ABERDEEN CITY COUNCIL

COMMITTEE	Staff Governance
DATE	21 February 2022
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Employee Assistance Service Annual Progress Update Occupational Health and Absence Annual Update January 2021 – December 2021
REPORT NUMBER	RES/22/029
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TERMS OF REFERENCE	2.7

1. PURPOSE OF REPORT

1.1 This report updates the Committee on utilisation of the Employee Assistance Service (EAS) provided by Time for Talking during the last 12 month period 1st January 2021 – 31st December 2021 and provides a 12 monthly update on the Occupational Health and Absence period 1st January 2021 – 31st December 2021.

2. RECOMMENDATION

2.1 That the Committee considers the contents of the report.

3. BACKGROUND

3.1 Following a joint tender evaluation process with Aberdeenshire Council, Therapeutic Counselling Services Ltd. (Time for Talking) were awarded the Employee Assistance Service (EAS) contract. The contract commenced on 01 January 2017 and is for the duration of 3 years and with the option of a one-year extension which was taken up in January 2020. A report was taken to Strategic Commissioning Committee in November 2020 and approval was given to renew the contract until June 2024, with a further option to extend for two years at the end of this period.

3.2 Iqarus were awarded the Occupational Health Contract which commenced in August 2018 for a period of 3 years with the option of a further two years. Following discussion with Aberdeenshire Council, who are part of the joint contact, the option to extend the contract for a period of 2 years was taken up in August 2021, with the contract being extended until July 2023.

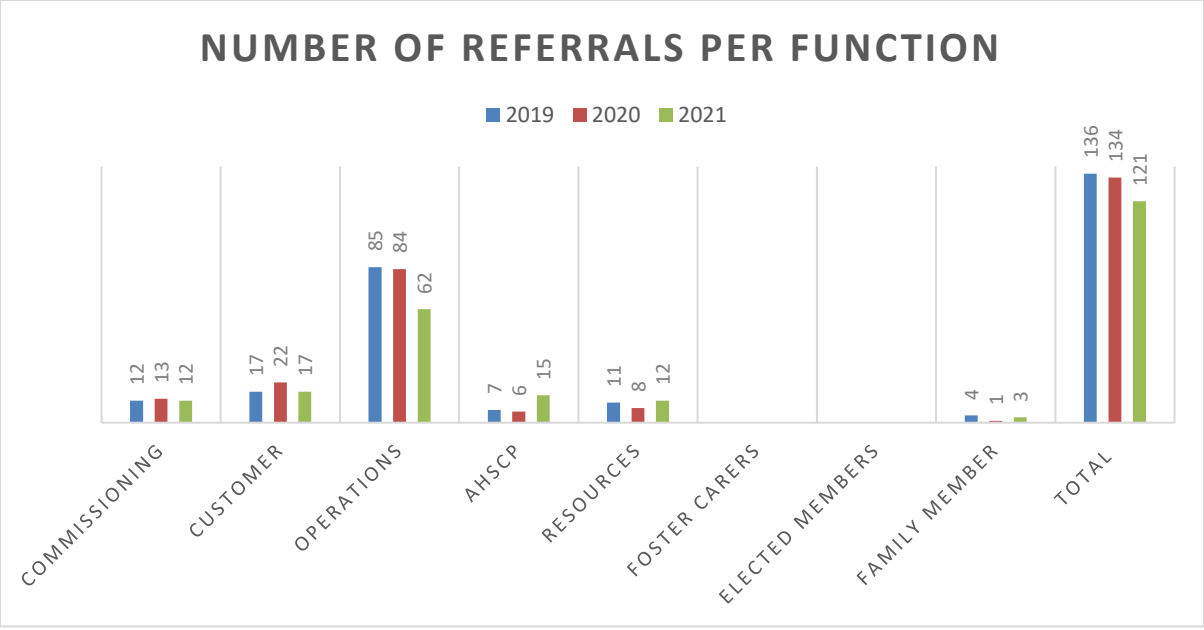
This report contains Employee Assistance Service utilisation information on the 12-month reporting period (January 2021 – December 2021) and information relating to the EAS, Absence and Occupational Health (January 2021 – December 2021). This brings both the reporting cycles in line with each other.

3.3 An effective EAS service supports individuals with difficulties in their lives; sometimes these problems can affect an individual's ability to function fully at work or at home. This in turn may impact on their mental health and wellbeing, which may also impact on their productivity, attendance and associated costs. Both direct and indirect costs require to be considered.

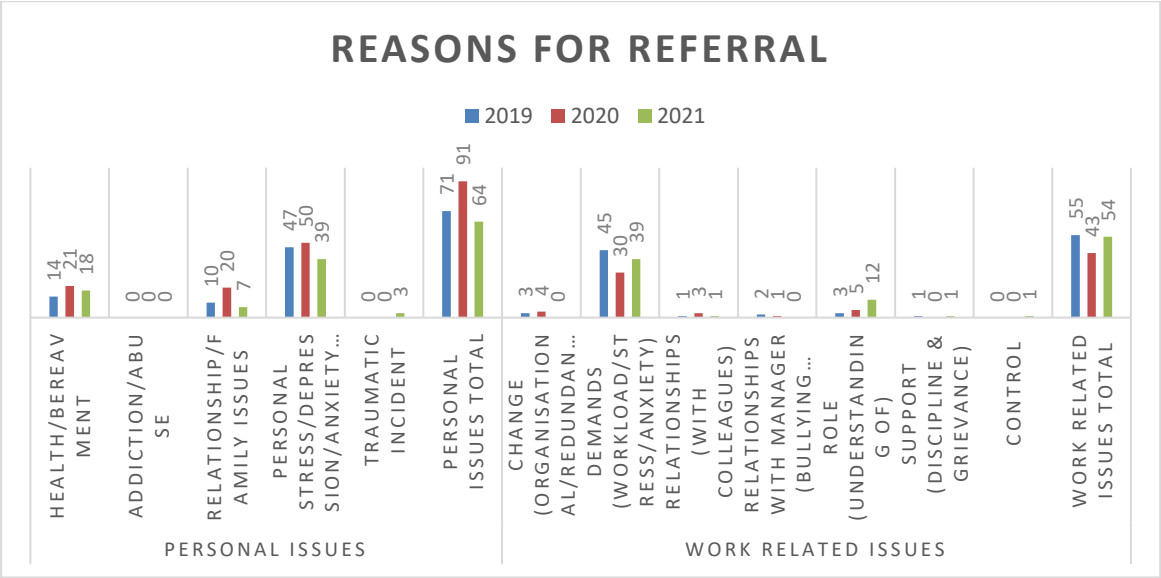
3.4 The longer an employee is off work the more challenging it becomes to manage their health problems and less likely that they will return to work. Long-term absence is costly. There is mutual benefit if we can proactively support employees in the workplace and help employees avoid long waiting times for, e.g. counselling or psychological therapy.

Employee Assistance Service Utilisation 12 Monthly Reporting Period January 2021 – December 2021)

3.5 A total of 121 referrals were made during the 12-month period (1 January 2021 to 31 December 2021) comprising employees (118) and family members (3). The overall figure is lower than the same period (January 2020 – December 2020) which was 134 and compared with 136 referrals to the service in the period (1 January 2019 to 31 December 2019) shows a downward trend in staff accessing the service over the last 3 years.



3.5.1 There were a higher number of referrals relating to Personal Issues (64) compared to Work-Related Issues (54) which represents a similar trend as the last reporting period (1 January 2020 to 31 December 2020) and accounts for 55% of the use of the Employee Assistance Service. 45% of users accessing the service do so for work-related issues.



3.5.2 The two main reasons for non-work-related use of the EAS are personal stress (32% of referrals) and health/bereavement (15% of referrals). The greatest number of referrals came from the Operations function (51%), this includes Integrated Children's and Family Services and Protective Services and accounts for 75% of all employees in the workplace. The greatest percentage of staff usage within a function came from Resources at 4.65%.

3.5.3 Overall the 2021 data for staff using the employee assistance service has decreased compared to the previous year, 1 January 2020 to 31 December 2020. Work related issues have increased since the last period, and of those work-related issues, demands (workload/ stress/anxiety), remained consistently the most common reason for using the employee assistance service with 39 out of 121, 32%, although down slightly as a percentage of overall service usage in this reporting period. These figures show a similar trend compared to the last 2 reporting periods (2020 and 2019) where previously, of work-related issues demands accounted for 40% and 61% respectively. Of the Personal Issues, 39 out of 64, 60% relates to personal stress/depression/anxiety/anger which again shows a decrease from the last reporting period, 50 out of 91, 55%.

1 January 2021 - 31 December 2021	Number of Staff within Service	% of Staff usage	Number of referrals	Personal Issues	Health/Bereavment	Addiction/Abuse	Relationship/Family Issues	Personal Stress/Depression/Anxiety/Anger	Traumatic Incident	Work Related Issues	**Change** (Organisational/redundancy)	**Demands** (Workload/Stress/Anxiety)	**Relationships** (with colleagues)	**Relationships** with manager (Bullying Harassment)	**Role** (Understanding of)	**Support** (discipline & grievance)	**Control**
Functions																	
Commissioning	416	2.88	12		<5	0	<5	<5	0		0	<5	0	0	0	<5	0
Customer	941	1.81	17		<5	0	0	7	0		0	<5	0	0	<5	0	<5
Operations	6231	1.00	62		6	0	<5	22	<5		0	19	0	0	11	0	0
AHSCP	464	3.23	15		<5	0	<5	<5	0		0	7	0	0	0	0	0
Resources	258	4.65	12		<5	0	<5	<5	0		0	5	<5	0	0	0	0
Foster Carers	0	0	0		0	0	0	0	0		0	0	0	0	0	0	0
Elected Members	0	0	0		0	0	0	0	0		0	0	0	0	0	0	0
Family Member	0	0	<5		0	0	0	<5	<5		0	0	0	0	0	0	0
Total Number of Referrals/C'ling	**8310**	**1.46**	**121**		**18**	**0**	**7**	**39**	**<5**		**0**	**39**	**<5**	**0**	**12**	**<5**	**<5**

3.5.4 The breakdown of figures for access to the service by function for the period January 2021 to December 2021 is shown in the table below: -

	Ccommercial and Procurement	ALEO's	Governance	Strategic Place Planning	City Growth	Customer Experience	Early Interven and Comm Emp	Digital and technology	Data & Insights	External Communications	Integrated Childrens and Fam Serv	Operations and Protective Services	Health & Social Care Partnership	Finance	Capital	People and Organisational Development	Corporate Landlord	Foster Carers	Elected Members	Family Member
Commissioning	<5	<5	<5	<5	<5	0	0	0	<5	0	0	0	0	0	0	0	0	0	0	0
Customer	0	0	0	0	0	5	11	0	0	<5	0	0	0	0	0	0	0	0	0	0
Operations	0	0	0	0	0	0	0	0	0	0	46	16	0	0	0	0	0	0	0	0
AHSCP	0	0	0	0	0	0	0	0	0	0	0	0	15	0	0	0	0	0	0	0
Resources	0	0	0	0	0	0	0	0	0	0	0	0	0	<5	0	11	0	0	0	0
Foster Carers	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Elected Members	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Family Member	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	<5
	1	**1**	**<5**	**<5**	**<5**	**5**	**11**	**0**	**<5**	**<5**	**46**	**16**	**15**	**<5**	**0**	**11**	**0**	**0**	**0**	**<5**

3.5.5 The steady decrease in employees accessing the service could be attributed to a significant increase in the number of proactive workplace support initiatives available to employees, including the increased coverage of the Mental Health First Aid network which gives staff a supportive listening ear to talk through any issues they might be facing in the workplace.
Further work will be undertaken to ensure that staff are aware of the service, and to seek to understand the reasons behind this downward trend in more detail.

3.5.6 A further breakdown of figures by cluster for the period January 2021 to December 2021 is shown in the table below: -

	Clusters	Commercial and Procurement	Governance	Strategic Place Planning	City Growth	ALEO's	Customer Experience	Data and Insights	Early Interven and Comm Emp	Digital and technology	External Communications	Childrens and Fam Serv	Education	Operations and Protective Services	Operations AHSCP	Finance	Capital	People and Organisation	Corporate Landlord	Foster Carers	Elected Members	Family Member
Commissioning		0	<5	<5	<5	<5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Customer		0	0	0	0	0	<5	<5	14	5	0	0	0	0	0	0	0	0	0	0	0	0
Operations		0	0	0	0	0	0	0	0	0	0	65	0	19	0	0	0	0	0	0	0	0
AHSCP		0	0	0	0	0	0	0	0	0	0	0	0	0	6	0	0	0	0	0	0	0
Resources		0	0	0	0	0	0	0	0	0	0	0	0	0	0	<5	0	5	0	0	0	0
Foster Carers		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Elected Members		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Family Member		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	<5
		0	**<5**	**<5**	**<5**	**<5**	**<5**	**<5**	**14**	**5**	**0**	**65**	**0**	**19**	**6**	**<5**	**0**	**5**	**0**	**0**	**0**	**<5**

3.6 As shown below, the number of referrals for the same reporting period for the last 3 years (January to December) shows a slight decrease in numbers accessing the employee assistance service. This is in line with the trend we have seen over the last few years which can be seen in the table below.

Period		Numbers Accessing Service
From	To	
1 January 2021	31 December 2021	121
1 January 2020	31 December 2020	134
1 January 2019	31 December 2019	136

3.7 The Future of Work Survey contained the question “What steps have you taken to protect/improve your wellbeing while working from home.” Out of the 1085 responses received, 18 made reference to the supports offered around mental health and wellbeing. Out of the 18 responses, 3 referred to the Employee Assistance Service:

- *I appreciate there are mechanisms in place to support employees with mental wellbeing (mental health 1st Aid / Time to Talk)*
- *I used the people anytime health info and made use of the free counselling sessions.*
- *I have accessed counselling including Time to Talk*

3.8 The remaining 15 responses made reference to the other support resources and services; some examples of the comments made are detailed below:

- *I feel the council has provided excellent resources in our time WFH, in the PeopleAnytime mental health webinars and The Blether magazine - which provides a resource for networking, more informal chat and a sense of community to internal staff.*
- *the mental health and wellbeing sessions run recently provided some great tools on recognising your own mental wellbeing, along with how to support your teams and wider colleagues.*
- *I attended the SAMH Wellbeing training and this was excellent.*

- *Visited the Mental Health pages on the new intranet and used some of the suggestions/tips provided there.*
- *Joined webinars/training courses about mental health and wellbeing*

3.9 Additionally, there has been a huge amount of work undertaken in the run up to and during the pandemic to increase awareness of the Employee Assistance Service. For example, posters have been displayed in all workplaces, new information leaflets have been produced and distributed to all our front-line employees, regular wellbeing blogs have been circulated via the intranet and more information has been made available on our People Anytime pages, promoting the different ways to contact Time for Talking.

3.10 The percentage of the Council's workforce that used the service is detailed below, along with similar sized local authorities' industry averages for comparison for the annual reporting period:

Comparison of Service Usage Against Other Councils	
Aberdeen City Council	**1.49%**
Council B	1.09%
Council C	1.41%
Council D	2.61%

3.11 Both full-time (111) and part-time (10) employees are using the service (23% male; 77% females). There has been a decrease in full-time (120) and decrease in part-time (14) using the service from the previous same period last year. The majority of employees have been at work (78) compared to those absent from work (43) when receiving support.

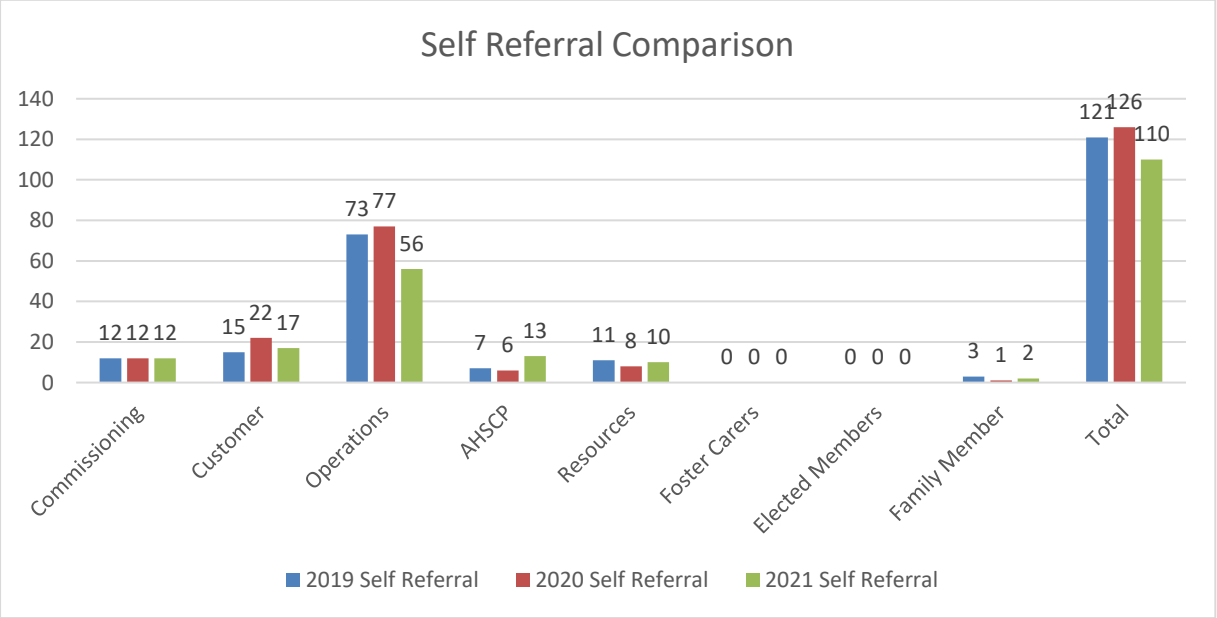
This represents a decrease in employees from the same period last year, accessing the service whilst currently at work and an increase of those who were absent from work while accessing the service on the last same 12 month period in 2020 (35). Three family members 6 have also used the service which is an increase on the last same 12 month period (1).

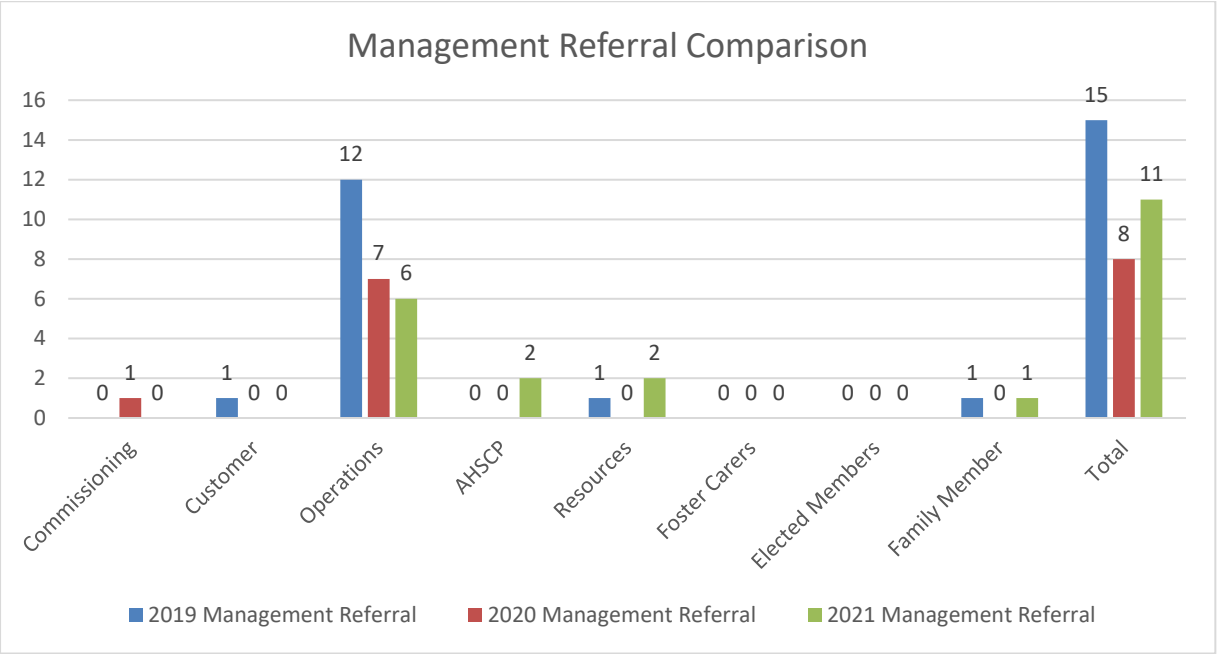
Full details are shown in the table below:

1 January 2021 - 31 December 2021	Demographics	Male	Female	Full Time	Part Time		Currently at work	Absent from work
Commissioning		4	8	11	<5		11	<5
Customer		<5	15	15	<5		12	5
Operations		15	47	57	5		35	27
AHSCP		<5	13	14	<5		11	<5
Resources		<5	8	11	<5		6	6
Foster Carers		0	0	0	0		0	0
Elected Members		0	0	0	0		0	0
Family Member		<5	<5	<5	0		<5	0
		28	**93**	**111**	**10**		**78**	**43**

A project to promote the Employee Assistance Service among other support available is being undertaken jointly with Trade Union colleagues to ensure frontline employees have access to information about accessing these vital service. This will include our predominantly male workforce in our Operations Service.

3.12 In the reporting period there were both self-referrals (110) and management referrals (511). Self-referrals (2020 – 126 / 2019 -121) have decreased slightly from the same reporting period in 2020 and management-referrals (8) have increased slightly since the last reporting period in 2020.





3.13 The assistance provided was mainly via telephone counselling (78) along with along with face-to-face counselling (10), helpline advice and support (28), CBT Counselling Sessions (3) and Online Counselling Sessions (1) which allows face to face counselling to be done through a video call.

1 January 2021 - 31 December 2021	Assistance Provided	Helpline/Advice Only	No contact from client	Telephone Counselling	Face to face counselling	CBT Counselling Sessions	Online Counseling sessions	Type of Referral	Management Referral	Self Referral
Commissioning		<5	0	9	0	0	0		0	12
Customer		5	0	12	0	0	0		0	17
Operations		14	0	42	5	<5	0		6	56
AHSCP		<5	<5	6	<5	0	<5		<5	13
Resources		<5	0	8	<5	<5	0		<5	10
Foster Carers		0	0	0	0	0	0		0	0
Elected Members		0	0	0	0	0	0		0	0
Family Member		<5	0	<5	0	0	0		<5	<5
		28	**<5**	**78**	**10**	**<5**	**<5**		**11**	**110**

How Employees heard about Service	Website/Posters/Leaflets	Managers	Colleagues	HR	Wallet Cards
	16	**52**	**19**	**29**	**5**

3.14 Face to face counselling has significantly decreased (10 in 2021 compared to 24 in 2020 and further significantly decreased from 90 in 2019) and telephone counselling has remained significantly higher (78 in 2021 compared to 87 in 2020 and remains a significant increase on pre-pandemic figures in 2019 of 17).

This may be due to the following reasons:

1. There has been a shift in how people interact with each other since 2019 and many feel more comfortable with telephone counselling to prevent against the spread of Covid-19.

2. Human behaviour has shifted due to the previous restrictions on meeting face to face and this has resulted in people preference and confidence in using online and over the phone methods of communication to increase and become the preferred option.
3. The convenience of having a telephone session and not having to commute for appointments making it easier to schedule and fit these into the employees working day.

3.15 Service users are offered an opportunity to provide feedback on the service via a short questionnaire. Feedback on the service delivered by the provider was positive, a sample of which can be seen below:

Client Feedback

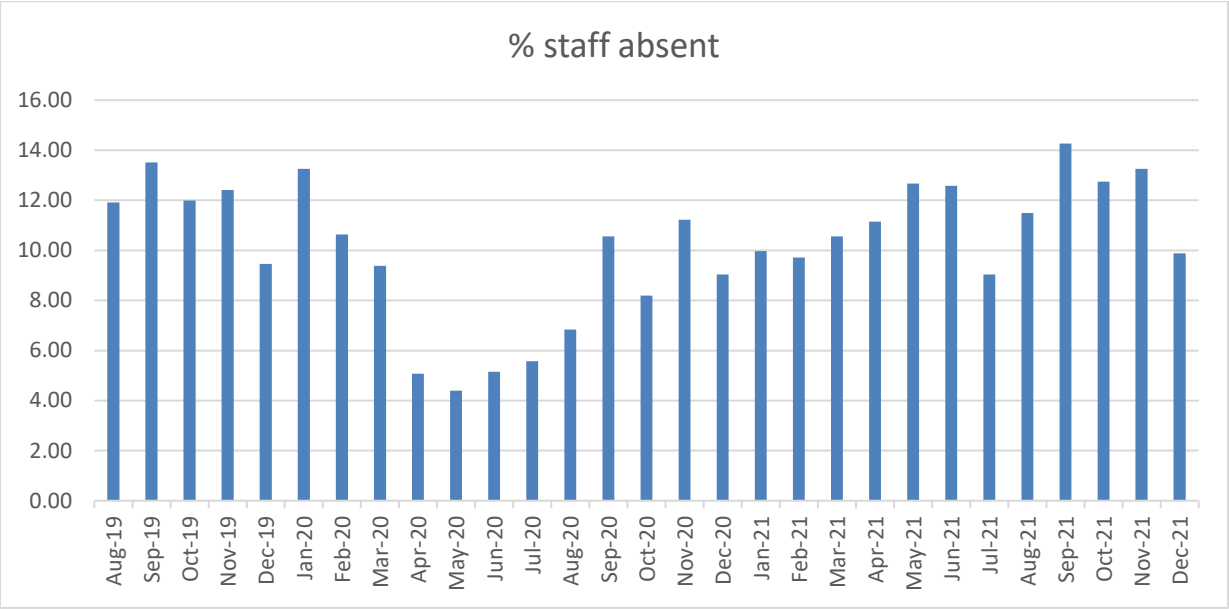
"Being listened to. Having a space to talk without judgement"
"She really listened and gave good advice"
"Talking to someone outside of family and friends"
"Having someone I could trust to speak to straight away.
"Knowing I would not be judged"
"Being able to speak to someone outwith my friends and family"

Occupational Health and Absence

3.16 The chart below shows the % of staff absent for the period August 2019 – December 2021 (prior to August 2019, absence was recorded and reported in a different format, and thus it is not possible to provide a true comparison for data prior to this date). The data shows that following an initial dramatic decrease in absence rates at the start of the pandemic, over the past 12 months rates have gradually begun to return to pre-pandemic levels.

3.17 The figures for 2021 replicate the more normal annual pattern, whereby absence levels tend to decline in July and December, because a large percentage of staff are on annual leave during these periods.

The rates of absence for 2021 also suggest that, whilst COVID 19 was still an issue throughout the year, it did not significantly inflate absence rates across the Council.



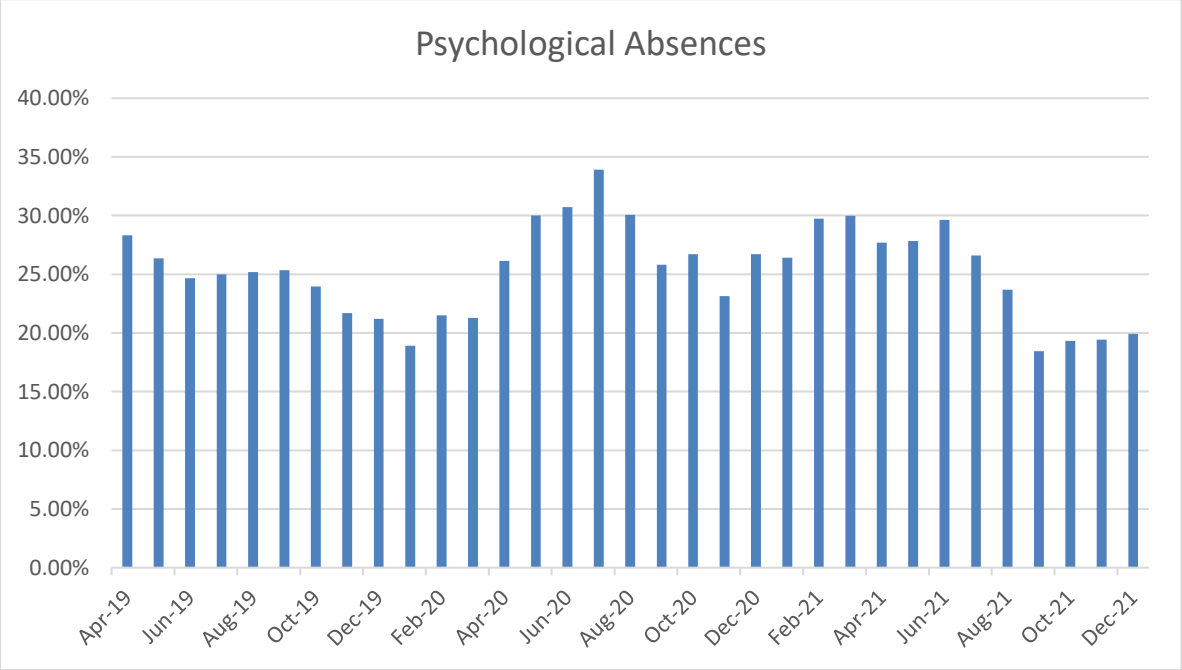
3.18 The breakdown of the reasons for sickness absence over the past 3 years are shown in the table below. *(please note the figures for 2019, 2020 and 2021 are provided to allow a comparison of pre-pandemic data with the data from the 2 years of the pandemic)* :

Absence Reason	% total absence 2019	% total absence 2020	% total absence 2021
Psychological	24.63	26.24	24.89
Musculoskeletal	21.64	16.81	18.54
Other	6.76	10.87	13.68
Respiratory	7.89	7.77	7.67
Gastro-intestinal	9.72	6.87	6.41
Hospitalisation	6.91	8.06	6.40
Neurological	5.34	4.67	6.29
Covid-19 Related	0	4.26	6
Malignancy	5.67	5.72	3.21
Gynaecological	2.49	1.54	1.43
Cardiovascular	1.45	2.03	1.37
Dermatological	0.96	0.89	0.85
Viral	1.71	1.02	0.79
Unauthorised Absence	0.18	0.38	0.67
Urological	1.70	1.25	0.66
Bacterial	0.13	0.12	0.48
Ophthalmic	0.57	0.37	0.34
Endocrine	0.17	0.07	0.03

3.19 As can be seen above, the most common reason for absence remains psychological. This is reflected nationally also; the 2021 CIPD survey 'Health and Wellbeing at Work' identified that 33% of respondents identified stress as being one of the top 3 causes of short term absence and 26% identified mental health as being one of the top 3 reasons for short term absence; in relation to long term absence, 58% of respondents identified mental health being one of the top 3 reasons for absence, with stress being one of the top 3 reasons for long term absence for 48% of respondents. (source: Health and wellbeing at work 2021: survey report (cipd.co.uk))

3.20 Since the initial approval of the Mental Health Action Plan in January 2019, there has been a strong focus on providing support and tools for employees around improving and maintaining their mental health and wellbeing. Our focus on mental health and wellbeing reflects the national trend; the 2021 CIPD survey on Health and Wellbeing at Work found that 57% of organisations surveyed had mental health as their primary area of focus in their health and wellbeing agenda – an increase from 41% in 2020.

3.21 The table below shows the percentage of total absences recorded as psychological for the period April 2019 to December 2021. The data shows an increase in psychological absences during the pandemic, in particular, at times where infection rates were rising, and/or there were changes to guidance and restrictions. Despite the increase in COVID infection rates and the associated additional restrictions being put in place towards the end of 2022, psychological absences dropped significantly between June 2021 and September 2021, and despite a small increase over the Omicron period October to December 2021, levels of psychological absence over these months remained lower than at any time since January 2020 prior to the start of the pandemic. Current rates of psychological absence are also lower than at any point during the pre-pandemic period between April 2019 and December 2019.



3.22 Given that the figures in the table show the number of psychological absences as a percentage of total absence for the month, the decrease in Aug – Dec must mean that there was a corresponding increase in other reasons for absence. The table below shows the reasons for absence for 2021.

Sickness Category Breakdown, Monthly

SICKNESS_CATEGORY	January 2021	February 2021	March 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021
Psychological	26.42%	29.74%	29.98%	27.70%	27.82%	29.64%	26.60%	23.69%	18.45%	19.32%	19.42%	19.91%
Musculoskeletal	19.00%	18.32%	17.60%	20.33%	18.83%	18.93%	21.92%	20.88%	18.17%	18.74%	14.74%	15.07%
Other	11.07%	12.58%	11.69%	13.55%	14.99%	14.78%	14.35%	15.26%	15.73%	14.11%	12.13%	13.96%
Respiratory	6.36%	5.62%	5.09%	5.05%	5.98%	5.20%	5.21%	4.75%	9.61%	11.92%	14.51%	12.69%
Covid-19 Related	8.82%	2.97%	1.83%	0.24%	0.62%	1.88%	2.97%	4.69%	11.03%	7.79%	14.99%	14.18%
Gastro-intestinal	6.03%	6.63%	7.51%	8.11%	7.50%	6.52%	4.78%	6.35%	5.71%	6.17%	6.75%	4.88%
Hospitalisation	6.32%	7.07%	7.59%	7.03%	6.63%	7.08%	6.46%	6.33%	5.83%	6.48%	4.38%	5.63%
Neurological	4.96%	6.10%	6.38%	6.03%	6.60%	6.70%	8.16%	7.90%	6.05%	6.42%	5.06%	5.17%
Malignancy	3.17%	3.64%	4.88%	5.07%	4.44%	2.77%	3.12%	2.64%	2.05%	2.13%	1.82%	2.80%
Gynaecological	1.42%	1.58%	1.58%	1.84%	1.61%	1.36%	1.64%	1.68%	1.70%	0.97%	0.99%	0.84%
Cardiovascular	2.13%	1.90%	1.75%	1.38%	1.03%	0.96%	0.92%	1.59%	1.47%	0.98%	1.18%	1.21%
Dermatalogical	0.82%	0.67%	1.31%	0.93%	0.88%	0.58%	1.01%	0.92%	0.68%	0.99%	0.65%	0.71%
Viral	0.66%	0.60%	0.53%	0.75%	0.87%	1.24%	0.44%	0.34%	0.77%	1.04%	1.22%	0.99%
Unauthorised Absence	0.54%	0.30%	0.09%	0.08%	0.37%	0.67%	0.64%	1.02%	1.14%	1.42%	0.86%	0.90%
Urological	1.03%	1.15%	0.72%	0.81%	0.88%	0.53%	0.55%	0.60%	0.44%	0.35%	0.70%	0.20%
Bacterial	0.54%	0.15%	0.31%	0.31%	0.50%	0.63%	0.73%	0.90%	0.42%	0.55%	0.32%	0.36%
Opthalmic	0.40%	0.66%	0.82%	0.47%	0.16%	0.21%	0.14%	0.14%	0.44%	0.27%	0.06%	0.27%
	0.31%	0.31%	0.31%	0.31%	0.26%	0.26%	0.34%	0.30%	0.21%	0.24%	0.19%	0.22%
Endocrine			0.04%		0.05%	0.05%		0.03%	0.11%	0.10%	0.03%	0.00%
Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

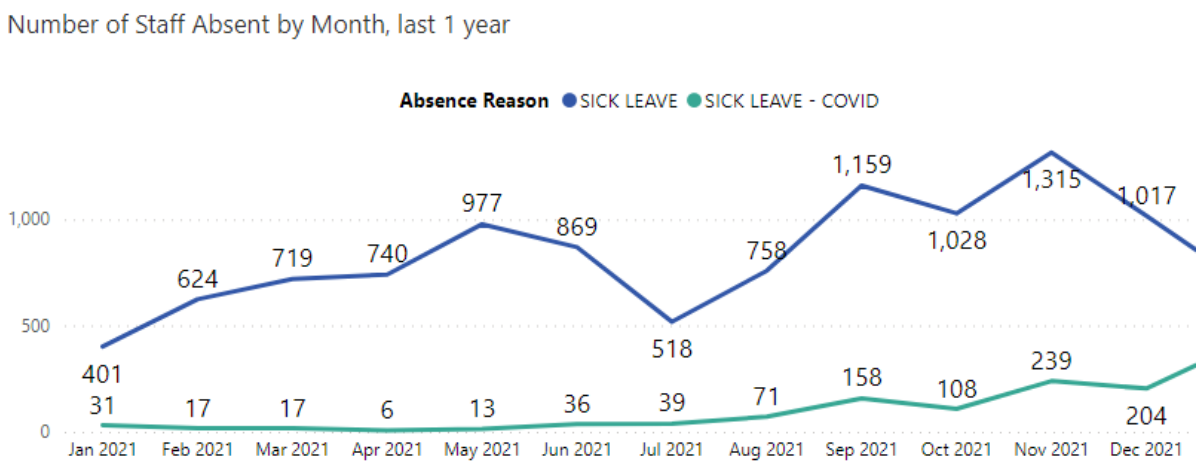
3.23 The table shows that whilst psychological absences decreased in the last 4 months of the year, there was an increase in respiratory absences and COVID related absences. This was the period during which the Omicron variant was at its most virulent, so the rise in COVID absences is consistent with this; the Autumn/Winter months tend to have higher levels of respiratory absences as this is the traditional cold and flu season; in addition, the “super cold” was prevalent at the end of 2021.

3.24 Musculoskeletal conditions continue to be the second highest cause of sickness absence; recent improvements in absence data reporting will allow more in-depth analysis of these absences (i.e. a further breakdown in reasons related to limb injuries, back pain or muscular/joint pain), which will allow more targeted support and training to be offered to both individuals and service areas at a local level. This analysis will form part of ongoing absence improvement work.

3.25 This work will also focus on a review of the absence reasons captured within CoreHR in order that those absences currently recorded as “other” can be more accurately reported.

COVID related absence

3.26 The table below compares the number of employees absent during each month due to COVID-19 compared to the number of staff absent for other reasons.



3.28 The CIPD Health and Wellbeing Survey reported that 44% of respondents identified that 1-10% of sickness absence was due to COVID-19, with 15% stating that 11-25% was COVID-19 related absence. Only 5% of respondents reported >26% of absences being due to COVID-19.ACC COVID-19 absence levels are broadly in line with the median figures reported in the CIPD survey, with absence levels due to COVID-19 ranging between a low of 0.24% of absences in April 2021 and a high of 14.99% of absences in November 2021.

Areas of Focus

3.29The areas of focus for supporting absence improvement for 2020 were reported to Committee in June 2021 [(Public Pack)Agenda Document for Staff Governance Committee, 12/04/2021 14:00 (aberdeencity.gov.uk)]

330 In 2021, the focus has been on improving the data available and trialling a number of bespoke approaches to supporting managers within the Operations and protective Services Cluster. The table below details work undertaken:

Focus Area	Action taken
Ensure accurate data available to managers, to include rolling absence rates, trend analysis, long term absence data, trigger data	Absence report on absences of all direct reports available to managers and supervisors in CoreHR Managers' Portal New ACC Absence report developed in PowerBI including rolling absence rates, absence trends, absence category breakdown, COVID-19 data – **next steps** – roll out to all SMTs.

Explore wider options for keeping employees in work	Process drafted using Microsoft Forms to allow managers to highlight employees who cannot immediately return to substantive post but who may be able to undertake alternative duties on a temporary basis. Process to be administered in the same way as Temporary movement of Staff **next steps** – report to ECMT prior to roll out across services
Ensure that all managers/supervisors have appropriate training and support to allow them to manage attendance effectively	Absence drop in sessions in place for target services, whereby managers and supervisors can request an individual appointment to discuss specific cases with a P&OD Advisor. Feedback has been that these sessions have been helpful, particularly in complex cases. **Next steps –** roll out across organisation
Targeted, partnership approach to management of long term absence cases between manager and P&OD team	Absence drop in sessions have allowed greater consistency in approach to management of long term absence cases. Issues identified with Occupational Health provider ill health retirement process; raised with OH, who have provided a dedicated resource to liaise re IHR cases. **Next steps –** ongoing monitoring of ill health retirement cases by Service Managers/ People and Organisational Development Advisors

3.31 The key areas of focus that have been identified for 2022 are shown in the table below

Focus Area	Action to be taken
Ensure accurate data available to managers, to include rolling absence rates, trend analysis, long term absence data, trigger data	ACC absence report to be published on People Performance Dashboard so all managers have access to live data for their teams.; ER&W Manager and Analytics and Insight Manager to brief SMTs on the new dashboard February 2022 Target completion date April 2022
Scrutiny of absence data to be standing item on all SMT agendas	Absence data to be added to all SMT agendas once dashboard is published Target completion date April 2022
Explore early intervention options by seeking potential root cause problems in areas of higher absence and addressing these	Further development to be undertaken to allow further drilling down into sub categories of absence to identify possible areas for intervention, training and support Target completion date – September 2022
Explore wider options for keeping employees in work	Report to ECMT; roll out process across the organisation Target completion date – April 2022
Ensure that all managers/supervisors have appropriate training and support to allow them to manage attendance effectively	Review and update training modules where required Expand absence drop in sessions across the organisation. Target completion date – June 2022
Consider use of Disability Passports	Undertake research Consult with managers, employees and Trade Unions Report to ECMT Target completion date – September 2022

Occupational Health Service

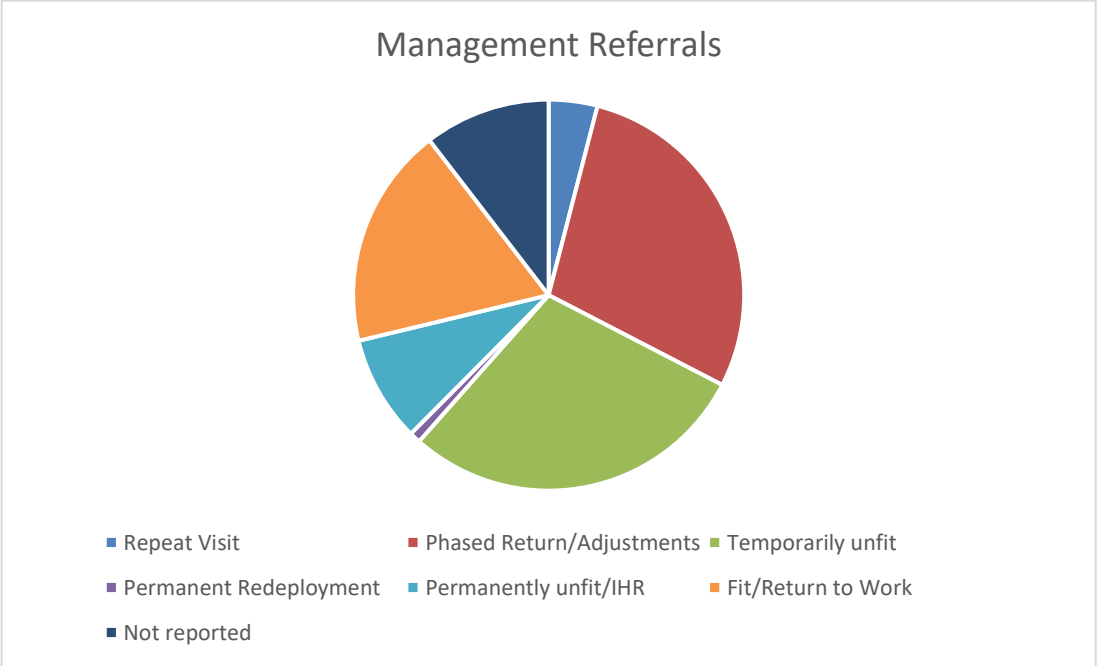
3.32 The table below shows the volume of appointments for the period January – December 2021

	Jan 21	Feb 21	Mr 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
No of Appts	112	128	145	85	85	108	95	108	93	113	128	105
Attended	102	113	121	71	73	95	77	98	86	96	108	94
Cancelled	4	13	11	8	17	4	7	5	5	8	11	5
Did not attend	6	2	13	6	6	9	11	5	2	9	9	6

3.33 Whilst some face to face surveillance appointments were not going ahead at some points during 2021 due to the pandemic, levels of appointments were closer to the expected levels than had been the case during 2020. The high level of appointments in the first quarter of the year reflects a backlog of some health surveillance appointments which had been delayed due to restrictions during the pandemic. This accounts for the spike in appointments in March

3.34 Appointments recorded as cancelled were, in the main, cancelled due to the employee returning to work and the appointment no longer being required. Appointments recorded as Did Not Attend (DNA) were due to the employee not answering the call when contacted by Occupational Health for the appointment. All DNA appointments are flagged up to line managers for follow up.

3.35 The graph below shows the outcomes of management referrals made to the occupational health service during 2021



3.36 A total of 256 management referrals resulted in the employee returning to work, either fully (in 100 cases) or on a phased return or with reasonable adjustments (156 cases).

3.37 In 158 cases the employee was reported as being temporarily unfit for work, however only 22 cases required a follow up appointment with Occupational Health.

3.38 A total of 53 management referrals resulted in an Occupational Health determination that the employee was permanently unable to continue in their role, with 5 individuals being recommended for redeployment into an alternative role and 48 being identified as permanently unfit or suitable for ill heath retirement.

3.39 In 57 cases of management referrals no report was issued. As the Occupational Health report is classed as the employee's medical information, the employee can request that the report is withheld. In such circumstances, management continues to manage the employee's absence on the basis of the information that is available (for example the information contained on fit notes from the GP.)

4. FINANCIAL IMPLICATIONS

4.1 The direct financial costs associated with sickness absence relate to the payment of occupational sick pay and cover of essential services. The indirect costs relate to impact on service delivery.

4.2 There is also the potential for employment tribunal associated costs if an employee was to make an employment related claim against the Council.

5. LEGAL IMPLICATIONS

5.1 Failure to comply with legislation in ensuring a safe and healthy workplace has the potential to result in enforcement action by the Health and Safety Executive (HSE). Such intervention can result in potential prosecution (criminal) equally, employees (civil claims) are more likely to succeed following as successful HSE prosecution. Changes in the Sentencing and Fines Guidance for health and safety non-compliances are resulting in increased financial penalties. Fine starting points are based on an organisation's turnover. As Local Authorities do not have turnover; Annual Revenue Budget is deemed to be the equivalent. This amount is then altered depending on the culpability of the organisation and harm factors to employees and members of the public.

5.2 Under the Health and Safety at Work Act 1974 and Management of Health and Safety at Work Regulations 1999 there is a legal requirement to ensure the health safety and welfare at work of our employees. This includes minimising the risk of stress-related illness or injury to employees.

5.3 The provision of an EAS is in line with guidance produced by the HSE as one of the measures to control that risk. One person in four in the UK will experience a mental health problem in their lives.

5.4 HSE potential prosecution (criminal) can attract fines, imprisonment and remedial orders. There is also the possibility of employee claims (civil). Provision of an EAS can be used as mitigation against potential claims from employees exposed to work related stress.

6. MANAGEMENT OF RISK

6.1 The risks with the potential to impact the decision being sought from the Committee are categorised as:

Category	Risk	Low (L) Medium (M) High (H)	Mitigation
Compliance	Compliance with legal requirements ensures the health and safety of employees. Poor management of the risks and lack of support has the potential to attract enforcement action (criminal and civil).	M	Assessment of risk via stress and QWL's risk assessments with identification and implementation of safe working arrangements. Functions acting on utilisation, trend and root cause information to develop and implement controls to prevent a reoccurrence. Completion of Line Manager Competency Indicator Tool (HSE) by line managers acting on feedback. Provision of specialist support / advice.
Operational		M	As above. Provision of information, instruction and training as identified in Job Profiles, skills and training matrices and in risk assessment. Open and clear two-way communication at all levels within the organisation. Non-judgmental and proactive support provided to employees who experience mental health problems. Good self-management of personal wellbeing and resilience.

Financial	If no action is taken to support individuals and address trends, then the organisation will incur both direct and indirect costs.	M	Implementation of the Mental Health and Wellbeing in the Workplace Policy and supporting Stress Procedure. Effective management and maintenance of a mentally healthy workplace and provision of appropriate support. Review and identification of EAS use and related absence to act on lessons learned. Corporate and individual awareness of mental health in the workplace. Active monitoring of workloads.
Reputational	Without ensuring suitable employee support there is a risk of the organisation not being seen as an employer of choice and having recruitment and retention issues..	L	As above.

7. OUTCOMES

COUNCIL DELIVERY PLAN	
Aberdeen City Local Outcome Improvement Plan	
Prosperous People Stretch Outcomes	The Prosperous People theme in the LOIP indicates that all people in the City are entitled to feel safe, protected from harm and supported where necessary, which would include employees of the Council. Adopting the approach outlined int the report will support the workforce.
Council Deliver Plan	The Council Delivery Plan identifies areas of action to support the capacity of the organisation to deliver its purpose, including mental health and wellbeing of the workforce.
Workforce Plan	As set out in the Workforce Plan, the emphasis on developing internal capacity and the need for flexibility and efficiency in our reducing workforce, there is a need to focus on supporting employee health and wellbeing.

8. IMPACT ASSESSMENTS

Assessment	Outcome
Impact Assessment	Not required
Data Protection Impact Assessment	Not required

9. BACKGROUND PAPERS

None

10. APPENDICES

None

11. REPORT AUTHOR CONTACT DETAILS

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