Employers already accommodate many rehabilitation arrangements, but changes to physical layouts are likely to prove more challenging.

Company contact with GPs

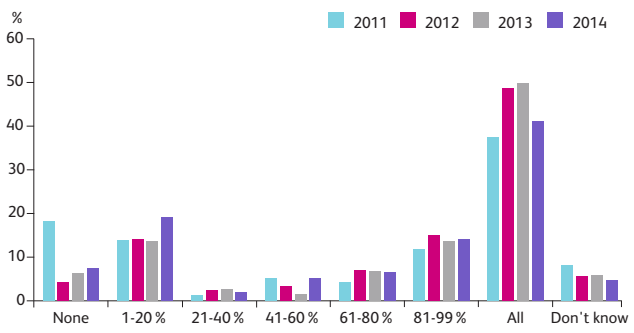
Engagement between employer and GP and GP and employer needs to be reciprocal. EEF is committed to improving the dialogue between medical professionals and employers.

The proportion of survey respondents proactively contacting local GPs about workplace adjustments that can be provided remains low, at 23%. See Chart 20. This figure has been unchanged over a four-year period and is partly, we believe, a reflection of the lack of response by GPs to employer contacts. We do still believe, however, that if more companies were more active in contacting their employees' GPs, it would convince GPs to issue more 'may be fit for work' fit notes.

Chart 19

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

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

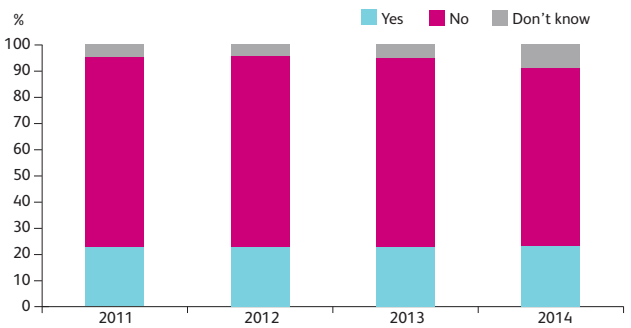


Source: EEF Sickness Absence Surveys 2012–2015

Chart 20

A fifth of employers contact their GPs about workplace adjustments

% of companies who contact GPs about employee workplace adjustments



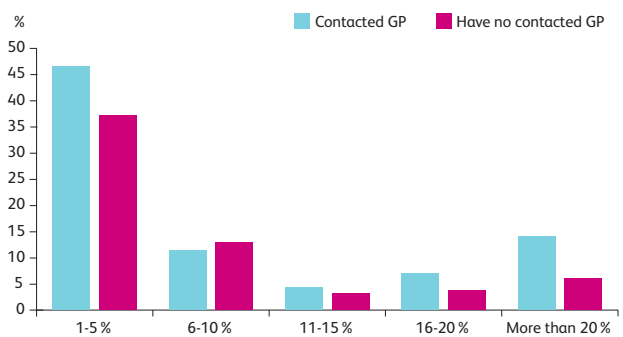
Source: EEF Sickness Absence Survey 2015

We have clear evidence that two-fifths of all survey respondents can accommodate the work modifications included on fit notes. Chart 21 reveals that companies are more likely to receive 'may be fit for work' fit notes if they contact the GP.

Chart 21

GP contact yields more 'may be fit for work' fit notes

% of companies receiving fit notes identifying 'may be fit for work' and work adjustments, by whether they contacted GPs about available work adjustments

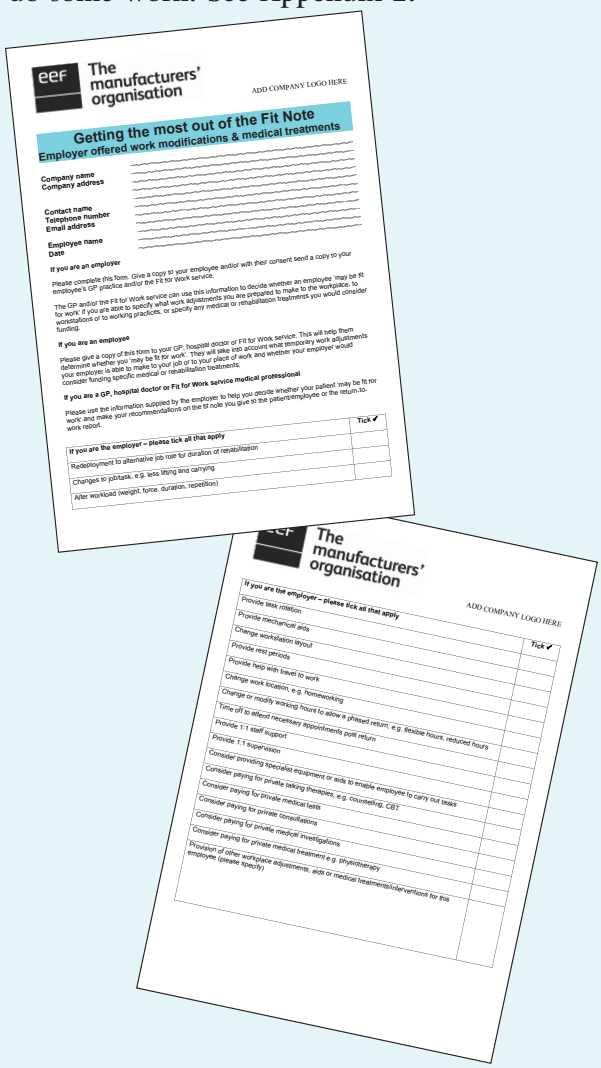


Source: EEF Sickness Absence Survey 2015

Following the EEF/DWP sickness absence summit in December 2013, we made a commitment to improve the dialogue between medical professionals and employers. To help this, we developed a template that employees or employers can give to the GP and Fit for Work service which describes the adaptations and modifications that the employer is willing to make to facilitate an employee's earlier return to work.

GETTING THE MOST OUT OF THE FIT NOTE – EMPLOYER OFFERED WORK MODIFICATIONS & MEDICAL TREATMENTS

Following on from the 2013 EEF/DWP sickness absence summit, EEF developed a document which could be given to GP's by employees to explain what action their employer would be willing to consider taking when the GP decided that someone was fit to do some work. See Appendix 2.



Fit note improvements

With the Fit for Work service coming on stream this year, there is a need to clarify the relationship between the fit note, the Fit for Work service, GPs and employers so that it works effectively.

In respect of the fit note, there are some improvements which would make a difference. These include:

- set a date by all which all GPs and hospital medical professionals who are required to issue fit notes have been trained in completion of the fit note;
- link evidence of fit note training to GP and medical professional CPD and appraisal systems;
- create e-communities to allow more effective interaction and communication between GPs and employers and employer occupational health services in the fit note process;
- provide targeted advice for SMEs who may come across a fit note infrequently;
- target training of line managers about awareness of the fit note process;
- target employee awareness and training of the fit note process at induction;
- analyse and publish GP performance in using the fit note and issuing 'may be fit for work' fit notes;
- modify the fit note to include a referral to the Fit for Work Service (FWS);
- produce clear guidance to show the interaction between the Fit for Work service and the fit note.

Next steps

The government needs to take a long hard look at why the fit note has not achieved its original objectives and to consider its status going forward, following the introduction of the Fit for Work service.

At the outset, we believed that the fit note would be an extremely important initiative in helping people return to work and in preventing employees from sliding into long-term absence. Our survey results do not support this.

8 Employee health and wellbeing benefits

Health and wellbeing benefits can form part of an overall strategy to improve the productivity, engagement and health care of employees. Such benefits have progressively become an important constituent of company health care and sickness absence schemes. They include lifestyle programmes, health promotion, wellbeing health checks, income protection insurance and private medical insurance.

Our 2013 survey was the first time we asked companies about the health and wellbeing benefits they offer employees. Last year we explored whether health and wellbeing benefits were offered to all employees or just senior employees, and determined the reasons why benefits and services were offered. This year, no distinction was made about category of employee, but we wanted to know more about 'lifestyle' programmes, such as smoking cessation, which companies had introduced.

We also followed up on a key question to ascertain whether or not more companies were measuring the return on investment of the benefits and services offered and their impact on sickness absence levels.

Most popular health and wellbeing benefits

Chart 22 clearly illustrates that private medical insurance is the most popular benefit or service, offered to almost two-thirds (63%) of employees.

The next four most commonly ranked benefits or services offered are wellbeing health checks (46%), online counselling (38%), health promotion events (32%) and smoking cessation programmes (32%). Jelf's 2013 Employee Benefits survey found that health checks were the most popular benefit offered (54%) for all employment sectors.

Almost one-fifth (19.4%) of the survey respondents do not offer any benefits and services at all.

Private medical insurance

Private medical insurance pays for private medical treatment and enables claimants to arrange treatment at a convenient time. It is popular with staff and also convenient for employers. Benefit levels vary widely, but most pay out for inpatient and outpatient treatments, specialist consultations and diagnostic tests. Some very large employers opt to set up their own health insurance trust instead of using a private medical insurer.

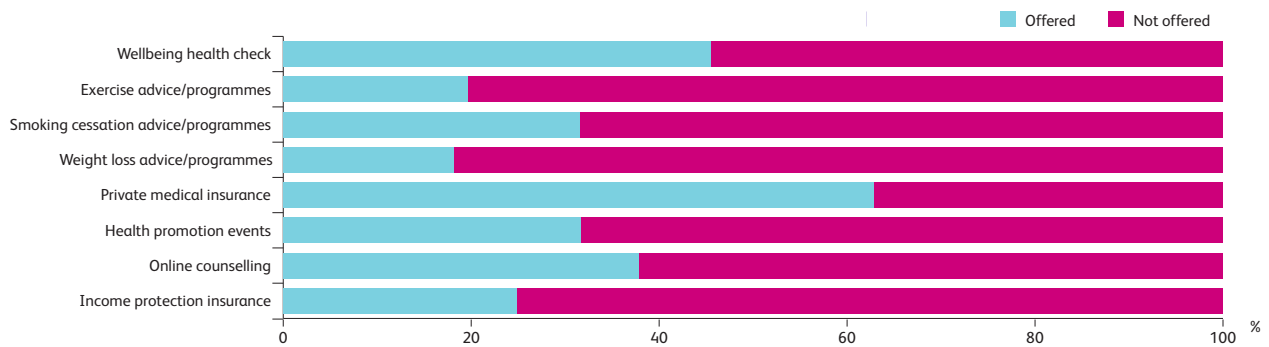
Private medical insurance is often provided for those in key positions where unique skills, capabilities and competences are required, as an aid to attract and retain staff who are difficult to find and replace. It is no longer just seen just as the preserve of senior managers, although they are still more likely to be offered the benefit.

Traditionally, this has been regarded by the government as a benefit solely for the convenience of the employee and, as such, attracts tax. With the increasing importance of keeping employees in work

Chart 22

Access to private medical insurance – the most commonly offered benefit/service

% of companies and the different health and wellbeing benefits currently being offered to employees



Source: EEF Sickness Absence Survey 2015

and the role of work in keeping employees healthy, perhaps it is time to reconsider this tax liability.

The £500 tax exemption for treatments recommended by the Fit for Work service or employer-funded occupational health services has attracted a lot of support, but raises the question about 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.

Privately delivered investigations into medical conditions are often quicker to plan and arrange than those carried out by the NHS. This can benefit both the employee and the employer in allowing an employee to be investigated, treated and back to work more quickly than if they were to have to wait on an NHS waiting list.

The advantages of a quick return to work make it advantageous to stop considering private medical insurance as a benefit and more as an essential tool in running and managing a business, hence attracting tax relief. A new tax relief for employer-provided private medical insurance would, arguably, be good for the UK, as it would improve productivity by getting people back to work more quickly and reduce the pressure on the NHS.

Wellbeing health checks

Wellbeing checks can be offered both online and face to face. Employees provide information about their physical and emotional health and wellbeing. This information is used to develop a tailored action plan so that individuals can make changes and improve overall health and wellbeing. Well-person health checks can include blood pressure, body mass index, diet, exercise, smoking cessation, alcohol intake, stress management, gender-related health screening and cardiovascular risk screening. This allows employees to make decisions about lifestyle matters that are most relevant to themselves. Employees wrestle with questions like, 'How do I eat healthily?', 'How much alcohol is safe?' and 'Is smoking really bad for me?'

Online counselling

Online counselling (employee assistance programmes) are basically confidential information and support services designed to assist employees who have work or personal problems. They include 24-hour helplines and sometimes also offer access to face-to-face or telephone counselling. These schemes are recognised as being an important benefit in helping support employees with stress-related issues and are evidence of employers taking action to manage workplace stress.

General health promotion events

Health promotion is about keeping healthy, living a healthy lifestyle, preventing illness and preventing any existing illness from becoming worse. It often covers lifestyle aspects of diet, obesity, smoking, exercise, alcohol, blood pressure, prevention of heart disease, cervical screening, breast screening, etc.

Health promotion events are a way of providing reliable information to a large number of employees on how to positively change their diet, exercise and lifestyle to promote their health and that of their family, and they can provide information on treatments which may be available. Public health campaigns on issues such as testicular cancer can be undertaken in the workplace to raise awareness among young men more effectively than in other environments.

Smoking cessation programmes

The introduction of successful workplace smoking cessation programmes can not only help to improve employee health but also provide business benefits in terms of reduced sickness absence and reduced medical care costs. Such programmes can also be selectively targeted at occupations where there is a greater potential risk of lung disease.

The workplace has three conspicuous advantages as a means for providing cessation support. These include:

- Access: Worksites provide opportunities to reach smokers, especially individuals who may not engage regularly with health services.
- Flexibility: Smoking cessation programmes can be tailored to fit the circumstances and

preferences of individuals who may struggle to find time or not be inclined to make health-care appointments.

- Influence: Workplace policy and culture can shape an employee's day-to-day environment and influence behaviour, including health practices, in a way that health services cannot. Smoke-free workplaces can discourage or stop an employee from smoking during the entire work day.

It is often suggested that smoking cessation programmes should form a core element of a business's workplace wellness policy, and be integrated into broader wellness programmes to address other chronic disease risk factors, such as promoting a healthy diet and increasing physical activity.

Least popular health and wellbeing benefits

The benefits or services least offered by employers include weight loss advice and programmes (18%), exercise advice or programmes (20%) and income protection insurance (25%). Weight loss advice or programmes and income protection insurance also featured among the least favoured benefits in our survey last year.

It seems contrary that member companies place more emphasis on smoking cessation than they do on specific weight loss and exercise advice programmes. Perhaps this relates (unlike smoking) to the level of control that employers can exert over weight and exercise lifestyle choices in the workplace. Employers can, after all, ban all workplace smoking (a positive impact of legislation), but they are not in a position to require individuals to take exercise or bring in a healthy lunch as part of their employment contract. Perhaps employers do not see any direct evidence that investment in such programmes can help to retain staff, reduce sickness absence and improve productivity, or perhaps they believe that these lifestyle factors are best addressed by more general health promotion or wellness health check activities provided via the GP or public health services.

Income protection insurance

As we have already said, income protection insurance is offered by around a quarter (25%) of all respondents, a slight increase on the previous year (22%). This can include both cover for individual employees and group income protection (GIP) policies, which provide replacement income if an employee is unable to work because of illness or injury. Depending on the contract, the benefit is paid until the individual returns to work, the end of a fixed term or retirement. Employers can usually receive corporation tax relief on premiums, and it is not a P11D benefit.

Why is GIP not more popular? Well, full cover can cost between 1% and 1.5% of gross payroll.

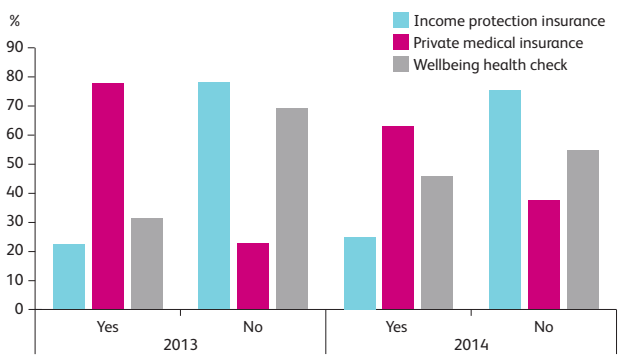
There are some calls to make GIP compulsory, as part of the current government's drive for welfare reform, so allowing the insurance market to take some pressure off the state. Many employees have this cover anyway as, increasingly, membership of a GIP scheme is often a condition of participating in the workplace pension.

Chart 23 gives comparisons between our 2013 and 2014 survey data on employer provision of specific categories of wellbeing benefit or service. We can see that almost half (46%) of employers offered wellbeing health checks in 2014, compared with a third (31%) in 2013. Fewer employers are offering private medical insurance (78% in 2014 and 63% in 2013). Companies offering income protection insurance this year is relatively static at around one quarter (25%).

Chart 23

More companies offering wellbeing health checks

% of companies offering health and wellbeing benefits by year



Source: EEF Sickness Absence Survey 2015

Money well spent?

Companies were asked whether they measure the return on investment for the wellbeing benefits and services they offer. Seven-tenths (70%) of our respondents do not (81% in 2013). Only 3% (as last year) say that they actually measure the return on investment. We found that the average spend (or investment) per employee on wellbeing, health promotion and lifestyle advice came to £91.

When asked whether companies measure the impact of wellbeing benefits and services on sickness absence levels, 71% say they do not (79% in 2013). Only 5% (as reported last year) say that they measure the impact on sickness absence.

The responses from our past two surveys are consistent. Companies do not appear to be asking fundamental questions on why they are investing in providing health and wellbeing benefits and whether or not they reduce sickness absence levels. It does seem extraordinary.

We repeat the views we stated last year. We think companies need be careful in choosing the health and wellbeing products which both provide the best value and demonstrate the greatest health and wellbeing improvements. Companies are not able to do this if they do not measure their effectiveness.

It would seem that our survey respondents need considerably more help and guidance to select the most appropriate methods to enable them to determine returns on investment and to enable them to determine whether the wellness programme – such as a well person check – is actually enhancing wellbeing, incentivising attendance or reducing the costs associated with lost productivity and absenteeism. To do this means it is essential that employers record the main reasons for sickness absence accurately to differentiate reasons for health-related and non-health-related absences.

Attraction and retention

Like last year, survey respondents were asked why they offer health and wellbeing benefits and services to their employees. Is it to attract and/or retain employees or to reduce absence and/or improve health?

Table 3 shows that the two most significant benefits offered to both attract and retain employees are

Table 3

Top offered benefits by reasons for offering

% of companies and the reasons for offering health and wellbeing benefits and services

Rank	Employee attraction	%	Employee retention	%	Reducing absence	%	Improving health	%
1	Private medical insurance	67	Income protection insurance	68	Online counselling	71	Smoking cessation advice or programmes	91
2	Income protection insurance	64	Private medical insurance	48	Wellbeing health checks	68	Weight loss advice or programmes	89
3	Exercise advice or programmes	25	Online counselling	31	Weight loss advice or programmes	66	Health promotion events	88
4	Wellbeing health checks	24	Wellbeing health checks	31	Health promotion events	57	Exercise advice or programmes	85
5	Online counselling	24	Health promotion events	30	Exercise advice or programmes	56	Wellbeing health checks	81
6	Health promotion Events	23	Weight loss advice or programmes	23	Smoking cessation advice or programmes	53	Online counselling	71
7	Weight loss advice or programmes	19	Exercise advice or programmes	19	Private medical insurance	44	Private medical insurance	35
8	Smoking cessation advice or programmes	15	Smoking cessation advice or programmes	15	Income protection insurance	16	Income protection insurance	19

Source: EEF Sickness Absence Survey 2015

private medical insurance and income protection insurance. Perhaps this is not surprising. What is relevant is that companies seem to recognise that income protection insurance on its own is unlikely to be such a significant contributor in terms of reducing absence (16%) or improving health (19%). Although almost two-thirds (64%) rank income protection insurance second for employee attraction and almost seven-tenths (68%) rank this first for staff retention, it is only offered by around a quarter (25%) of all respondents.

A quarter (25%) of survey respondents rank exercise advice or programmes third for employee attraction, yet only 20% of companies offer this as a benefit.

A sixth (15%) rank smoking cessation programmes last (eighth) for employee attraction, yet these are offered by almost a third (32%) of our respondents.

A quarter (25%) of survey respondents rank wellbeing health checks as fourth for employee attraction and almost a third (31%) rank it fourth for employee retention, yet it is offered by almost half (46%) of all companies.

Reduce absence and/or improve health

Table 3 reveals that access to online counselling is viewed as the most significant benefit offered to reduce absence (71%). While counselling can provide valuable support to staff, this could be regarded as a more unconscious approach to absence management. The next most significant benefits offered to reduce absence are wellbeing health checks (68%) followed by weight loss advice or programmes (66%), health promotion events (57%) and exercise advice or programmes (56%).

In terms of improving health, the most significant benefit offered is smoking cessation advice or programmes (91%), followed by weight loss advice or programmes (89%), health promotion events (88%), exercise advice or programmes (85%) and wellbeing health checks (81%).

Although 71% of survey respondents rank online counselling first for reducing absence and 71% rank it sixth for improving health, only two-fifths (38%) offer this as a benefit.

Although 68% of survey respondents rank wellbeing health checks second for reducing absence, and just over four-fifths (81%) rank it fifth for improving health, only 46% offer this as a benefit.

Just over nine-tenths (91%) of survey respondents rank smoking cessation advice or programmes first for improving health, and just over a half (53%) rank it sixth for reducing absence, yet only a third (32%) of companies offer this as a benefit.

Just under nine-tenths (89%) of survey respondents rank weight loss advice or programmes second for improving health, and two-thirds (66%) rank it third for reducing absence, yet only one-fifth (18%) of companies offer this as a benefit.

Eighty-five per cent of survey respondents rank exercise advice or programmes fourth for improving health, and just over a half (56%) rank it fifth for reducing absence, yet only one-fifth (20%) of companies offer this as a benefit.

What can companies do to help themselves?

Employers need better-quality and more objective information to make judicious decisions about the benefits and services that are effective in their workplace and which reduce absence and improve health.

NICE has produced guidelines specifically for the workplace on mental wellbeing, physical activity and sickness absence. The Department of Health's Responsibility Deal has good examples of initiatives by employers to promote wellbeing and to manage sickness absence and employees with long-term health conditions.

Employers should really start to help themselves by doing their own cost–benefit analysis and monitoring to determine whether the benefits and services they provide in the workplace are effective. Before embarking on this journey, companies need an all-inclusive picture of employee health and wellbeing in order to make the most appropriate decisions. The process of assessing the impact of workplace health-care benefits involves examining any existing healthcare benefits, evaluating existing data and identifying a baseline. Employers should identify objectives around why the benefit has been introduced. Finally, it is necessary to monitor objective indicators and set timelines for measuring the impact.

Appendix 1: Notes

Sickness absence levels

With the data collected from the survey, the average number of working days absent per employee was able to be calculated along with the absence rate. Formulas for calculating these are below.

$$\text{Average number of days absent per employee} = \frac{\text{Total number of working days lost to absence}}{\text{Average number of employees across the year}}$$

$$\text{Absence rate} = \frac{\text{Total number of working days lost to absence}}{\text{228 days x Average number of employees across the year}} \times 100$$

Ranking average and weighted ranking average calculation methodology (Table 2)

The ranking average is calculated as follows, where:

W = weight of answer choice
X = response count for answer choice

$$\frac{(X_1 \star 1) + (X_2 \star 2) + (X_3 \star 3) + (X_4 \star 4) + (X_5 \star 5) + (X_6 \star 6)}{(X_1 + X_2 + X_3 + X_4 + X_5 + X_6)}$$

The weighted ranking average is calculated as follows, where:

W = weight of ranked position
X = response count for answer choice

$$\frac{X_1W_1 + X_2W_2 + X_3W_3 \ldots X_nW_n}{\text{Total}}$$

Weights are applied in reverse. The respondent's most preferred choice (which they rank as #1) has the largest weight (in this case 6), and their least preferred choice (which they rank in the last position) has a weight of 1.

Our ranking question has 6 answer choices, and weights were assigned as follows:

- The #1 choice has a weight of 6
- The #2 choice has a weight of 5
- The #3 choice has a weight of 4
- The #4 choice has a weight of 3
- The #5 choice has a weight of 2
- The #6 choice has a weight of 1

Appendix 2: Employer Fit Note assistance template

eef The manufacturers' organisation

ADD COMPANY LOGO HERE

Getting the most out of the Fit Note
Employer offered work modifications & medical treatments

Company name _____
Company address _____
_____
_____

Contact name _____
Telephone number _____
Email address _____
_____

Employee name _____
Date _____

If you are an employer

Please complete this form. Give a copy to your employee and/or with their consent send a copy to your employee's GP practice and/or the Fit for Work service.

The GP and/or the Fit for Work service can use this information to decide whether an employee 'may be fit for work' if you are able to specify what work adjustments you are prepared to make to the workplace, to workstations or to working practices, or specify any medical or rehabilitation treatments you would consider funding.

If you are an employee

Please give a copy of this form to your GP, hospital doctor or Fit for Work service. This will help them determine whether you 'may be fit for work'. They will take into account what temporary work adjustments your employer is able to make to your job or to your place of work and whether your employer would consider funding specific medical or rehabilitation treatments.

If you are a GP, hospital doctor or Fit for Work service medical professional

Please use the information supplied by the employer to help you decide whether your patient 'may be fit for work' and make your recommendations on the fit note you give to the patient/employee or the return-to-work report.

If you are the employer – please tick all that apply	**Tick ✓**
Redeployment to alternative job role for duration of rehabilitation	
Changes to job/task, e.g. less lifting and carrying	
Alter workload (weight, force, duration, repetition)	

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If you are the employer – please tick all that apply	**Tick ✓**
Provide task rotation	
Provide mechanical aids	
Change workstation layout	
Provide rest periods	
Provide help with travel to work	
Change work location, e.g. homeworking	
Change or modify working hours to allow a phased return, e.g. flexible hours, reduced hours	
Time off to attend necessary appointments post return	
Provide 1:1 staff support	
Provide 1:1 supervision	
Consider providing specialist equipment or aids to enable employee to carry out tasks	
Consider paying for private talking therapies, e.g. counselling, CBT	
Consider paying for private medical tests	
Consider paying for private consultations	
Consider paying for private medical investigations	
Consider paying for private medical treatment e.g. physiotherapy	
Provision of other workplace adjustments, aids or medical treatments/interventions for this employee (please specify)	

Appendix 3: Benchmarking data 2015

Table A1

Breakdown of survey respondents by company size (%)

1-50	25.4
51-100	22.2
101-250	34.1
251-500	11.7
501+	6.7
Total	100

Source: EEF Sickness Absence Survey 2015

Table A2

Breakdown of survey respondents by sector (%)

Rubber & Chemicals	7.6
Metals	23.6
Machinery	16.3
Electrical & Optical	11.4
Transport	7.6
Other manufacturing	22.4
Non-manufacturing	11.1
Total	100.0

Source: EEF Sickness Absence Survey 2015

Table A3

Size categorisation used in EEF sickness absence surveys

Number of employees	EEF survey size categorisation	BIS categorisation
1-50	Micro	Small
51-100	Small	Medium
101-250	Medium	Medium
251-500	Mid-sized	Large
501+	Large	Large

Source: EEF Sickness Absence Survey 2015

Table A4

Sickness absence levels in 2010-2014 by type of employee

Average days lost to sickness absence

	All employees	Sample size	Manual	Sample size	Non-manual	Sample size
2014	5.1	343	6.1	234	3.5	235
2013	4.8	304	6.2	195	2.9	202
2012	5.3	308	6.4	205	3.4	217
2011	5.1	392	6.7	257	3.2	272
2010	5.0	411	6.2	296	3.5	309

Average absence rate %

	All employees	Sample size	Manual	Sample size	Non-manual	Sample size
2014	2.2	343	2.7	234	1.5	235
2013	2.1	304	2.7	195	1.3	202
2012	2.3	308	2.8	205	1.5	217
2011	2.2	392	2.9	258	1.4	272
2010	2.2	411	2.7	296	1.5	309

Source: EEF Sickness Absence Survey 2011–2015

Table A5

Average number of working days lost to sickness absence per employee by numbers employed and employee type

	All employees		Manual		Non-manual	
	Days	Sample size	Days	Sample size	Days	Sample size
1–50	4.4	87	5.2	71	2.9	72
51–100	5.0	76	6.3	50	3.1	50
101–250	5.5	117	6.8	74	4.2	74
251–500	4.6	40	5.2	24	3.6	24
501+	6.3	23	8.5	15	4.0	15

Source: EEF Sickness Absence Survey 2015

Table A6

Average absence rate (%) by numbers employed and employee type

	All employees		Manual		Non-manual	
	%	Sample size	%	Sample size	%	Sample size
1–50	1.9	87	2.3	71	1.3	72
51–100	2.2	76	2.8	50	1.3	50
101–250	2.4	117	3.0	74	1.8	74
251–500	2.0	40	2.3	24	1.6	24
501+	2.8	23	3.7	15	1.8	15

Source: EEF Sickness Absence Survey 2015

Table A7

Average number of working days lost to sickness absence per employee by sector and employee type

	All employees		Manual		Non-manual	
	Days	Sample size	Days	Sample size	Days	Sample size
Rubber & Chemicals	5.0	26	5.8	20	3.0	20
Metals	5.0	81	5.5	63	4.0	62
Machinery	5.6	56	6.6	41	3.5	41
Electrical & Optical	3.5	39	3.4	22	2.2	22
Transport	5.5	26	7.6	19	5.1	19
Other manufacturing	5.6	77	7.6	48	3.1	48
Non-manufacturing	4.7	38	5.9	21	3.0	23

Source: EEF Sickness Absence Survey 2015

Table A8

Average absence rate (%) by sector and employee type

	All employees		Manual		Non-manual	
	Absence rate	Sample size	Absence rate	Sample size	Absence rate	Sample size
Rubber & Chemicals	2.2	26	2.6	20	1.3	20
Metals	2.2	81	2.4	63	1.8	62
Machinery	2.5	56	2.9	41	1.5	41
Electrical & Optical	1.5	39	1.5	22	0.9	22
Transport	2.4	26	3.3	19	2.2	19
Other manufacturing	2.4	77	3.3	48	1.4	48
Non-manufacturing	2.0	38	2.6	21	1.3	23

Source: EEF Sickness Absence Survey 2015

Table A9

Average number of working days lost to sickness absence per employee by region and employee type

	All employees		Manual		Non-manual	
	Days	Sample size	Days	Sample size	Days	Sample size
South East & Greater London	5.1	28	5.3	15	3.5	15
Eastern	4.4	29	6.5	21	2.5	21
South West	5.6	28	6.6	15	4.7	15
West Midlands	4.2	39	4.7	26	2.1	26
East Midlands	5.7	23	9.0	13	6.8	13
Yorkshire & Humber	5.2	43	5.6	31	3.7	30
North West	6.2	28	6.6	17	4.0	17
North East	4.3	35	5.0	28	3.2	28
Wales	5.2	12	6.7	9	5.1	10
Scotland	5.1	74	6.7	58	2.9	59
Northern Ireland	5.7	4	7.4	1	0.5	1

Source: EEF Sickness Absence Survey 2015

Table A10

Average absence rate (%) by region and employee type

	All employees		Manual		Non-manual	
	Absence rate	Sample size	Absence rate	Sample size	Absence rate	Sample size
South East & Greater London	2.2	28	2.3	15	1.5	15
Eastern	2.0	29	2.8	21	1.1	21
South West	2.5	28	2.9	15	2.1	15
West Midlands	1.8	39	2.1	26	0.9	26
East Midlands	2.5	23	3.9	13	3.0	13
Yorkshire & Humber	2.3	43	2.5	31	1.6	30
North West	2.7	28	2.9	17	1.8	17
North East	1.9	35	2.2	28	1.4	28
Wales	2.3	12	2.9	9	2.2	10
Scotland	2.2	74	2.9	58	1.3	59
Northern Ireland	2.5	4	3.2	1	0.2	1

Source: EEF Sickness Absence Survey 2015

About us

EEF is dedicated to the future of manufacturing. Everything we do is designed to help manufacturing businesses evolve, innovate and compete in a fast-changing world. With our unique combination of business services, government representation and industry intelligence, no other organisation is better placed to provide the skills, knowledge and networks they need to thrive.

We work with the UK's manufacturers, from the largest to the smallest, to help them work better, compete harder and innovate faster. Because we understand manufacturers so well, policy makers trust our advice and welcome our involvement in their deliberations. We work with them to create policies that are in the best interests of manufacturing, that encourage a high growth industry and boost its ability to make a positive contribution to the UK's real economy.

Our policy work delivers real business value for our members, giving us 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 services; services that unlock business potential by creating highly productive workplaces in which innovation, creativity and competitiveness can thrive.

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