June/2014

SICKNESS ABSENCE SURVEY 2014

"This is our eleventh EEF sickness absence survey. As we enter a period of growth, keeping people in work and getting people back to work is as important as ever.
One of the biggest challenges faced by employers is managing long term sickness. Managing sickness absence needs to complement flexibility within workforces by retaining strong employee engagement and investing in employees wellbeing.
A number of stakeholders still have more to do to co-ordinate and improve services to support employees and employers."

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1 Introduction

As we enter a period of growth, keeping people in work and helping people return to work is as important as ever. Government and other agencies still have more to do to coordinate and improve services to support employees and employers.

One of the biggest challenges faced by employers is managing long-term sickness rates – caused in the main by waiting times for diagnosis and treatment and, increasingly, mental ill health and musculoskeletal disorders. The old adage 'healthy bodies, healthy minds = healthy workers' still applies! More enlightened employers recognise this link.

Manufacturers need flexible workforces to respond quickly to changes in customers' needs. Employers secure this flexibility by paying increasing attention to employee engagement and communication, by investing in the wellbeing of staff and by providing employees with the flexibility they need to balance their work and non-work commitments. Management of sickness absence needs to complement this two-way flexibility. Manufacturers recognise the importance of managing sickness absence and the wellbeing of employees, but they need more support from government and other stakeholders if they are going to be able to help reduce long-term sickness absence further.

Companies are increasingly aware of the need for effective sickness absence management. Many understand that they can influence aspects of their employees' physical and psychological wellbeing in ways that can improve their productivity, commitment and attendance. However, they are increasingly concerned that they are being asked by government and others to take on even more responsibility for non-work related psychosocial factors, worsening public health, poor diet, growing obesity, smoking and more sedentary lifestyles.

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

This survey is an important opportunity to assess the continuing progress of the fit note, after its fourth year of operation, including the bedding down of the computer-generated fit note. This follows on from the joint EEF/DWP sickness absence summit held in December 2013 where twenty-four key stakeholders met and discussed what actions they could take to help employers, medical professionals and employees make best use of the fit note.

In this survey, we revisited questions about the fit note which were previously covered in our 2011 sickness absence report to see if respondent views have changed. We asked companies whether or not they manage sickness absence as a business risk and whether or not they measure the economic cost of sickness absence. We also asked companies for the first time whether they measure the return on investment and changes in the levels of sickness absence as a result of introducing wellbeing benefits and services. Finally, in view of the Health and Work Service (HWS) launch this autumn, we asked companies whether or not they currently pay for medical interventions to encourage employees to return to work earlier, and if they don't, whether they would pay if they were to receive some form of tax relief from government.

The survey questionnaire was sent to manufacturers across the UK, and we received 335 responses. As in previous surveys, there was a high response rate from SMEs with up to 250 employees, who accounted for four-fifths (82%) of the respondents. As well as the survey of members, we conducted focus groups in order to obtain more detailed member feedback on specific matters such as the fit note and the government's forthcoming Health and Work Service (HWS).

As always, the survey helps us to identify the key sickness absence issues which employers in the manufacturing sector as well as in industry more broadly need to address. These priorities are relevant for many stakeholders as well as for government, and resolution can only be achieved through extensive collaboration by all concerned.

2 Key findings

The key messages arising from our survey and focus groups are:

- Britain's economic growth prospects depend on people working, being fit and well and being productive;
- Sickness absence rates are at record low levels, but there is increasing concern about the growing number of cases of long-term sickness;
- Mental ill health and musculoskeletal disorders (MSDs), as well as illnesses leading to surgery, top the list of long-term issues;
- Government's flagship fit note still isn't working, and this is a key tool in encouraging those absent from work to return to work earlier;
- There is insufficient GP and medical professional training in the use of the fit note;
- Government should (through the computer-generated fit note) be actively monitoring and reporting on any geographical inconsistencies between GPs who issue 'may be fit for work' fit notes;
- The DWP guidance to GPs makes it clear that the fit note is not suitable for non-health-related issues; this should be reinforced by medical professionals;
- GPs and employers need to work more closely with each other to help people return to work and to use the fit note as intended;
- It is important that the new Health and Work Service (HWS) is ready for launch in the autumn of this year – but use of the service should be mandatory, not voluntary;
- Investing in occupational health training for all GPs with a smaller, more specialist HWS is worth considering if it provides a better outcome for patients and a better return on investment for government;
- The government should give as much focus to reducing long-term sickness absence associated with medical investigations, tests and surgery as to mental ill health and MSDs;
- Government must improve tax incentives for employers to encourage them (especially SMEs) to pay for medical rehabilitation for employees;
- Employers can do more to improve the wellbeing of their workforce by offering the wellbeing benefits and services which have the greatest impact on sickness absence levels and return on investment – although they are wary of 'taking on all of society's ills'.

Absence trends

Our survey has shown the lowest absence rate, at 2.1%, in eleven years of our survey. This translates to an average of 4.9 sickness absence days per employee per year. While absence rates have matched or arrived at their lowest levels, 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 four years.

Half of employees (50%) continue to have no absence because of sickness, which is a consistent story over the past three years.

More than a third (36%) of companies say that long-term sickness absence has increased over the past two years and that the greatest cause of long-term sickness absence is recovery from surgery and time taken out for medical investigations and tests (31%). Reported increases in long-term sickness absence have been a familiar theme in our survey over many years.

Two-fifths (39%) of firms do not set a sickness absence target. This is a similar proportion to that seen in our previous surveys. Of those that set a target in 2013, almost two-thirds (63%) achieved it.

Health and Work Service

The success of the HWS is partially dependent on employers being willing to pay for medical interventions to help their employees return to work earlier. What we found is that almost half (46%) of companies say that they currently pay for medical interventions. The remainder (54%) do not currently pay for medical interventions. Of these employers, almost half (46%) say they would be willing to fund interventions if they were to receive direct tax relief from the government, and almost half (48%) say they would make use of the

government's proposed £500 tax relief cap for employees. However, this means that approximately one quarter (27%) of companies surveyed say that they would not be willing to fund medical interventions. Our focus group participants shed some light on this and told us that the government's proposed tax relief incentives are insufficient and that many companies (in particular SMEs) would only fund medical interventions if these costs could be simply offset against business costs.

For companies making workplace adjustments for their employees in cases of long-term sickness absence, the most difficult to accommodate are mental ill health conditions (30%), MSDs (22%) and post-surgery/medical interventions (17%). This is consistent with our 2012 and 2013 reports and supports the HWS focus on tackling mental ill health and MSDs, but it also suggests that as much focus should be given by the government to reducing long-term sickness absence associated with medical investigations and tests and surgery. This is, of course, dependent on NHS resourcing and NHS waiting lists.

Our focus group responses suggest that the funds being made available for the HWS could more helpfully be put to use by investing in occupational health training for GPs, with a leaner, more specialist HWS managing more complex cases. In a DWP Research report, 96% of working-age patients surveyed said that it should be the role of the GP to help them access treatment and therapy for long-term back pain and long-term depression to help them manage at work.[1] The cost of providing half a day's occupational health training for 40,000 GPs would be approximately £6-8 m (based on the costs of providing the current RCGP training), and the creation of a smaller, more specialist HWS (much less than the £170m proposed) could potentially give a better return on investment for the government. The focus groups also told us that if the government is serious about reducing long-term sickness absence, use of the HWS should not be voluntary, as currently proposed, but mandatory, and that all the stakeholders, including the employer, should have an active role in agreeing employee return-to-work plans.

[1] NICE public health guidance 13, 'Promoting physical activity in the workplace', May 2008, guidance.nice.org.uk/ph13 (accessed 20 May 2014),

The fit note: year 4 progress

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 actions were to be taken.

In terms of progress, we see very little change in the views of EEF members over a four-year period. The fit note is still not delivering on its key objective to return employees to work earlier, and in addition, employers are still reporting that the quality of the advice given by GPs is poor.

Our survey tells us that after four years of the fit note, two-fifths (40%) of employers are reporting that the fit note is not helping employees to return to work earlier. (This figure was also 40% in 2012.) This compares with 24% saying that it has resulted in earlier returns to work. The balance or difference between those agreeing and disagreeing has increased over both the 2012 and the 2013 surveys. If we look at the advice given by GPs about employees' fitness for work, more companies disagree (45%) than agree (16%) that this advice has improved. In both situations, more than a quarter of respondents say that they feel able neither to agree nor to disagree.

Also frustrating is that, overall, a third (33%) of companies report that they did not receive any fit notes in 2013 which were signed 'may be fit for work'. In the four years the fit note has been operating, our surveys have shown that this has consistently ranged between 30% and 35%. It is frustrating because for two consecutive years, half of all employers (50%) have said 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 6% of employers said they are not able to make any adjustments (a decrease from 18% in 2011).

The computer-generated fit note had been in full operation for about nine months at the time of the survey. Our expectation was that we would see a rather higher utilisation of computer-generated fit notes. What we see from our survey is that a quarter (23%) say that none of the fit notes they have received was computer generated. Although some progress has been made, we would like to see a rather faster take-up as well as active monitoring and reporting by government on any geographical inconsistencies between GPs who issue 'may be fit for work' fit notes.

Our focus groups told us that they believe there to be insufficient GP and medical professional training in the use of the fit note, that there is little evidence of hospitals issuing fit notes at all, that the availability of computer-generated fit notes is variable between GP practices and that, although legibility has improved, the quality of the information on the fit note has not. Our focus groups reported continued use of the fit note for non-health-related matters, despite DWP guidance to GPs making it clear that the fit note is not suitable for this purpose.

Health and wellbeing benefits and services

This is the second year we have asked companies about the health and wellbeing benefits they provide to their employees. In addition, this year we asked whether their rationale for offering these benefits is to attract employees, retain employees, reduce sickness absence or improve employee health.

We found that occupational health services (68%) are considered to be the most commonly offered benefit/service for all employees and that private medical insurance (61%) is the most commonly offered benefit/service for senior employees. Provision of facilities for physical activity is the least commonly offered benefit/service at 7%.

The most significant benefit offered to both attract (78%) and retain (70%) senior employees is private medical insurance, whereas the most significant benefit offered to reduce absence (78%) and improve health (65%) is access to an occupational health service.

The benefit least likely to be offered to attract (4%) or retain (3%) employees is the implementation of weight loss advice programmes. The benefit least likely to be offered to reduce sickness absence (2%) is physical activity facilities, and the benefit least likely to be offered to improve health (3%) is income protection insurance.

It is encouraging that two-thirds (66%) of companies say they proactively manage sickness absence as a ‘business risk’. However, it is rather disheartening that four-fifths of companies say they measure neither the return on investment of the wellbeing benefits and services they offer, nor the impact of wellbeing benefits and services on sickness absence levels.

3 Key messages to policymakers

Tackling long-term sickness absence – making the Health and Work Service work for business

We support the government's Health and Work Service initiative to reduce levels of long-term sickness absence. Throughout the history of our Sickness Absence Survey we have seen trends in reported long-term sickness absence increase year on year. Two fifths (40%) of companies report that the most common causes of long-term sickness absence are MSDs, stress and other mental ill health conditions. These are the conditions we are told the HWS will primarily focus on.

We said in our 2013 report that the success of the HWS depends on intervention at an early stage in the referral process, as well as the provision of sufficient incentives for companies to invest in workplace interventions. This is still the case, but success will also depend on the right HWS framework being put in place. To achieve credibility, the HWS must be staffed by healthcare professionals with the right level of occupational health competence, such as mental health professionals with experience. These professionals need to understand and have a good working knowledge of the industries they are dealing with so that they are equipped to recommend the most appropriate adjustments and interventions for that work environment. There also needs to be effective and timely interaction between all those who have a stake in the process. This, of course, includes the patient, GP, HWS, company and, if present, company occupational health provider. Only then will we see return-to-work plans that are agreed by all.

The good news is that almost half (46%) of our members tell us that they already fund medical interventions to help employees return to work earlier. Approximately half (48%) of companies who don't currently fund interventions say they are likely to make use of the government's proposed £500 tax relief cap. However, just over a quarter (27%) of employers who currently don't fund interventions (mainly SMEs) told us that they would not make use of the government's proposed tax relief. Our focus groups said it was not a sufficient incentive for them to pay for medical interventions for their employees.

We are concerned about the government's current tax relief approach because we believe that the success of the HWS will partially depend on employers being willing to fund medical interventions. If employers do not or will not pay, then long-term sickness absence levels will not reduce. We have previously called and continue to call for government to properly incentivise companies by either a simple health tax credit system (percentage savings on health costs incurred) or by allowing companies to simply offset the cost of the intervention (up to a ceiling) against business costs – perhaps as an allowable business expense. The government's own estimate of the net benefits of the HWS suggests that it can afford to look at other ways of incentivising employers.

Our survey tells us that a third (33%) of companies report that long-term sickness absences are concerned with medical tests, medical investigations, waiting times for surgery and post-operative recovery. This is the most significant single cause of long-term sickness absence. Government needs to address this, and we think that the Clinical Commissioning Group should be tasked with facilitating reductions in waiting times from diagnosis to treatment.

We understand why the government has introduced the HWS as a voluntary scheme in order to promote acceptance as it is being rolled out. We do not agree with this 'soft' approach, however. To be serious about preventing unnecessary long-term sickness absence, we think GPs should be obliged to refer employees who have been absent or are likely to be absent from work for more than four weeks (subject to exceptions). Employees themselves should perhaps only receive SSP on condition that they cooperate with the service. GPs could be restricted from signing off a patient for more than four weeks unless the patient engages with the HWS.

Although we support what the HWS is setting out to achieve, some have questioned whether this is the best model for tackling long-term sickness absence. Is the HWS another unaccountable layer of bureaucracy coming between the GP, the patient and the employer? Perhaps we should consider whether GPs should be given greater prominence in the process of facilitating earlier returns to work, and indeed whether GPs themselves should be better trained in occupational health. They would then be in a position to be able to deal directly with their patients and liaise with employers to devise return-to-work plans for the majority of routine long-term sickness absence issues. The minority of issues requiring more specialised referral could be dealt with by a much leaner national occupational health service.

Making the fit note work better

Following our 2013 Sickness Absence Survey 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?

To help answer that question we decided to hold a joint summit with the Department for Work and Pensions (DWP) in December 2013. We brought together twenty-four stakeholder organisations covering the government, employers, the medical profession and other professional bodies including the British Medical Association (BMA) and the Royal College of GPs (RCGP). The summit identified a number of actions to be taken, all of which are still relevant now that we have analysed the results of this year's EEF Sickness Absence Survey.

What the results of the survey show is that the concerns about the fit note expressed in our 2013 survey continue to be concerns in 2014. These can be summarised by saying that although employers support and understand the philosophy behind the fit note, they are not seeing employees returning to work earlier, nor are they seeing improvements in the quality of GP advice to the employer. The computer-generated fit note is gradually being implemented, but the number of 'may be fit for work' fit notes issued is lower than anticipated, even though half of all employers are able to make appropriate workplace adjustments. There is also considerable variability in the quality of the information provided. Medical professionals in hospitals do not appear to be engaged, and the contact between GPs and employers and vice versa is relatively low.

We urgently need to translate the actions from the sickness absence summit and the feedback from EEF members into reality so that the fit note is able to work effectively for business in tandem with the HWS when it becomes operational next autumn. Some of the actions we want to see implemented by the different stakeholders include:

- 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;
- evidence that fit note training is linked to CPD and appraisal systems;
- a date by which all GPs should be using computer-generated fit notes in their surgeries;
- an estimate on the fit note of how long the sickness absence is going to last so employers can plan cover – i.e. 1–3 months, 6–12 months, 12 months+ – with some commentary in the comments box;
- better interaction and communication between GPs and employers and employer occupational health services in the fit note process;
- better targeted advice for SMEs who may come across a fit note infrequently;
- targeting of line manager training and awareness on the fit note process;
- promotion of the fit note process on the first day of employees' induction training;
- development of a template which employees can give to their GP describing the adaptations and modifications their employer can make to facilitate earlier returns to work;
- better analysis of GP performance in using the fit note and issuing 'may be fit for work' fit notes;
- a modification to the fit note to include a referral to the Health and Work Service (HWS).

We have had the debate; we know what we need to do. Now is the time to put these ideas and actions into effect.

Promulgating evidence on whether or not health and wellbeing benefits and services are effective

Our survey has shown that there is considerable variability in the type of health and wellbeing benefits that employers offer to their employees. This raises the question, to what extent do these health and wellbeing benefits reduce sickness absence or improve employee health?

Although two-thirds of those surveyed say that they manage sickness absence as a business risk, four-fifths do not measure the impact on sickness absence or calculate their return on investment. There is a lack of knowledge and information within industry about these health and wellbeing benefits and their true value in improving the productivity, engagement and health of employees.

We would like to see the adoption of a simple, universally accepted and peer-reviewed cost-benefit analysis toolkit – perhaps a further development of the Business in the Community (BITC) wellbeing tool, or the Partnership for European Research in Occupational Safety and Health (PEROSH) wellbeing interactive tree, which employers can use to make informed decisions about the provision of health and wellbeing benefits in the workplace.

This is an important part of the Corporate Social Responsibility (CSR) agenda and will help organisations decide to what extent they want to support the government's public health agenda in encouraging and educating the general public to make healthier choices in their lives.

4 Jelf Employee Benefits' market view

Productivity is directly linked to good work in a safe environment with a positive culture. It is equally affected by the physical, emotional and financial wellbeing of employees. Employers have always understood the impact of absence upon their business and they are increasingly recognising that they are able to mitigate this impact through investment in protecting and promoting positive employee health.

This investment extends beyond a robust absence recording and management process, as awareness must be complemented with action to achieve a successful outcome. The National Health Service is an amazing organisation, but it has finite resources and an inexorable growth in demand, so it can struggle to provide care in time to prevent workplace absence. Careful consideration of budgets and objectives enables employers to justify employee benefits through the direct health-related gains to them as an employer. A robust absence recording and management process, while fundamental to measuring the core gains in isolation, is insufficient to deliver the available gains. We are unsurprised to see that a majority of survey respondents recognise the role of occupational health benefits in reducing absence and improving health, but it is surprising that only a minority chooses to apply this understanding to the business.

Through the recession we have seen little reduction in the provision of private medical benefits and a continued growth in health cash plans. As we emerge into a more certain economy, an increasing number of companies are choosing to extend health benefits to a wider range of employees or to introduce these with the sole purpose of protecting their business by investing in employee health.

We fully recognise that costs remain a determining factor, but Jelf Employee Benefits continues to find that the lean resourcing required for global competitiveness places greater reliance on individuals and their performance. Accordingly, the direct and often more significant indirect costs of absence are becoming better understood, resulting in more employers wishing to provide health benefits. Insurers are responding to this opportunity by developing significantly lower cost products that are targeted at the employer rather than marketed as employee benefits – for example, private medical plans that provide cover solely for diagnosis, or only treat musculoskeletal conditions.

This focus on prevention must become a priority for UK employers, who need to maintain a competitive workforce within an overall population that is both ageing and ailing. This is essential not only to tackle absence but to also address the less easily identifiable issue of presenteeism (reduced job performance resulting from ill health), with people going to work when they are unwell. This is fundamentally a wellbeing problem, with stress and musculoskeletal issues almost certainly mirrored as the main causes, as with absenteeism.

Equally, insurers are responding to the need to shift expenditure from treatment to prevention by building an increasingly sophisticated but easy-to-use range of wellbeing features into their plans. These offer employees information, education and paths to change. Jelf Employee Benefits is increasingly helping employers to promote and highlight these features as part of wellbeing initiatives and policies.

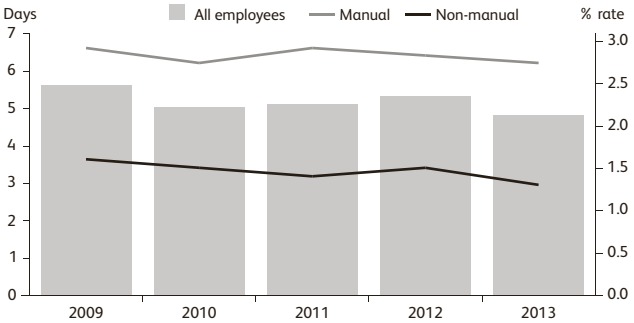
Iain Laws
Managing Director, UK Healthcare
Jelf Employee Benefits

5 Absence trends

Chart 1

Sickness absence fluctuating 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 2014

The average number of days lost to sickness absence in this year's survey stands at 4.9 days, equivalent to an absence rate of 2.1%. Manual workers, at 6.2 days, continue to have higher levels of absence than non-manual employees at 2.9 days. This corresponds to an absence rate of 2.7% and 1.3% respectively.

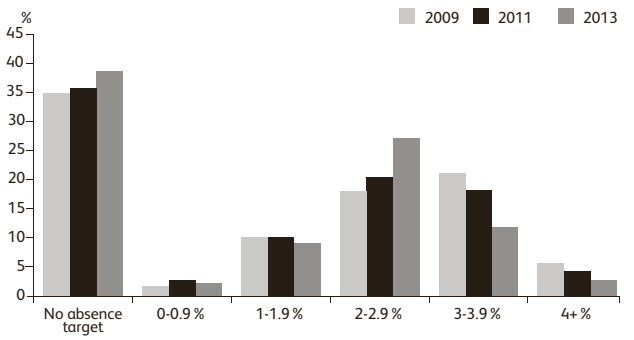
While absence rates have matched or arrived at their lowest levels in the history of the survey, the average number of days lost to sickness absence has been fluctuating at around five days (or a rate of 2.2%) for the past four years. Manual and non-manual employee rates have also levelled out at around 6.4 days (2.8%) and 3.2 days (1.4%) respectively.

The average number of days lost to firms with between one and fifty employees has dipped to less than the four days (2%) mark at 3.7 days (1.6%), while all other sizes of companies show average rates of more than 4.5 days. Companies with 251–500 employees have the highest average number of days lost, at 6.1 days (2.7%). This is a similar picture to the average number of days seen in previous surveys.

Chart 2

Two-fifths of firms have no absence target

% of companies setting absence target by year



Source: EEF Sickness Absence Survey 2010, 2012 & 2014

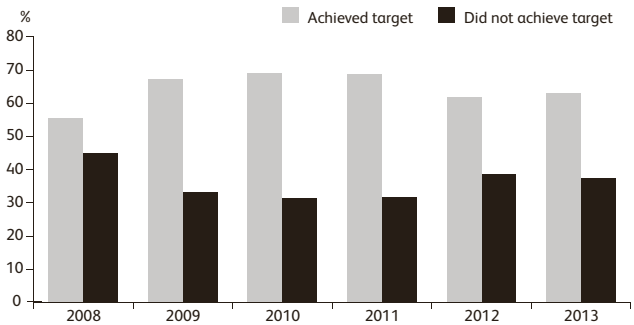
A little less than two-fifths of companies surveyed reported they had set no absence target in 2013. This is a similar proportion to that seen in our previous surveys. Companies reporting they set no target are most likely to be small businesses: incidence of a target increases as company size increases. Almost two-thirds (63%) of those with 1–50 employees did not set a target in 2013, compared with just 13% of those with more than 500 employees. However, companies with fewer than 100 employees are the only ones to have set a target of 0–0.9% (0–2.1 days).

Of those companies that did have a target, 63% report having achieved it in 2013. This was the case even for those companies with the most stretching targets of 0–0.9% (0–2.1 days) and 1–1.9% (2.1–4.3 days).

Chart 3

A little less than two-thirds of companies achieved their absence target

% of companies with absence target who achieved it



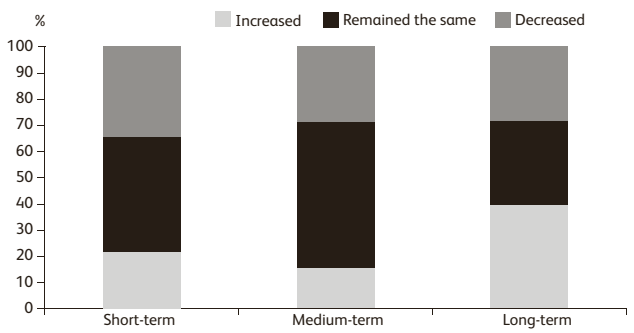
Source: EEF Sickness Absence Survey 2010-2014

Overall we saw that two-thirds (66%) of respondents managed to achieve the sickness absence rate targets they had set of less than 2% (<4.6 days), 62% achieved targets of 2–2.9% (4.6–6.6 days), 58% of 3–3.9% (6.8–8.9 days) and almost four-fifths (78%) achieved targets of 4+% (9.1+ days).

Chart 4

Changes in sickness absence

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



Source: EEF Sickness Absence Survey 2014

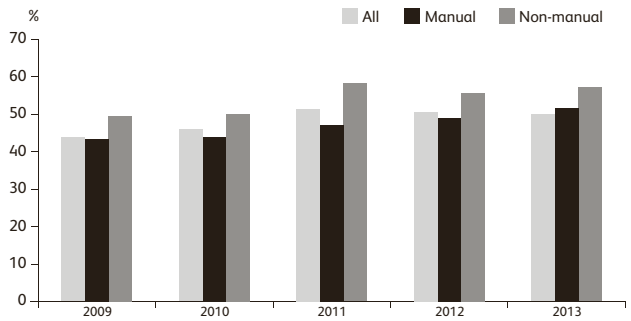
A little more than a fifth of companies reported that their short-term sickness absence (fewer than seven days) has increased in the past two years, while a little more than a third said it has fallen. The picture for medium-term absence (more than seven days but less than four weeks) was a little different, with nearly three-fifths saying that in the past two years the picture has not changed, and just 15% saying it has increased.

There is a marked difference when companies report what has happened with long-term sickness absence, with two-fifths saying it has increased. Increases in long-term sickness absence have been reported in previous surveys. This is perhaps not surprising given that if short-term sickness absence is better managed, long-term sickness absence will be proportionally higher.

Chart 5

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 2014

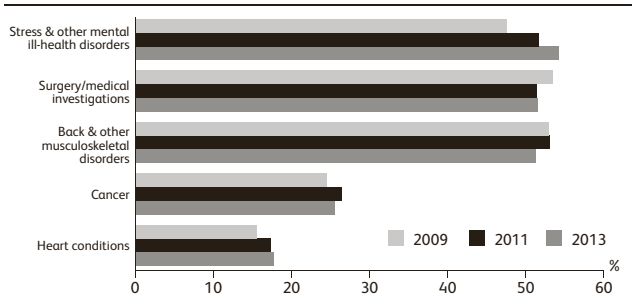
For our 2013 data, the proportion of employees with zero sickness absence remains at the same level as the previous two surveys, at 50%. There has been an increase of ten percentage points since 2007 but it has levelled out at more or less the same figure for the past three years. Smaller companies with fewer than 100 employees show a slightly higher proportion, with around 55% of employees on average taking no sickness absence, while medium and large companies show an average of around 45% of employees with zero sickness absence.

Non-manual workers continue to have higher levels of zero sickness absence than manual workers (57%), although we are now seeing manual workers achieving zero sickness absence levels of more than 50% for the first time.

Chart 6

Mental ill health has overtaken musculoskeletal disorders as one of the main causes cited of long-term sickness absence

% of companies citing the main causes of long-term sickness absence



Source: EEF Sickness Absence Survey 2014

Stress and other mental ill health disorders are reported to be a cause of long-term sickness absence by a little more than half (54%) of surveyed companies, and the proportion of companies reporting this as a cause has increased by 6% over the past five years. It is cited as the most common cause by a little more than one-fifth (21%) of all companies – an increase of five percentage points over the past five years.

Surgery, medical investigations and tests are reported to be a cause of long-term sickness absence by a little more than half (52%) of surveyed companies and the most common cause by a third (31%).

Back and other musculoskeletal disorders are reported as a cause of long-term sickness absence by a little more than half (51%) of respondents, and this remains at similar levels as past survey data. It was considered by a fifth of all companies (20%) to be the most common cause.

The proportion of companies reporting surgery and medical investigations as a cause of long-term sickness absence increases by company size – almost two-fifths (39%) of firms with 1–50 employees compared with almost two-thirds (65%) of companies with 250–500 employees.

6 Health and Work Service

The government is due to introduce the Health and Work Service (HWS), formerly known as the Health and Work Assessment and Advisory Service (HWAAS), from around October 2014. The government expects the HWS to be phased in gradually from October 2014, with the service being available nationally by April 2015. It will apply in England, Wales, Scotland and Northern Ireland.

The service will comprise three elements:

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

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

Employees who are either on, or in the GP's opinion expected to reach, a four-week period of sickness absence can be referred, although employees who are expected to return to work imminently without further assistance would not be suitable for referral. Nor would referral be suitable for employees who are unlikely to return to work. GPs will be able to refer earlier than four weeks if they expect the patient to be off work for more than four weeks and anticipate either a full or partial return to work.

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

The service will produce a return-to-work plan, detailing any obstacles and recommended interventions, and a timetable of when it is anticipated the employee might return to work.

The case manager will have the ability to engage with the employer to understand the workplace and discuss potential interventions to help a person return to work.

The DWP believes that the primary means of conducting the occupational health (OH) assessment will be by telephone, with face-to-face consultation only being required in 5–10% of cases.

The assessment stage of the service following referral will comprise two steps:

- An initial assessment in which the case manager will contact the employee for an initial telephone assessment to enquire about their health condition, absence and details about their job and work pattern. A return-to-work plan will be agreed and weekly progress calls will be made.
- Stage two will provide more specialist advice from a more experienced OH professional or a relevant expert who can give specific advice, more detailed discussion with the employer and a face-to-face assessment.

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

Long-term sickness absence

Chart 7 from our most recent survey shows that musculoskeletal disorders (MSDs) and mental health conditions are the most common causes of long-term sickness absence cited by companies, after surgery and medical investigations.

We also asked companies which conditions they find the most difficult to manage or make workplace adjustments for. Chart 8 illustrates that a little less than a third (30%) cite mental health conditions, a little more than one-fifth (22%) state musculoskeletal conditions and a little less than one-fifth (17%) refer to surgery.

It would seem prudent therefore for the HWS to focus on MSDs and mental health conditions as two of the most significant areas of long-term ill health. However, we do not believe that the HWS should focus on these areas to the exclusion of everything else. Indeed, our focus groups told us that the HWS should deal with all cases of workplace absence and not be limited to mental wellbeing and MSD issues.

We believe an equal amount of focus should be given to reducing long-term sickness absence associated with patients who have to wait for

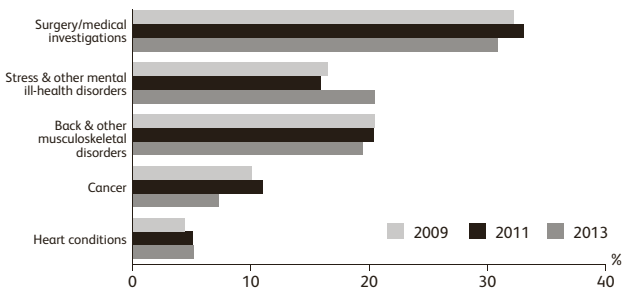
medical investigations and tests for underlying conditions, as well as recovery times from surgery. This was also independently raised by our focus group participants. Chart 7 shows that a third of survey respondents cite this as the most common cause of long-term sickness absence – greater than either MSDs or mental ill health – and this has been a consistent finding in previous EEF surveys.

Another consistent finding from previous surveys is that almost 90% of companies who identify surgery or medical investigations/tests as a cause of long-term sickness absence also identify recovery from treatments and operations as a problem.

Chart 7

Surgery/medical investigations most common cause of long-term sickness absence

% of companies citing the most common cause of long-term sickness absence

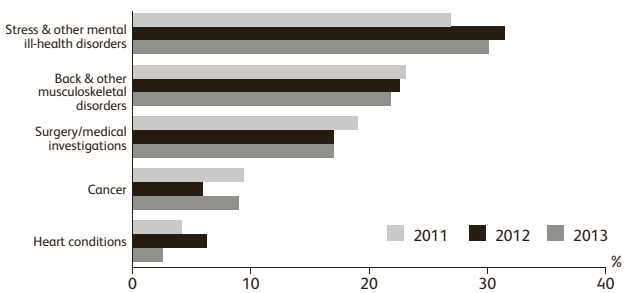


Source: EEF Sickness Absence Surveys 2012-2014

Chart 8

Mental health conditions are the most difficult to manage

% of companies by their most difficult causes of long-term sickness absence for which to make work adjustments



Source: EEF Sickness Absence Surveys 2012-2014

Workplace adjustments and medical interventions

Part of the success in enabling employees to return to work earlier and the HWS reducing the length of sickness absence will be a reliance on employers either (a) making workplace adjustments or (b) funding medical interventions recommended by the return-to-work plan. How this works in practice will largely determine whether the HWS is ultimately successful in helping people return to work earlier and reducing the government's benefits bill as well as employers' occupational sick pay bills.

At the 2013 budget the government announced the introduction of a tax relief for health-related interventions recommended by the HWS. This relief is to be implemented as an exemption from personal income tax and National Insurance contributions (NICs) up to £500 per employee per year for recommended medical interventions that are paid for by employers. In its Autumn Statement 2013, the government decided to extend the tax exemption to medical treatments recommended by employer-arranged occupational health services in addition to those recommended by the new Health and Work Service.

It is unclear at the moment how this will work in practice, from both an administrative and a practical perspective. For example, where an employer-arranged occupational health service recommends a medical treatment, can this be done independently or is a referral by the GP or the employer to the HWS still required? There also needs to be clear advice for companies on whether or not a recommended treatment would qualify for the tax exemption.

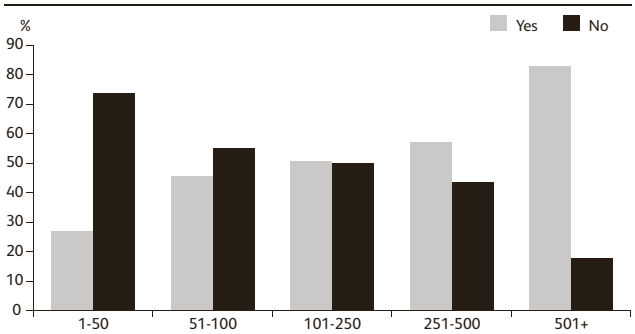
Do companies pay for medical interventions?

EEF asked its members whether they are currently paying for medical interventions to enable employees to return to work sooner. Almost half of all respondents (46%) say they are already doing this, although we do not know how much companies pay on average per individual. However, Chart 9 shows that the willingness to pay is clearly related to company size, with a smaller proportion of SMEs currently paying for medical interventions. This is encouraging from an HWS perspective as it suggests that if almost half of companies are doing this now, they should be willing to fund medical interventions recommended by HWS return-to-work plans when it is fully operational. However, it is also discouraging because the key focus of the HWS is SMEs, who are less likely to pay.

Chart 9

Smaller companies less likely to fund medical interventions

% of companies currently paying for medical interventions in order to enable employees to return to work earlier, by company size



Source: EEF Sickness Absence Survey 2014

Of the respondents who say they are not currently funding medical interventions (54%), almost half (46%) say they would fund medical interventions if the company were to receive some form of direct tax relief from the government towards the cost of the intervention. In addition, 48% say they would fund medical interventions if the expenditure (up to a cap of £500) was exempt from employee income tax and National Insurance contributions.

A little more than a quarter (27%) of our survey respondents do not currently fund medical interventions and do not appear to be attracted to either (a) direct tax relief or (b) a £500 per employee per annum cap where the employee is not be required to pay income tax or national insurance. Why is this?

We asked that question of our focus group participants (mainly SMEs). The majority told us that they do not have a company policy of paying for medical interventions to help employees to return to work more quickly. Payment for medical interventions is not considered the 'norm'.

Most of the focus group members did say that they would consider paying in exceptional circumstances on a discretionary basis to enable a 'key' employee to return to work. It would be managed on a case-by-case basis and would depend on the cost, the individual's value to the organisation and current NHS waiting list times, and it would have to be OH led. Many of the focus group members were concerned that this might show favouritism and would be setting a precedent so that everyone would expect it.

Where companies have paid for medical interventions – such as physiotherapy or individual counselling – the costs are simply considered to be another business cost and are not treated as a benefit in kind. Companies do not complete P11D forms as to do so is considered too time consuming and bureaucratic for what effectively are very small sums of money.

Nearly all of the focus group members said that they are unlikely to make use of the government's £500 tax exemption because there are still no direct cost incentives to employers who effectively would be paying for treatment costs. They also said it would be too burdensome to complete P11D forms for each employee who was to make use of the exemption or to keep internal records to track spending on medical treatments for each individual so that they could demonstrate whether or not they had exceeded the £500 tax exemption limit.

The focus group participants do not believe that the proposed £500 tax exemption will work in practice, nor do they see a health tax credit system working (similar to R&D), unless there is a much more streamlined and less bureaucratic process in place to claim the tax credit against individual employees.

Almost all of the focus group participants told us that they are only likely to be incentivised to pay for medical interventions if the cost of the intervention (up to a ceiling) were to be simply offset against business costs – perhaps as an allowable business expense.

Do we need a Health and Work Service?

The majority of focus group members questioned whether or not the Health and Work Service was the best model for enabling employees to return to work more quickly. The question asked was whether £170m invested in running the HWS over five years represents good value for money and whether it will achieve its aim of reducing levels of long-term sickness absence.

There was a persuasive argument from many of the focus group members that GPs are best placed to help people return to work because of the nature of their relationship with their patients. Very strong

views were expressed that perhaps it would be better to invest some of the HWS budget of £170m in GP training, rather than the HWS, in order to give GPs more occupational health expertise. There was a view that the HWS will simply result in another administrative layer which is too detached from the patient, the GP and the employer.

The HWS is intended primarily to support employers who currently do not fund access to or provision of an OH service. Our previous surveys show this to be around 25% of employers – mainly SMEs with fewer than 100 employees. The HWS clearly fills a gap in the market.

All the focus group participants pay for some form of OH support, although provision varies considerably. Even one employer with thirty staff has access to OH support. The question asked by focus group participants was: what will the HWS service offer over and above the service they are already receiving from OH professionals?

Employer referral

Focus groups members welcome the fact that employers will be able to refer employees to the HWS. They believe delays in the NHS would mean that GPs would wait longer than four weeks before referring.

Voluntary or mandatory?

Focus group members told us that the only way the HWS will work effectively is if GPs were to be obliged to refer employees to the HWS and employees themselves were to be obliged to cooperate with the service. Some went much further, saying that SSP benefits should be withheld from individuals who do not cooperate with the HWS and that it should be compulsory for individuals to see the HWS when a face-to-face meeting is required. It was also suggested that GPs be unable to sign off a patient for more than four weeks unless the patient cooperates with the HWS.

HWS competence

The current specification would allow the HWS to be delivered by healthcare professionals who are only required to demonstrate experience and skills appropriate to working in an occupational health context. In terms of medical competence, our focus groups felt strongly that any healthcare professional working for the HWS should have as a minimum a relevant OH qualification. In addition, it was felt that they should have an expertise/competence in the relevant industry sector they are dealing with, such as chemicals or manufacturing. They also said that for mental wellbeing issues, the HWS would need significant levels of access to mental health professionals.

Telephone or face-to-face consultations

The current HWS specification suggests that the majority of consultations are likely to be carried out by telephone. Focus group members stated a preference for HWS referrals to involve face-to-face meetings rather than a telephone contact and said that in reality this ought to be the default for certain kinds of medical condition, such as mental ill health. There were concerns about how the service would work effectively via telephone contacts – for example, how would the HWS guarantee that they were speaking to the correct person on the telephone?

Where face-to-face meetings do take place, the focus groups said it would be necessary to make it convenient for individuals to meet the HWS through the establishment of local centres – perhaps attached to local medical centres – or indeed home visits, which have been precluded from the government's HWS Invitation to Tender.[2] Thirty minutes' travel time is considered to be reasonable. The maximum ninety minutes' travel time outlined in the government's HWS Invitation to Tender is not considered to be reasonable.[3] The view expressed is that the further individuals have to travel, the less likely they would be to attend.

Interaction between all stakeholders

The focus group participants were unclear as to how the interaction between the employee, GP, HWS, company OH service and employer will be made to work efficiently and effectively. They said they would expect all stakeholders to be involved in the decision-making process, to be told when an employee has been referred to the HWS and to be involved in discussions about the return-to-work plan, including any recommended medical interventions.

[2] Health and Work Service (HWS), Invitation to Tender, Specification and Supporting Information, England and Wales – Contract Package Area Department for Work and Pension, 2014.

[3] Ibid.

7 The fit note (year 4)

In our previous Sickness Absence Surveys we have articulated our continued support for the benefits the fit note can potentially bring in helping employees return to work if suitable work can be found. We have also expressed our concerns that these benefits do not seem to be being realised by our member companies.

This concern led us to organise a joint EEF/DWP sickness absence summit in December 2013. This summit was organised as a result of the 2013 Sickness Absence Survey,[4] which showed that an increasing number of employers believed that the fit note was not resulting in employees making earlier returns to work. It also showed that the average duration of long-term sickness absence had increased over the previous five years. These key factors both have a part to play in economic growth.

The summit included representatives from twenty-four stakeholder organisations including the Department for Work & Pensions (DWP), the British Medical Association (BMA), the Royal College of GPs (RCGP), the Chartered Institute of Personnel Development (CIPD), British Chambers of Commerce (BCC), the Federation of Small Businesses (FSB), the Council for Work and Health, and of course the EEF. It was organised to create a forum for discussion between government, employers, the medical profession and other professional bodies to secure stakeholder commitments on making best use of the fit note by employers, medical professionals and employees, and to share novel and innovative solutions to help reduce the length of long-term sickness absence.

It is too early to have seen the impact of any of the commitments made at the summit in these survey results, as EEF members were surveyed in January 2014. What the results of the survey will do, however, is to see whether the concerns expressed in our 2013 survey continue to be concerns in 2014. As you will see, the survey results regarding the fit note are supplemented by direct feedback which we received from EEF focus groups comprising mainly SMEs.

Fit note or sick note

Focus group participants were asked what they think are the benefits of the current fit note system. They all agree that the fit note concept of specifying whether employees may be fit for work is a positive one, as is the potential for enabling individuals to return to work earlier by helping employees who have in place a phased return to continue to work as part of their rehabilitation. Participants said that the fit note now allows discussions with the individual about a return-to-work programme. Such discussions did not take place so frequently under the previous sick note regime, so the fit note is helping to lead to more effective management of mainly short-term sickness absence.

On balance, the focus group participants do not see many 'real' benefits over the previous sick note system, but they consider it to be marginally better. They said that they do not see any real differences between the fit note and the sick note in reducing sickness absence and in enabling employees to return to work earlier. They said that in their experience the same number of 'not fit for work' notes are being issued now as under the previous sick note system.

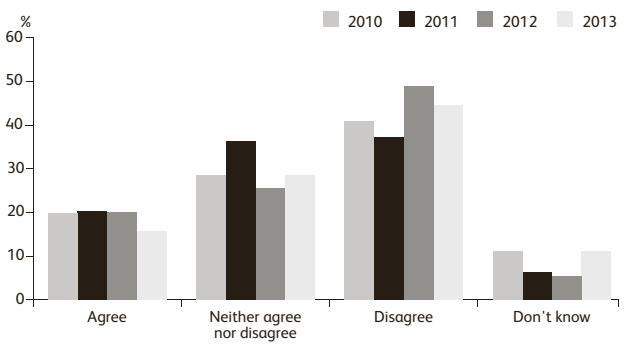
Quality of GP advice and early return to work by employees

Two of the key success measures for the fit note are whether employees return to work earlier and whether employers receive good advice from the GP. These are covered by Charts 10 and 11.

Chart 10

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'



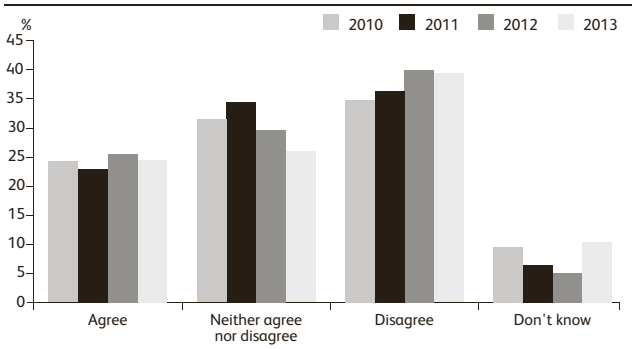
Source: EEF Sickness Absence Surveys 2011-2014

[4] EEF Sickness Absence and Rehabilitation Survey 2013 – a report prepared for EEF by Terence Woolmer, June 2013.

Chart 11

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 2011-2014

After four years of the fit note, two-fifths (40%) of employers (also 40% in 2012) are reporting that employees are not returning to work earlier, compared with 24% who are saying that the fit note has resulted in earlier returns to work. The question of whether the fit note overall has helped employees make an earlier return to work shows a slight increase over both our 2011 and 2012 surveys, with a balance of 15% of employers disagreeing.

More companies disagree than agree with the statement that the fit note has improved the advice given by GPs about employees' fitness for work (balance of -29%), which is the same as our figure from last year.

Charts 10 and 11 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. Our focus group participants told us that they do not see many real differences between the fit note and the previous sick note certification system.

What we see is very little change in the views of EEF members over a four-year period. The fit note is still not delivering on its key objective to return employees to work earlier, and employers are reporting that the quality of the advice given by GPs is poor.

What are the reasons for this? Our focus group participants said that, in their view, some GPs are either not trained or are poorly trained in the use of the fit note, largely because of the differences they see between the way different GPs use the fit note and the extent to which it is considered that a patient 'may be fit for work'. The focus groups told us that they believe the training of medical professionals in the use of the fit note to be a real issue.

In previous survey reports, we have highlighted as an issue access to training in the use of the fit note. We have previously said that anyone in the medical profession who may have to issue a fit note needs to have undertaken some form of training, either online or face to face. We also said that in order to encourage medical professionals to undertake this training, it should be linked to their Continuing Professional Development (CPD) so that health at work and certification is part of the appraisal discussion.

Following our stakeholder summit, the RCGP said, 'We recognise the need to ensure all GPs are fully engaged with the effective operation of the fit note so that employees are helped to get back to work earlier through the "fit for work" and "may be fit for work" assessment process. The RCGP is committed to the continuation of its national education programme on health and work in general practice. The RCGP will also aim to raise the profile of the fit note by embedding health and work in the continuing education of all GPs, including those in training.'

Our focus group participants told us that they have not seen any evidence of fit notes being issued by hospital doctors, and that employees often tell them they have been told by the hospitals to obtain a fit note from their GP. We have also previously reported that there has as yet been no significant training of hospital doctors in certification. This needs to be addressed. Following our summit, the BMA said, 'We recognise the necessity to make the fit note function more effectively for the patient. There is a recognition by the BMA that "good work" improves both physical and mental health. Our commitment to this process is to help the non GP medical professional understand their part in the fit note process and consider the work element of patients who are discharged from hospital following treatment or who return as outpatients.'

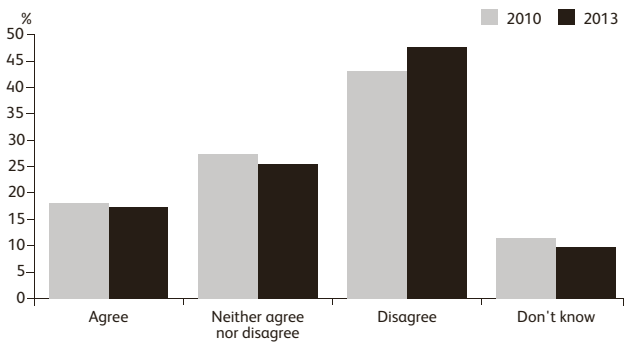
As part of the 2014 survey we took the opportunity to ask questions about the fit note that were previously addressed in our 2011 report when the fit note had been in operation for just one year. Companies were asked whether the fit note had improved the advice given by GPs on what employers can do to help employees make an earlier return to work and whether it had improved the quality of discussions between line managers and employees about returning to work.

Chart 12 records the responses given in 2010 (reported in the 2011 survey) and those given in 2013. Four years after the fit note was introduced, almost half (48%) of all respondents (43% in 2010) report that the fit note has not improved the advice given by GPs on what employers can do to help employees make an earlier return to work. This compares with 17% (18% in 2010) who agree it has improved the advice. A balance of 31% of employers disagree with the statement, which is an increase of six percentage points over that reported in 2010.

Chart 12

More companies disagree that the GP advice on what employers can do for employee return to work has improved

% of companies agreeing with statement, 'Has improved the advice given by GPs on what employers can do help employees make an earlier return to work'



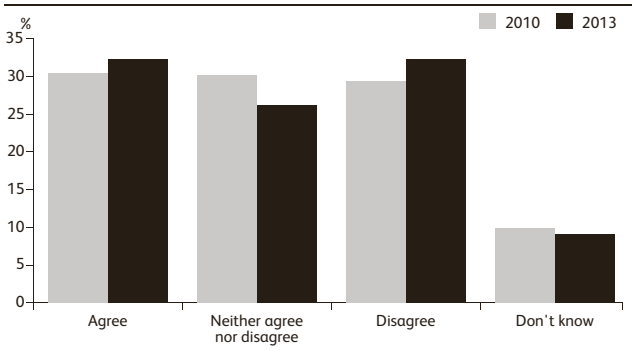
Source: EEF Sickness Absence Surveys 2011 & 2014

Perhaps more positively, Chart 13 illustrates that a little less than a third (32%) of companies agree that the fit note has improved return-to-work discussions between employees and managers. This is a very similar proportion to that reported in 2010 (33%). We should point out, however, that that the same proportion of respondents (32%) disagree that fit note discussions have improved. In 2010, 29% disagreed.

Chart 13

On balance, the fit note has not improved employer/employee discussions about returning to work

% of companies agreeing with statement 'Improved the quality of discussions between line managers and employees about returning to work'



Source: EEF Sickness Absence Surveys 2011 & 2014

Computer-generated or manual fit note

The computer-generated fit note was piloted in July 2012 and the complete roll-out was completed by April 2013.

Our most recent survey was conducted in January 2014. In our 2013 survey report we said that we would expect to see the take-up dramatically increase throughout 2014 and anticipated that by now all GP practices would be issuing computer-generated fit notes to their patients.

Chart 14 shows that by the end of 2013, almost a quarter (23%) (42% in 2012) of employers say that none of the fit notes they received was computer generated. This suggests that GPs are issuing more computer-generated fit notes but that it is not yet commonplace.

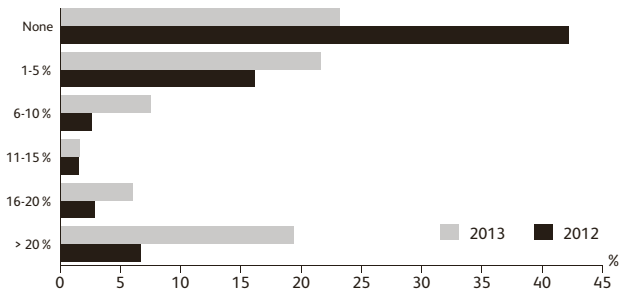
When we asked our EEF focus group participants about the impact of the computer-generated fit note, they said that legibility has improved but the quality of the information on the fit note has not. They also said that they are not seeing many computer-generated fit notes and that manually written fit notes are mostly being issued.

One of the improvements our focus group participants wish to see is the publication of a date by government by which all GPs should be issuing computer-generated fit notes when physically based in their surgeries.

Chart 14

Take-up of computer-generated fit notes gradually improving

% of computer-generated fit notes received by companies



Source: EEF Sickness Absence Surveys 2013 & 2014

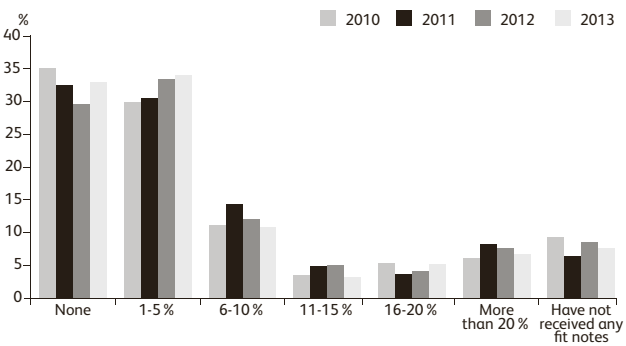
May be fit for work

Chart 15 shows that, overall, a third (33%) of companies report that they did not receive any fit notes in 2013 which were signed 'may be fit for work'. This is rather discouraging. In the four years the fit note has been operating, our surveys have shown this has consistently ranged somewhere between 30% and 35%.

Chart 15

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 2011-2014

Table 1 shows that over two different years of the survey, smaller companies were less likely to be issued with 'may be fit for work' fit notes. In the past we have attributed this to the fact that smaller companies of up to 100 employees have a lower sickness absence rate, have fewer employees and therefore are less likely to receive fit notes. What our focus group participants from smaller SMEs are telling us does reflect the data in Table 1, but we would expect that SMEs should on average be receiving the same proportion of 'may be fit for work' fit notes relative to the number of employees as larger organisations.

Table 1

Smaller companies receive less 'may be fit' for work notes

% of companies receiving fit notes stating 'may be fit for work', by company size

	2011		2013	
	Have not received 'may be fit for work' fit notes	Have not received any fit notes	Have not received 'may be fit for work' fit notes	Have not received any fit notes
1-50	49	21	55	24
51-100	49	3	42	4
101-250	24	1	22	1
251-500	6	2	9	0
501+	8	0	10	0

Source: EEF Sickness Absence Surveys 2012 & 2014

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. The GP fit note guidance issued by the DWP in January 2014 refers to DWP Research Report 733, where employers were reported as wanting more use to be made of the 'may be fit for work' option so that they could explore whether employees could be supported to return to work.[5] In particular, employers wanted clearer and fuller information in the comments section about employees' functional capabilities.

[5]Hann M and Sibbald B (2011), 'General Practitioners' attitudes towards patients' health and work', DWP Research Report 733, http://research.dwp.gov.uk/asd/asd5/rports2011-2012/rrep733.pdf (accessed 20 May 2014).

EEF focus group participants told us that the number of 'may be fit for work' notes issued is variable. This variation occurs in the same GP practices and between GP practices in the same region, as well as geographically between regions.

The focus group participants have observed differences between GPs in how they use the fit note and the extent to which a patient is considered 'may be fit for work'. Most of the focus group participants are of the view that there are GPs who are either not trained or have been poorly trained in the use of the fit note.

They also told us that they often receive 'may be fit for work' fit notes where the comments box is not completed or is not specific enough and the advice is vague and limited – for example, suitability for 'light duties'.

More generally, focus group members told us that they find inconsistencies in the way GPs complete fit notes, not just between GP practices but also between GPs in the same practice. Employers are of the view that GPs usually state what the patient wants to see on the fit note. They also said that the comments box is often empty when the GP ticks the 'not fit for work' option. Other issues identified by the focus groups include fit notes not being signed, employees making modifications to the fit note and GPs not backdating a second fit note if the first fit note has expired.

Focus group contributors do not consider or expect GPs to be occupational health (OH) experts. They believe that generally GPs do not know much about the workplace and that they perhaps are not best equipped to make OH recommendations. There is a strongly held view that OH services/professionals working in or for employers are in a better position to suggest workplace modifications or adaptations than GPs. Indeed, all the focus group participants said that one of the first things they do when presented with a fit note is to discuss with their OH service whether they can accommodate a phased return to work, altered hours, amended duties or workplace adaptations for that employee.

Our focus group participants said that some employees weigh up why they should come back to work if they can be off work and receive sick pay. As a consequence, some of the focus group companies have introduced a policy where sick pay is withheld from employees who refuse to go to the company occupational health service or ignore OH advice about fitness for work. It would be helpful to employers if OH providers are 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.

The GP guidance on 'Getting the most out of the fit note' was updated in March 2013, and we believe it is clear what GPs need to do.[6] It is uncertain why GPs are not issuing more 'may be fit for work' fit notes if they are simply giving functional clinical advice. Perhaps they are not following the DWP advice; perhaps it is a reflection that many GPs still have not received any training; or perhaps the presumption that employers expect to see more 'may be fit for work' fit notes issued is simply unrealistic. We think government should by now (through the computer-generated fit note) be actively monitoring and reporting on any geographical inconsistencies between GPs who issue 'may be fit for work' fit notes.

Workplace adjustments

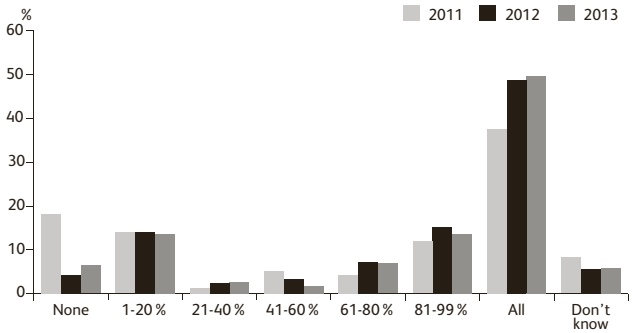
If proof is needed that employers take action when they receive 'may be fit for work' fit notes, it is exemplified by Chart 16. Half of all employers (50%) say that they are able to make all the required workplace adjustments for employees whose fit note is signed 'may be fit for work' (an increase from 38% in 2011), and a further 14% of survey respondents are able to accommodate between 80 and 99% of 'may be fit for work' fit notes. Only 6% of employers say they are not able to make any adjustments (a decrease from 18% in 2011). This demonstrates that there is an appetite by employers to engage with employees and involve them in some form of productive work. It should be an encouragement to GPs to reconsider carefully before they sign patients off as 'not fit for work'.

[6] Department for Work and Pensions, 'Getting the most out of the fit note: GP guidance', January 2014, www.dwp.gov.uk (accessed 20 May 2014), Doc. no: fitnote_gp_v1.

Chart 16

Half 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 2012-2014

For individuals where work adjustments cannot be made, almost three-quarters (72%) of the respondents say this is because suitable work is not available. This is consistent with our findings from 2012. Rather surprisingly, it is larger companies who are more likely to report that alternative work is not available. Almost two-fifths (40%) say there has been insufficient information in fit notes to make a decision (up from 33% in 2012) – something also reported by our focus groups. A further two-fifths (37%) say that it is not possible to make the suggested adjustment, and almost half (46%) of respondents say that they are unable to change the physical aspects of the workplace to accommodate the adjustment. As in last year's survey, it is again the largest companies who report having the greatest difficulty in making physical workplace adjustments. Only 1% of respondents have not understood the advice given in a fit note by a GP – down from 6% in 2012. This could be a reflection of increased use of the computer-generated fit note.

In our 2012 survey, the most common interventions companies implemented as a result of receiving fit notes are 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 are changing the physical layout of the workplace, which we have seen reflected again in the 2014 survey results.

It will be interesting to see what recommendations are made by the Health and Work Service when it becomes established. Employers already accommodate many rehabilitation arrangements, but changes to physical layouts are likely to prove more challenging.

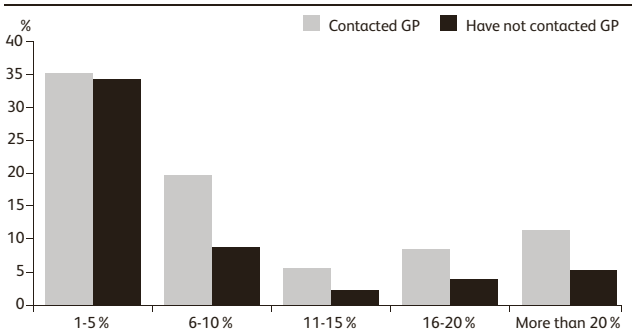
Company contact with GPs

We would like to see employers engaging more with GPs, or indeed GPs engaging with employers. The proportion of survey respondents proactively contacting local GPs about workplace adjustments that can be provided remains low, at 23%. This figure has been similar for the past three years. We still believe that if companies were to be more active in contacting GPs, it might convince GPs to issue more 'may be fit for work' fit notes, especially as we have clear evidence that half of the survey respondents say they could accommodate all the work modifications suggested on a fit note. Chart 17 tells us that companies are more likely to receive 'may be fit for work' fit notes if they contact the GP.

Chart 17

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 2014

Our focus group members are particularly keen to see greater interaction between companies and GPs but they recognise the practicality of doing this, especially if an employer has a wide catchment area with a large number of GP practices. However, where focus group participants have tried to liaise with local GP practices, they have not usually received a reply. As a consequence, these employers now feel disinclined to write to GPs.

The EEF and other employers' organisations clearly have a role to play in facilitating contact between employers and GPs. Following the EEF/DWP sickness absence summit, we said, 'Enabling an earlier return to work is a key factor in promoting economic growth. It is important to make the fit note work better for both patients and employees who want to make an earlier return to work. EEF is committed to improving the dialogue between medical professionals and employers. To help this we will develop a template which employees can give to their GP describing the adaptations and modifications their employer can make to facilitate earlier return to work.'

Backdating of fit notes

Backdating of fit notes is not considered to be a significant problem by focus group members, but is reported to be more prevalent in specific GP locations. Fit notes associated with stress/depression are often backdated, as are those in situations where the patient has been unable to make an appointment with the GP.

Fit note improvements

In terms of improvements to the fit note, our focus groups told us that they would like to see more interaction between GP practices and employers, as well as greater linkages between company OH providers and GPs. With the HWS coming on stream in October 2014, the participants identify a need to incentivise the relationship between the HWS and GPs so that it works effectively.

Focus group participants told us that they have seen many situations where fit notes are issued for non-health-related issues, usually for a performance issue which led to a stress-related fit note, for domestic reasons or where there was a need to care for somebody else. The DWP guidance to GPs is already clear that the fit note is not suitable to cover non-health issues, and this should be reinforced by medical professionals.

Other improvements our focus group participants wish to see are:

- a date by which all GPs should be using computer-generated fit notes in their surgeries;
- clarity that employees can come back to work before the fit note expires;
- an estimate on the fit note of how long the sickness absence is likely to last so employers can plan cover – i.e. 1–3 months; 6–12 months, 12 months+ – with some commentary in the comments box;
- greater interaction and communication between GPs and the company-employed occupational health professional in the fit note process;
- a date by all which all GPs have been trained in completion of the fit note.

Sickness absence summit

A number of suggestions were made at the EEF/DWP sickness absence summit for making better use of the fit note by employers, medical professionals and employees. The principal commitments from the BMA, RCGP and EEF have already been mentioned, but other suggested actions mentioned are:

Employers and employers' organisations

- for better targeted advice for SMEs who may come across a fit note infrequently;
- for targeted line manager training and awareness on the fit note process;
- for guidance to employers that 'Good work is good for you' in terms of physical and mental fitness;
- to promote and deliver the fit note process on the first day of employees' induction training;
- to encourage conversations between employers and GPs about employer capability to make modifications so that GPs are more likely to complete 'may be fit for work' fit notes;
- to develop a template which employees can give to their GP describing the adaptations and modifications their employer can make to facilitate earlier return to work.

GPs and other medical professionals

- to ask patients whether they have access to an occupational health (OH) service and what steps the OH service can put in place to help the patient return to work;
- to make it clear that patients can go back to work before the fit note expires;
- to remind patients and employers that a return-to-work note is not required from the medical professional to say that the fit note has expired;
- to make it clear that either the person is 'fully' fit for normal work duties when the fit note expires or, if they are not 'fully' fit, that changes may have to be made to accommodate a return to work;
- for a reminder that retrospective signing of fit notes is appropriate if the GP has been provided with information or evidence that the individual was ill previously;
- for communication to GPs reminding them that the fit note is not suitable to cover non-health issues;
- for further training for GPs concerning how to manage patients who put them under pressure to issue fit notes for non-health issues, especially as the fit note will be used to claim benefits;
- to ensure training in the use of the fit note by medical professionals in hospitals;
- to ensure good communication between GPs and other healthcare professionals, such as physiotherapists, for appropriate input into the fit note process;
- to ensure fit note GP and medical professional training, which can include cascade training and the cascade of information;
- for provision of posters in workplaces, GP surgeries and hospitals specifying recovery times from surgery.

Government

- to add a contact telephone number on the back of the fit note so that employers can obtain further information on the fit note or use other government mechanisms to remind employers of the fit note process, such as HMRC;
- to consider modifying the fit note to include a referral to the Health and Work Service (HWS);
- to provide more articles making the case that 'Good work is good for you' in the national papers via health correspondents;
- to remind stakeholders, in terms of legal liability issues, that employees can return to work at any time (including before the expiry of the fit note) without going back to see their doctor, even if their doctor has indicated that they need to assess them again. This will not breach Employers Liability Compulsory Insurance, providing a suitable risk assessment has taken place if required;
- to consider the feasibility around whether medical professionals other than GPs could sign fit notes in certain circumstances (such as physiotherapists);
- to make a pitch to include some fit note public broadcast information storylines in relevant TV soaps, such as *Eastenders*.

Next steps

We still consider the fit note to be an extremely important initiative in helping people return to work and in preventing employees from sliding into long-term absence. We intend therefore to work constructively with other stakeholders and take forward both the actions arising out of the EEF/DWP sickness absence summit and the suggestions for improvement raised by the EEF focus groups.

8 Employee health and wellbeing benefits

Many of the measures taken by employers to improve workplace health are often categorised as 'perks' or employee benefits. However, health and wellbeing benefits can be part of a long-term strategy to improve the productivity, engagement and healthcare of employees. Wellness and wellbeing benefits have increasingly become an integral component of company healthcare and sickness absence strategies. Typical services include health assessments, healthcare cash plans, private medical insurance, counselling, fitness strategies and healthy eating.

Our 2013 survey was the first year we asked companies what health and wellbeing benefits they offer to their employees, those they are planning to withdraw, reduce or limit eligibility for and those they are considering offering to their employees over the next twelve months. This year we decided to explore in more detail whether these health and wellbeing benefits are offered to *all* employees or just senior employees, as well as the reasons why the benefits and services are offered. We also wanted to ascertain whether or not companies measure the return on investment of these benefits and services and whether their provision has any impact on sickness absence levels.

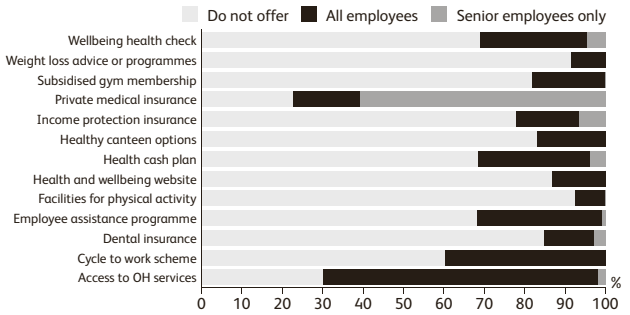
Most popular health and wellbeing benefits

Chart 18 clearly shows that the most popular benefit or service offered to all employees is the provision of access to an occupational health service. This is offered to almost seven-tenths (68%) of all employees. This coincides with responses we have received in our previous Sickness Absence Surveys where we have reported that the proportion of employers providing an OH service has increased year on year.

Chart 18

Access to occupational health services – the most commonly offered benefit/service

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



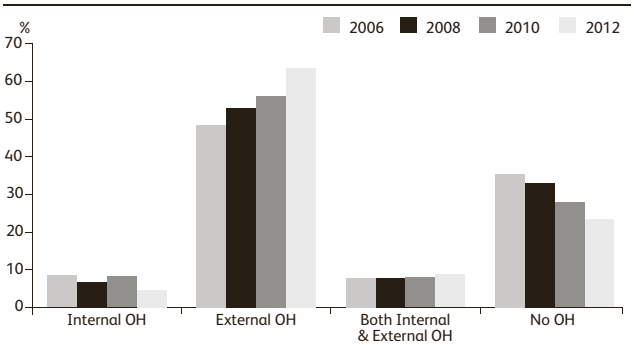
Source: EEF Sickness Absence Survey 2014

Chart 19 from our 2013 survey report shows that 70% of all employers make a provision for employees to access an OH service. Smaller companies with fewer than 100 employees are less likely to deliver an OH provision.

Chart 19

Lowest level of firms without OH provision

% of companies offering types of OH provision, by year



Source: EEF Sickness Absence Surveys 2007-2013

The next four most commonly ranked benefits or services offered to all employees are cycle to work schemes (40%), employee assistance programmes (31%), health cash plans (28%) and wellbeing health checks (27%). The ranking for wellbeing

health checks contrasts with our 2013 survey where they were identified as the most popular benefit offered (56%).

Of the top five ranked benefits provided, perhaps the provision of cycle to work schemes is the most surprising, although it is one of the fastest growing and most sought after employee benefits.

The cycle to work scheme is part of the government's Green Transport Plan which allows employers to provide cycles and safety equipment to employees as a tax-free benefit and can save the employee up to about 40% of the cost of a new bike. With a focus on health, economic and green credentials, cycle to work schemes are popular with both employers and employees.

Employee assistance programmes have long been offered by EEF member companies. Primarily they are confidential information and support services designed to support employees who have work or personal problems. They include twenty-four-hour helplines and sometimes also offer access to face-to-face or telephone counselling. They can be used to support companies with work-related issues through the generation of management information which can then be used to help employers identify potential problems in the workplace. These schemes are perceived to be an important benefit in helping support employees with stress-related issues.

Health cash plans are increasingly popular. They are effectively insurance products which allow employees to claim money back towards vital health costs such as eyecare, dental treatment, physiotherapy and diagnostic consultations. Employees have the option of enhancing their basic plan by paying for additional benefits. Employers see these plans as benefits of relatively low cost that have a high perceived value for employees. Unlike private medical insurance (PMI), employees do not have to wait until something goes wrong to utilise the benefit. The plans can be effective in helping to minimise sickness absence caused by delays in diagnosis and minor treatments.

Wellbeing checks are typically offered both online and face-to-face. Employees are invited to provide information about their physical and emotional health and wellbeing in order to develop an action plan to help them make realistic changes to their daily life in order to improve overall health and wellbeing. 'Well-person health checks' are often tailored to fit the employer's requirements and can include blood pressure, body mass index, diet, exercise, smoking cessation, alcohol intake, stress management, gender-specific health screening and even cardiovascular risk screening programmes. Health assessments and screenings allow employees to make decisions about lifestyle matters.

On the whole, the benefits offered are made available to all employees, although clearly private medical insurance is proffered more exclusively to senior managers (61%) than to other employees (17%). Private medical insurance is often also 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.

Least popular health and wellbeing benefits

The five benefits or services least offered by employers include the provision of facilities for physical activity (7%), weight loss advice or programme (9%), dental insurance (12%), a health and wellbeing website (13%) and income protection insurance (16%).

It is not surprising, perhaps, that only 7% of employers provide workplace facilities for physical activity as this requires investment and space; indeed, many larger companies historically sold off their sports facilities and playing fields. However, the link between prevention and improvement of chronic diseases and physical activity is well established, and regular physical activity has an important beneficial role in an individual's general psychological wellbeing. Guidance from NICE on promoting physical activity in the workplace suggests that if employers invest in the physical health of their workforce, this can bring business benefits such as reduced sickness absence, improved productivity and reduced costs for employers, as well as increased loyalty and better staff retention.[7]

So why are companies in our survey not providing workplace facilities? Perhaps they consider this to be a lifestyle choice for individuals to take up outside of work, or perhaps they don't see any direct evidence that investment in workplace facilities helps to reduce sickness absence and improve productivity. Our survey certainly shows that companies do not see this as a means to attract or retain employees or even to reduce sickness absence. It appears that enlightened companies are more likely to encourage

[7] NICE public health guidance 13, 'Promoting physical activity in the workplace'.

physical activity through subsidised membership at community or private facilities, such as gyms and sports clubs, than to provide their own facilities.

Income protection insurance is offered by around a sixth of all respondents. These may include both cover for individual employees as well as group income protection policies, which provide replacement income if an employee is unable to work due to illness or injury.

Money well spent?

When asked if companies measured the return on investment for the wellbeing benefits and services they offer, a staggering four-fifths (81%) of respondents say they do not. In fact, only 3% measure the return on investment.

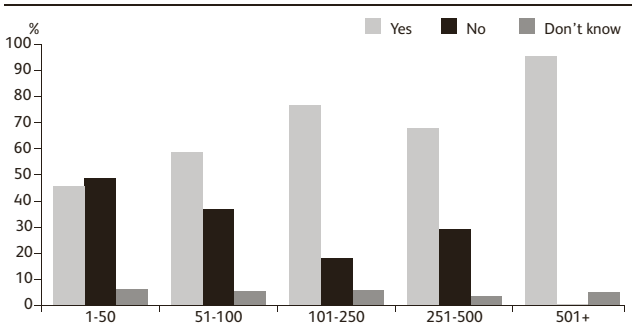
When asked whether companies measure the impact of wellbeing benefits and services on sickness absence levels, a remarkable four-fifths (79%) say they do not. Only 5% say that they measure the impact on sickness absence.

These responses seem to be all the more extraordinary as two-thirds (66%) of companies, when asked whether they proactively manage sickness absence as a 'business risk', say that they do. Chart 20 demonstrates the level of proactivity related to company size.

Chart 20

Proactivity in managing sickness risk linked to company size

% of companies proactively managing sickness absence as a 'business risk', by company size



Source: EEF Sickness Absence Survey 2014

These responses are revealing, especially now that employee health is considered to have an economic influence on production. It is likely that survey respondents have interpreted 'proactive' management of sickness absence to refer to the day-to-day management of individuals who are absent from work, involving self-certification, fit notes, referral to occupational health and return-to-work plans.

It does not appear from the responses received, however, that proactive management of sickness absence involves survey respondents asking fundamental questions on why companies are investing in providing health and wellbeing benefits and whether or not this reduces sickness absence levels, as claimed by the many providers of these products and services.

We think companies need to take workplace health and wellbeing as seriously as they take many of their other management responsibilities. They also need to be careful to choose products and services which both provide the best value and demonstrate the greatest health and wellbeing improvements.

Do health and wellbeing benefits reduce sickness absence? Survey data from our 2013 report suggests that there may be an association between lower absence rates in companies that offer some of these benefits, including workplace exercise programmes or subsidised private medical insurance.

It has been suggested that the best way to incentivise attendance is through wellness programmes which reduce the costs associated with lost productivity and absenteeism and result in improved performance, such as health promotion initiatives and well person checks. However, in order for organisations to develop attractive and suitable health and wellbeing programmes that include incentives (e.g. discounted gym membership), it is essential that employers record the main reasons for sickness absence accurately in order to differentiate from absences due to non-health-related reasons.

Attraction and retention

Survey respondents were asked why they offer health and wellbeing benefits and services to their employees – whether it is to attract and/or retain employees or to reduce absence and/or improve health.

Table 2 shows that the most significant benefit offered to both attract (78%) and retain (70%) senior employees is private medical insurance, which is perhaps not surprising. What is noteworthy is that offering private medical insurance is not considered to be so significant a reason in terms of reducing absence (39%) or improving health (31%).

Table 2

Top five mostly 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	78	Private medical insurance	70	Access to OH services	78	Access to OH services	65
2	Cycle to work scheme	32	Access to OH services	30	Private medical insurance	39	Wellbeing health check	38
3	Health cash plan	27	Health cash plan	28	Employee assistance programme	32	Private medical insurance	31
4	Income protection insurance	22	Cycle to work scheme	25	Wellbeing health check	25	Cycle to work scheme	31
5	Access to OH services	20	Employee assistance programme	22	Health cash plan	13	Employee assistance programme	25

Source: EEF Sickness Absence Survey 2014

The next most significant benefit offered to attract and retain employees is the cycle to work scheme, followed by health cash plans.

Reduce absence and/or improve health

Table 2 reveals that access to an occupational health service is the most significant benefit offered to reduce absence (78%) and improve health (65%). While OH services can provide valuable support to staff, this could be perceived as a reactive approach to absence management. The next most significant benefits offered to reduce absence are private medical insurance (39%) followed by an employee assistance programme (32%), wellbeing check (25%) and the health cash plan (13%). This last is surprising, as many health cash plans include annual allowances for health assessments and access to wellbeing information and pathways to change.

In terms of improving health, the next most significant benefit offered after occupational health is the wellbeing check (38%). This is followed by private medical insurance (31%), cycle to work schemes (31%) and employee assistance programmes (25%).

What was unexpected is that survey respondents do not view health cash plans particularly highly in terms of employee attraction and retention, nor in terms of absence reduction or health improvement. Many health cash plans are sold on the basis that they form part of an overall health and wellbeing programme to help improve absence rates. They often cover the cost of a wide range of everyday healthcare needs, such as visits to the dentist and the optician as well as physiotherapy, osteopathy and chiropractic treatments to manage musculoskeletal conditions.

What can companies do to help themselves?

Employers need better and more impartial information to make intelligent decisions about the benefits and services which work and which reduce absence and improve health. Claims are made, but need to be substantiated. Employers need to be convinced that these provide a better option than attendance incentives.

Employers can help themselves by doing their own cost-benefit analysis. Unfortunately, the responsibility for providing an employer's healthcare strategy and individual benefits is often divided between a number of different parts of the organisation – HR, occupational health, health and safety and finance, for example. This can result in ineffective strategies as teams fail to understand their responsibilities for providing the benefits.

Employers need to look at their healthcare strategies with a strategic overview of their current healthcare benefits and the employees tasked with delivering them, and then set a clear governance structure, determining where responsibility lies.

Employers need to consider where their employee benefits data is held and what it consists of. Healthcare benefits data can then be shared and tracked using a dashboard. This will allow the company to obtain a complete picture of employee health and wellbeing in order to inform and drive their healthcare strategy.

Appendix 1: Benchmarking data

Table A1

Breakdown of survey respondents by company size (%)

1–50	26.0
51–100	22.4
101–250	33.7
251–500	11.0
501+	6.9

Source: EEF Sickness Absence Survey 2014

Table A2

Breakdown of survey respondents by sector (%)

Rubber & Chemicals	8.4
Metals	21.8
Machinery	19.1
Electrical & Optical	9.9
Transport	5.7
Other manufacturing	23.0
Non-manufacturing	12.2

Source: EEF Sickness Absence Survey 2014

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 2014

Table A4

Sickness absence levels in 2009-2013 by type of employee

Average days lost to sickness absence

	All employees	Sample size	Manual	Sample size	Non-manual	Sample size
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
2009	5.6	454	6.6	315	3.6	339

Average absence rate %

	All employees	Sample size	Manual	Sample size	Non-manual	Sample size
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
2009	2.4	454	2.9	315	1.6	339

Source: EEF Sickness Absence Survey 2010-2014

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	3.7	81	5.0	59	1.9	64
51–100	4.7	70	6.3	51	3.0	51
101–250	5.4	102	6.9	58	3.4	59
251–500	6.1	29	6.7	13	2.9	14
501+	5.5	22	6.9	14	4.6	14

Source: EEF Sickness Absence Survey 2014

Table A6

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

	All employees		Manual		Non-manual	
	%	Sample size	%	Sample size	%	Sample size
1–50	1.6	81	2.2	59	0.8	64
51–100	2.0	70	2.8	51	1.3	51
101–250	2.4	102	3.0	58	1.5	59
251–500	2.7	29	3.0	13	1.3	14
501+	2.4	22	3.0	14	2.0	14

Source: EEF Sickness Absence Survey 2014

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	5.6	23	5.4	14	3.5	14
Metals	4.3	67	5.5	47	2.8	49
Machinery	4.3	60	6.0	47	2.9	46
Electrical & Optical	4.4	32	5.9	17	2.1	19
Transport	7.3	16	9.0	7	5.8	7
Other manufacturing	5.4	70	7.0	49	2.4	50
Non-manufacturing	4.5	36	5.4	14	3.6	17

Source: EEF Sickness Absence Survey 2014

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	2.4	23	2.4	14	1.5	14
Metals	1.9	67	2.4	47	1.2	49
Machinery	1.9	60	2.6	47	1.3	46
Electrical & Optical	1.9	32	2.6	17	0.9	19
Transport	3.2	16	3.9	7	2.5	7
Other manufacturing	2.3	70	3.1	49	1.1	50
Non-manufacturing	2.0	36	2.4	14	1.6	17

Source: EEF Sickness Absence Survey 2014

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	3.5	23	4.0	13	2.3	14
Eastern	4.5	25	6.1	15	2.3	17
South West	5.2	24	6.8	16	3.0	16
West Midlands	4.9	45	5.9	24	3.1	24
East Midlands	5.5	29	7.9	19	3.6	20
Yorkshire & Humber	5.1	28	6.8	17	3.6	20
North West	5.6	19	8.2	13	2.7	13
North East	5.5	29	7.4	19	3.3	19
Wales	5.7	8	8.2	4	3.1	4
Scotland	4.3	74	4.8	55	2.4	55

Source: EEF Sickness Absence Survey 2014

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	1.5	23	1.7	13	1.0	14
Eastern	2.0	25	2.7	15	1.0	17
South West	2.3	24	3.0	16	1.3	16
West Midlands	2.2	45	2.6	24	1.4	24
East Midlands	2.4	29	3.5	19	1.6	20
Yorkshire & Humber	2.2	28	3.0	17	1.6	20
North West	2.4	19	3.6	13	1.2	13
North East	2.4	29	3.2	19	1.4	19
Wales	2.5	8	3.6	4	1.4	4
Scotland	1.9	74	2.1	55	1.1	55

Source: EEF Sickness Absence Survey 2014

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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Jelf Employee Benefits is an award-winning specialist consultancy with expertise in designing solutions that bring sustainable benefits for your business. We currently advise c5000 companies on a range of employee benefits strategies.

Key areas where we can add real value to your business include

- Duty of care – help to satisfy your legal requirement for every employee
- Cost savings – by reducing sickness and absence
- Better employee health, engagement and productivity
- Improved morale and retention

How we work with clients

We build a detailed understanding of our clients' businesses, using a straight forward 5 stage process:

1. Consultation
- Client meeting
- Appreciate unique circumstances
- Understand objectives
- Agree requirements

2. Proposal
- Client meeting
- Present fully researched options
- Agree the way forward

3. Implementation
- Take ownership
- Manage the process
- Ease client workload

4. Communication
- Develop strategy
- Benefit provider communication
- Worksite communication

5. Ongoing Management
- On hand to help
- Regular reviews and comparisons
- Worksite communication
- Benefits kept up to date and relevant

Whether you're looking for a simple product solution, or a complete audit of your employee wellbeing strategy, Jelf Employee Benefits would be delighted to help.

For more information:
- Call: 0370 218 6236
- Email us: benefits@jelfgroup.com
- Visit: www.jelfgroup.com/wellbeingatwork

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