apse solutions

Cardiff Council

Sickness Absence Analysis: Final Report

This report has been prepared by Andy Mudd in October 2017

Final version

APSE (Association for Public Service Excellence) is a not for profit local government body working with over 300 councils throughout the UK. Promoting excellence in public services, APSE is the foremost specialist in local authority front line services, hosting a network for front line service providers in areas such as waste and refuse collection, parks and environmental services, leisure, school meals, cleaning, housing and building maintenance.

APSE provides services specifically designed for local authorities, such as benchmarking, consultancy, seminars, research, briefings and training. Through its consultancy arm APSE delivers expert assistance to councils with the overt aim of driving service improvement and value for money through service review and redesign. APSE delivers in excess of 100 projects a year and clients benefit from the consultancy's not for profit ethical approach to consultancy services.

Contents

Association for Public Service Excellence
2nd floor Washbrook House
Lancastrian Office Centre
Talbot Road, Old Trafford
Manchester M32 0FP
telephone: 0161 772 1810
fax: 0161 772 1811
email: enquiries@apse.org.uk
web:www.apse.org.uk

1. Introduction

1.1 Cardiff Council has engaged APSE Solutions to assist with establishing the reasons for a recent increase in sickness absence amongst the workforce of the council and to identify options for tackling the problem. Given that sickness absence cost the authority over £11m in 2016/17, there is a strong imperative, at a time of budgetary pressure, to keep sickness levels to a minimum.

1.2 Policy and practice was revised in 2015 following a report by the Auditor General for Wales in 2013 and a policy review by APSE Solutions in 2014. Both of these reports identified implementation of policy as a bigger issue than the absence management policy itself. The report of the Auditor General found that, 'corporate policies and procedures for the management of sickness absence have improved but are not being applied consistently at directorate level'. The APSE review found that the, 'revised Attendance and Wellbeing policy is in line with good practice and principles' and advised a 'focus on management capability and compliance'.

1.3 Along with the revised policy the Council published an Attendance and Wellbeing toolkit to help managers to take a more robust approach to the management of sickness absence. As a result overall absence rates fell sharply in the 2015/16 year, although it is notable that the fall was due almost entirely to a reduction in long term absence. Short term absence rates had already fallen significantly over the previous two years and do not appear to have been impacted further by the initiative.

1.4 The revised policy implemented changes to the treatment of trigger elements of the process. Managers are informed automatically by the HR management system of the requirement to carry out and record a return to work interview, or to take other action, depending on what stage is applicable, at the close of a sickness absence. If this doesn't happen the system sends a reminder after 10 days stating that if there is no action after a further 10 days the, 'Stage will be disregarded and DigiGov will be reset to the previous stage'. It also states that the line manager of the manager will be informed. The escalation process is presumably intended to reinforce the importance of early intervention and to ensure that there are consequences for managers that do not apply the procedures properly.

1.5 At its lowest point in 2015/16 overall absence was 75% of its 2012/13 level and was below average for Wales. This represented a significant achievement given that the 2012/13 figures were well above average. The increase in absence rates in 2016/17 has left them once again above the Welsh average, as well as above the CIPD average for the public sector, albeit still well below the 2012/13 baseline.

2. Overview

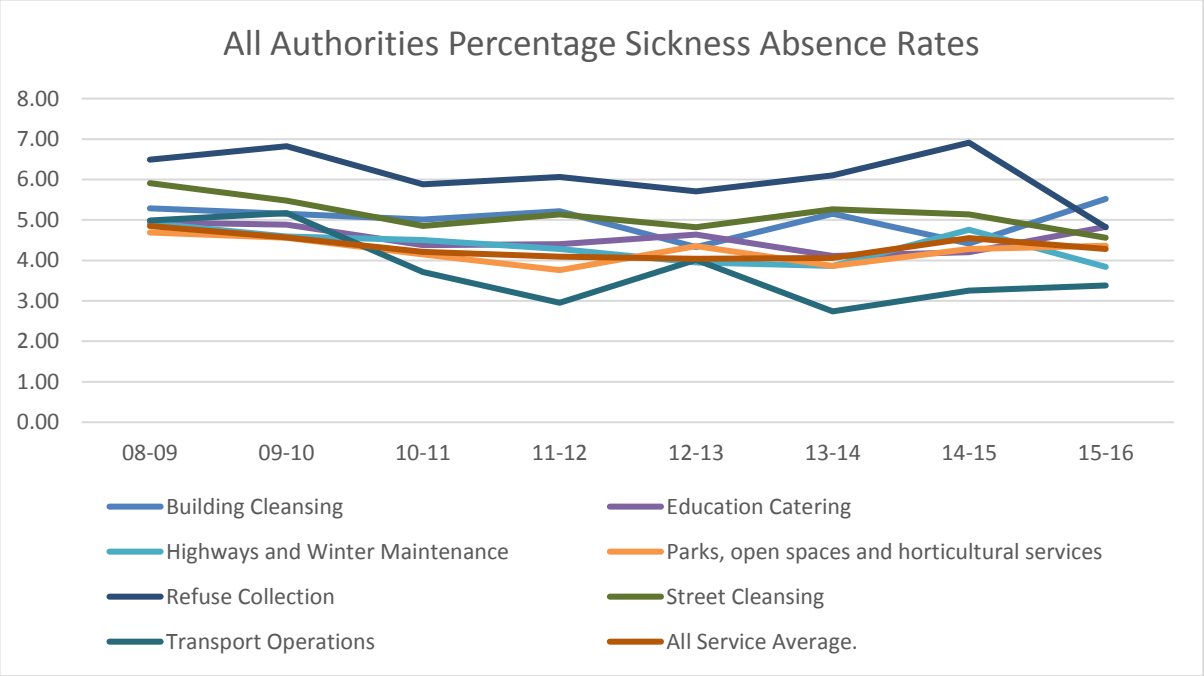
2.1 Although there was a small increase in short term absence, the increase in the overall rates in 2016/17 is predominately accounted for by an increase in long term sickness. The data indicate that some occupational groups in the Council are disproportionately likely to take time off sick. Although absence by teachers has the biggest economic impact and represents the highest number of days lost, this is because they make up the largest

proportion of the workforce. It is in fact grade 1, grade 4 and grade 5 staff that are disproportionately likely to take time off sick. Grade 1 staff make up 3% of the workforce but take 6% of the total days lost to sickness. Grade 4 staff at 17% of the workforce take 21% of total sick days and grade 5 make up 14% of the workforce but take 17% of the sick days. Teachers, who make up 27% of the workforce, are actually the least likely group to take time off sick taking 18% of the total days lost.

2.2 This analysis suggests that focussing on the grade 4 and 5 workers, who between them make up 31% of the workforce but account for 38% of the days lost to sickness, would be a sensible starting point for drilling down into sickness absence in Cardiff. The occupational groups represented by these grades include refuse collectors, care workers, teaching assistants, school catering staff and enforcement officers. Grade one staff only make up 3% of the workforce and whilst their absences make up 6% of the total, the cost attributed to it is far less significant than that of absences amongst grade four and five workers (£399,000 compared to £3.8m). The most significant grade one occupational group is cleaners.

2.3 It is essential to establish why absence amongst these groups is disproportionately high and in particular, whether it is high by comparison with people carrying out similar work elsewhere. APSE Performance Networks benchmarking data shows conclusively that manual and front line staff are more likely to take time off sick than non-manual and back office workers. To this extent then the nature of the work involved is a factor driving disproportionately high levels of absence amongst these sections of the work force.

2.4 The graph below plots aggregated data submitted to APSE Performance Networks by authorities throughout the UK for selected front line service areas. It shows that whilst overall levels of absence have fallen over the period since the financial crash (and the subsequent onset of austerity), this has not been in linear fashion and is not consistent across service areas. It is particularly relevant that the very significant early reductions in the budgets of English authorities that took place in 2010/11 were followed by a fall in absence rates, indicating that the more recent reductions in Welsh council budgets should not be expected to fuel an automatic increase in absence.



3. Analysis of Cardiff data

3.1 There are a number of patterns discernible in the Cardiff data that can provide a starting point for further analysis and drilling down. These are discussed below.

3.2 Long term absence has increased much more sharply than short term absence and accounts for most of the recent increase. It is also apparent that the fall in absence that took place following the implementation of the policy was also accounted for by long term absence.

3.3 Absence rates are highest amongst some grades of staff, with grades one, four and five being disproportionately likely to be absent. Grade one includes mostly cleaners whilst grades four and five include many of the Council's front line staff. Teaching assistants make up the largest occupational group.

3.4 Stress and muscular-skeletal issues are by far and away the biggest causes of long term absence. Manual workers can be assumed to be prone to muscular-skeletal conditions. Stress can affect anybody within the workforce but it is not unreasonable to expect non-work related stress in particular to impact on some groups more than others. Factors that might be expected to contribute would be low pay, shift working, part time work with multiple jobs and lone working.

3.5 Absence rates are notably high amongst some older, but not the oldest, age groups. Those in their fifties and sixties are the only members of the workforce that are disproportionately likely to be absent due to sickness.

3.6 A very small proportion of the workforce are subject to the formal process – less than 600 cases got to stage 1 of the absence management procedure. Dismissals stemming from long term absence have fallen by about 23% since 2014/15 but in any event are only a statistically insignificant proportion of the workforce.

3.7 Non-schools Education, Social Care and Commercial Services are the council departments that can be identified as making the most significant contribution to overall and long term absence, proportionate to the number of staff they employ. Grade one, four and five staff employed in these departments include: refuse collectors, drivers and other waste operatives (Commercial Services); cleaners and school kitchen staff (Non Education Catering) and home care providers (Social Care).

3.8 Analysis at the work group level, comparing the comparative level of absence recorded for different job titles, suggests that the following have a level of absence that is disproportionate to their numbers within the workforce.

- Refuse collectors
- Teaching Assistants
- Higher Teaching Assistants
- Home carers

- MRF Processors

3.9 It is notable that this list does not included cleaners or school kitchen staff who actually record overall levels of absence proportionate to their numbers in the work force. This is surprising for two reasons. Firstly, non schools education, as a department, experiences a higher level of absence than the number of FTE employees would indicate and secondly, because grade one workers who, as discussed above, are also disproportionately likely to be sick, appear to be mostly cleaners. Further drilling down is required to establish why this is the case.

3.10 There is no evidence to indicate that the work groups mentioned are more likely than others to claim sickness when they are actually fit to come to work. The nature of some jobs makes genuine sickness more likely and in some cases it is more difficult for a person who is sick to nevertheless attend work. The workshops with service managers explored some of these factors as is discussed elsewhere in the report.

3.11 Refuse collectors are the group that is most likely to be absent sick. This is however in line with the experience of other local authorities and there is no evidence that refuse collectors in Cardiff are more likely than refuse collectors elsewhere to be absent. The work is of a heavy manual nature, it is carried on outdoors and is difficult to perform if not fully fit.

3.12 Although they only contribute 1% to the total number of days lost to sickness, home carers are the group that is second most likely to take time off sick. As with the refuse collectors this is something that might be expected given the nature of the role.

3.13 Teaching assistants are the next most likely group to take time off sick. This is more difficult to understand, particularly in light of teachers being the group least likely to be absent due to sickness. Higher teaching assistants also record a disproportionately high level of sickness absence.

3.14 A further set of data that can be used to try and understand why some members of the workforce are more likely to be absent is the rate at which sickness cases are 'discounted'. Discounting is when an absence case does not proceed to stage one or to a later stage when it might otherwise be expected to do so. The policy states that there are certain circumstances when this should happen. These are when an absence is maternity related or when the Equality Act 2010 applies. In fact, the data indicate that far more cases are discounted than would be the case if the policy was being strictly adhered to. This can be seen from the table below:

Reason for discounting	**Number**
Stage Discount	725
Policy Related (pregnancy)	329

Stage in Progress	171
Manager Request	167
Appeal in Progress	4
Total	1396

3.15 Stage discount is where the absence management system automatically discounts an absence back to the previous stage (or completely if at stage one). This happens where a manager fails to carry out a required action in the required timeframe. It is the most significant reason for discounting, suggesting that proportionately high rates of discounting can be reasonably associated with process failure. Manager request includes Equality Act cases but may also include other reasons, even though this is not supposed to be the case under the policy.

3.16 The table below indicates discounting levels for those job titles that contribute 5% or more to the total amount of sick days recorded. Refuse collectors and home carers are also included.

	Proportion of total workforce	**Proportion of total sick days**	**Discount rate**
Teachers	27%	18%	13%
Teaching assistants	11.47%	13%	12%
Midday supervisors	4.75%	5%	11%
Senior teaching assistant	5.2%	5%	11%
Cleaners	5.89%	5%	6%
Refuse collectors	0.66%	1%	10%
Home carers	0.96%	1%	11%

3.17 The highest discount rates, where there are a significant number of absences, i.e. 5% or more of total sickness, are found for teachers at 13%, teaching assistants at 12%, and mid-

day supervisors at 11%. These rates provide a loose indication of where there may be issues in relation to management of the process. However, not all discounted cases imply failure or an absence of proactivity on the part of managers and can, in fact, imply the opposite. This indicator cannot therefore be used on its own. The case of teachers illustrates the point where there is a high discount rate but a proportionately low absence rate. Schools appear to be good at managing absence in relation to teachers – although apparently not so good in relation to teaching assistants where the proportion of sick days is higher than the proportion of teaching assistants in the workforce.

3.18 Smaller groups of workers that do not make a significant contribution to the overall total of sick days, are more likely to have high discount rates. 20% of cases were discounted for a range of staff in smaller work groups. In each case this appears to have been only one case out of a very small total number. This might indicate a need for a higher level of HR support/direction to the managers concerned with managing smaller groups of staff.

3.19 It is relevant that discounting levels are comparatively high for home carers (11%) and refuse collectors (10%) but low for Cleaners (6%).

4. Initial questions: Management and process

4.1 The data indicate a number of possible issues and give rise to questions around management and process as set out below:

- Are managers using the process as frequently as they should be or are cases being discounted without any meaningful (effective) management input?
- Do managers see the process through?
- Are the consequences for managers of not using or following the process properly meaningful?
- What are the incentives for managers to use or follow the process properly?
- What (human) support do operational managers/supervisors receive from HR?
- Are return to work interviews always carried out?
- Is the form completed and filed appropriately?
- Are the records up to date and accessible?
- Are some workers exposed to increased risk related to cuts or changes to the way they work?
- Is support/referral occurring early enough or often enough?

4.2 These questions were put to separate focus groups of trade union representatives, HR officers and service managers.

4.3 Some common themes were:

- That the sickness absence policy itself is on the whole fit for purpose

- That Occupational Health (O/H) referrals were clogged up with automatic referrals where little value is likely to flow from O/H involvement – e.g. a case where a manual worker had a broken leg. This is creating a backlog of six to eight weeks which in turn delays the implementation of workplace adjustments and in some cases, a return to work.

- There was some discussion about whether the short term absence procedures were leading to some people, presumably with the cooperation with their GPs, taking long term absence rather than risk a series of short term absences leading to disciplinary action.

- There is a need for a multi-disciplinary case management type approach focussed less on the process and more on the individual. It is recognised that HR have a case work team which is well regarded but pointed out that it is very unusual for all parties to meet together to work out strategy in relation to an individual member of staff.

- That whilst policy and process are comprehensive and on the whole effective, many people agreed that its ubiquity can be problematic for a multifunctional organisation. Standardised processes and procedures that may be effective for some members of the workforce were felt to be less effective for others.

- There is a lack of flexibility for front line staff by comparison with management colleagues. Managers of front line workers indicated that they would be reluctant to grant short notice leave – the so called duvet day - and there is little scope for home working amongst these sections of the workforce. It was pointed out by a number of people that managers were more likely to be able to work through a period of sickness by working from home or by taking a duvet day than were front line workers.

- There is a need to look more closely at how policy and process is managed and how it impacts on schools. There was a strong perception that schools operate outside of the system and all groups pointed out that the sanction for failure to take a required action, i.e. an email to the manager's line manager, would have little impact on head teachers. The data on discounting and the high level of absences recorded by teaching assistants tends to support this view.

- There was a widely held, but mistaken, belief that the measure of long term absence had changed from four weeks to two weeks. This may be because the procedure for managing long term absence requires managers to visit or otherwise meet with an absent staff member after two weeks of absence. This may be intended as a preventative measure but this is not entirely clear from the wording of the policy and has created a degree of confusion.

- Most participants agreed that whilst consistency was important, there was also a need for processes to be tailored to the needs of different elements of a diverse workforce. Managers need to be able to use the system as a tool rather than it determining actions for them without regard to individual or work group circumstances.

- All groups spoke in varying ways about what might be termed perverse incentives or unintended consequences in or flowing from the absence management system. This included a potential for managers to avoid having to operate a complicated procedure by not recording absences in the first place and a tendency for long term absence to last for just under six months, this being the point at which pay is reduced.

Trade Unions

4.4 There was general agreement amongst Trade Union representatives that the policy, (as distinct from its application), was generally fit for purpose. They raised some specific points about the automatic management system, including that the system uses calendar days rather than working days in relation to trigger points which, it was argued, discriminates against part time workers.

4.5 The group was very clear in its view that the policy does not allow discounting other than in relation to maternity and Equality Act cases. They were adamant that cases involving manual workers were rarely, if ever discounted for any other reasons.

4.6 The group were clear that the absence management system must be clear and consistently applied. They did not however rule out the potential for absence management to be tailored to the needs of different members of the workforce to recognise differences in the ways that people work. They pointed out that managerial staff were better able to manage their sicknesses by working from home or taking short notice leave to avoid triggering action points than were front line staff who did not have those options.

4.7 One member of the group was strongly of the view that absence amongst older women is closely related to them undergoing the menopause and that the policy should recognise this. This led to a wider discussion around gender which identified a wider range of reasons why women may be more likely to be absent than men. These included the fact that women are disproportionately likely to have caring responsibilities.

7.1 All groups were asked whether they considered absence management policy and process to be disciplinary or supportive in nature. The trade unions, each to a varying degree, perceive absence management in a generally negative light. This was exemplified at a meeting of the Cardiff Council Works Council where the initial findings of this review were reported. The trade union side expressed a view that referrals to occupational health following a return to work should be disallowed, arguing that the view of the GP that a person is fit for work should never be questioned or as they put it, overridden.

7.2 No evidence has been seen to support the proposition that occupational health referrals, (or any other element of the absence management process) are routinely used to the detriment of individual members of the workforce. It is nonetheless of concern that key partners in the overall management of health and safety perceive this to be the case.

HR Officer

4.8 HR staff were generally of the view that the sickness absence policy is fit for purpose and effective. They were however critical of some service managers who they perceived to be risk averse and inconsistent in their application of the policy. That said, the group also

recognised a need for the policy to be streamlined and felt it was too prescriptive in places.

4.9 It was postulated that the managers of some service areas were inflexible in relation to allowing short notice leave which was likely to lead to an increase in staff taking short term sickness leave.

4.10 In relation to specific groups within the workforce there was a clear recognition that the nature of some work is such as to lead to an increased likelihood of sickness and that early intervention to ensure safe working practice and to assist with work place and wider issues would be beneficial. The sort of factors that will increase the likelihood of workers taking sick leave include:

- That work is of a heavy manual nature
- That work is inherently stressful
- That work is mostly or entirely font line and cannot be carried out from home
- That work is carried out in (particularly split) shifts
- That work is part time and workers are likely to have multiple such jobs
- That workers work alone with little peer or supervisor contact
- That work is low paid – a number of people pointed out that the council provides good terms and conditions by comparison with private organisations

4.11 All groups were asked whether they considered absence management policy and process to be disciplinary or supportive in nature. The HR group were of the view that it is essentially supportive.

Service managers

4.12 Some managers expressed frustration at the process preventing managers from dealing with absence patterns which they believe are indicative of somebody 'playing the system'. This would include people timing absences to avoid being given warnings.

4.13 None of the managers who attended focus groups gave any indication that they did not treat sickness absence as a priority. Some did complain that the process can be time consuming and at times 'clunky'. All agreed that it would be helpful if the system facilitated a multi-disciplinary case management approach for some individuals.

4.14 The managers of the cleaning workforce were particularly keen to emphasise that they were very proactive in their absence management practice and were surprised to learn that a significant number of sickness cases are discounted for reason other than maternity or the Equality Act. The low level of discounting of cases involving cleaners suggests that there is indeed strict adherence to the policy in this department.

4.15 Managers did not agree that they were risk averse although they did indicate that at times they do not take action they believe is warranted because of a belief that the organisation will not support it. Some managers were more confident about their ability to use their own judgements than others saying that they saw HR as an advisory service and always took the lead in decision making. Others felt they could not take action that was not in line with the advice of HR and/or Occupational Health.

4.16 A number of managers stated that Occupational Health are prone to taking an uncritical approach to the assessment of a sick employee's condition. It was said that they take what the employee says at face value rather than challenging them.

4.17 Managers of front line staff accept that they are inflexible in relation to short notice leave. They pointed out however that this is because the nature of many of the posts concerned means that absences have to be covered through agency staff as changes to work rosters cannot be made at short notice.

4.18 It was suggested that some absences were related to the misuse of alcohol and drugs and that this posed issues in relation to the support needs of those affected and has wider health and safety implications. The Council recently agreed an updated drugs and alcohol policy framework which will hopefully assist with this.

4.19 A number of councils have implemented revised drug and alcohol policies to allow for testing as a condition of an offer of employment, e.g. West Lindsey DC. Some others have introduced random testing for employees in safety critical roles. This includes Birmingham, Calderdale and Barnsley. In the latter case members were advised in a cabinet report that the revised policy 'had the broad support of trade unions'. Cardiff has not gone down this route.

4.20 All groups were asked whether they considered absence management policy and process to be disciplinary or supportive in nature. The managers group were of the view that it can be and is a combination of both.

Head-teachers

4.21 The head-teacher group spoke well of the support they receive from HR but in common with the council managers, were very critical of the occupational health service. They were broadly supportive of policy but felt that it could be more robust. By this they meant that it could be more clearly focussed on the goal of securing a return to work and pointing out the consequences of absence. To this end they suggested that the language used in automatically generated letters should be reviewed. For example a warning that 'further absence may lead to….' Could be replaced with 'further absence is likely to lead to…'.

4.22 With regard to the data analysis the heads were of the view that it is unhelpful to treat schools as homogenous and that levels and patterns of absence vary from school to school. There was a strongly expressed view that a small number of schools had high absence which skewed the overall figures. None of those present thought that the high level of absence amongst teaching assistants reflected management practice. They thought that the stark contrast between teacher absence levels and that of teaching

assistants might be explained by reference to differences between the two roles as follows:

4.23 The teaching assistant role has traditionally been part time and comparatively low paid. Whilst the group thought that the 'mums helping out in the classroom' image of a teaching assistant was increasingly anachronistic, a number of people thought that longer serving members of staff may have come into the service on this basis and had a lower level of professional attachment to the job than teachers and more recently recruited teaching assistants. They suggested that an analysis of absence levels compared to length of service would be useful.

4.24 The head-teachers echoed some of the points that the trade union group made around low paid, part time, predominantly female members of the workforce and the pressures they can face in relation to out of work responsibilities. Moreover, whilst the role has been professionalised in recent years, it is still relatively low paid, often part time and unlike teachers, teaching assistants are employed on term time only contracts.

4.25 The significance of non-work related stress as a reason for absence tends to support the perception that teaching assistants are an element of the workforce that would benefit from a proactive approach to supporting members of the workforce to cope with both work and non-work related issues.

4.26 The group felt that the interests of fairness were not always met by ubiquity. Corporate systems bring benefits but should always be tailorable to the particular circumstances of different work places.

4.27 The schools operating environment is very different from mainstream council services and there are legitimate questions around the applicability of a system, designed for the council, to schools. One point originally raised by the trade union and HR groups is that the system is not as effective in prompting action and escalation in relation to school based staff as it is for council staff. Head-teachers do not have line managers as such and there is little point in sending emails to Chairs of Governors in relation to individual cases. The head-teachers themselves said that quarterly reports to governors, pointing out the level and cost of absences at a school level, would be more effective in focussing them on the need to proactively manage attendance.

5. Process workshop

5.1 A further workshop was held to drill down further into process and to establish how the different groups of people involved with them add value to sickness absence management. The analysis took the form of a SIPOC (suppliers, inputs, outputs and customers) which attempted to identify and value the input to the process of different groups. The analysis is intended to reflect the perception of the managers and may differ from how the process is intended to operate.

5.2 The workshop listed the suppliers as follows:

- The staff member who is sick

- Colleagues of the staff member who are impacted by their absence
- The line or designated manager of the staff member
- More senior operational managers
- Trade unions
- GPs and other external health professionals
- HR
- Occupational health
- Top management

5.3 Within the time available it was not possible to map the contribution to the process of all of these groups. The group was asked to focus on the absent staff member, the designated manager, HR and Occupational Health. The results are appended and can be summarised as follows.

5.4 The process begins with the absence of a staff member. They are required to make a telephone call personally to a designated manager. Clearly there will be a degree of non-compliance with this requirement in which case the manager is required to initiate direct contact themselves.

5.5 Once contact is established the manager is required to gather certain information around the nature of the sickness, the likely length of absence and details of work duties to be covered. Information is recorded on the Digigov system.

5.6 If the staff member does not return after seven days the system will prompt the manager to arrange a contact visit. This is likely to take place one week later. At the meeting the staff member must be informed of their obligations and the consequences that can flow from excessive levels of absence. They are also provided with advice and guidance about support that is available to them.

5.7 Absence of less than 4 weeks duration is categorised as short term and will only result in further action – other than a routine return to work interview, if it triggers action in accordance with stages set out in the policy or there are ongoing concerns over the relationship between an employee's health and their work duties. Action stages were not process mapped. Ongoing concerns could lead to a referral to occupational health.

5.8 Absent staff are referred to occupational health via the Digigov system after 4 weeks of absence. In theory managers can ignore a prompt to refer but none of those present said that they would and did not feel that the policy explicitly identified them as having a positive duty to make a considered judgement about the value that might be added by the involvement of occupational health. Given that they all had anecdotal evidence of cases where no or little value had been added, there seems to be an opportunity to introduce a more proactive approach to the referral of cases to the occupational health service. Aside from ensuring that only cases that would benefit from occupational health

involvement are referred this would also go some way to reducing the imbalance between the number of referrals and the capacity of the service to deal with them.

5.9 This is an important point in the process as in many cases it is the only opportunity for the manager to provide occupational health with detailed information about the nature of the job of the staff member. The manager of the occupational health service has stated that the quality of referrals is poor and that managers seem to be unaware that they are able to provide and ask for specific information at this stage in the process.

5.10 The group stated that referrals to occupational health can be self-referrals from staff members themselves. They were not entirely clear what process they need to follow to do this but the group were of the view that neither they (service managers) nor HR were in a position to act as gatekeepers in relation to self-referrals. This apparent inability for the authority to control demand emanating from self-referrals for the service may be a contributory factor to its inability to cope with the numbers of referrals it receives. However, it has subsequently been established that the process actually requires self-referrals to be redirected to managers for a referral through the normal process and are very low in numbers indicating that there might be a communication or training issue.

5.11 The group reported that, following referral, occupational health arrange a consultation with the staff member concerned from which a report is produced. Before the report is uploaded to Digigov it is agreed with the member of staff. Where agreement is not forthcoming the report does not become available to the manager of the person concerned. This is clearly a point in the process that is likely to create delay and where managers can be denied important information needed to make sound judgements.

5.12 This understanding of the process is at odds with a recently circulated process map created by the service itself. The diagram, which is attached as an appendix, clearly shows that reports that are not agreed are sent to managers after five days, regardless of whether the content has been agreed.

5.13 There may be some confusion about how the process is intended to work which should be addressed. It does however allow for a member of staff to refuse permission at the outset for the report to be released. Where this happens the medical report is prepared and filed but not forwarded to management who are provided instead with a 'standard report' which presumably records the fact that a consultation has taken place but that permission to release it has not been provided.

5.14 On the face of it preparing a report that is not to be released seems to be a waste of time and effort which contributes little to the aim of facilitating a return to work. Further exploration has established that such a report may be used at a later stage, e.g. at a tribunal. Nonetheless it would be better to try and avoid a situation where the report does not add value at a much earlier stage.

5.15 It has been pointed out that the General Medical Council guidance on confidentiality indicates that the employee will be able to access their medical reports and will need to understand the purpose of the report. Given that this is a legal requirement it must be adhered to in policy and practice but does not seem to preclude a presumption that the report will be provided to managers whether or not consent is forthcoming, albeit

possibly in a revised or redacted form to maintain medical confidentiality where required. Consideration could be given to whether it is possible to provide a report to a manager focussed on the capacity of an employee to carry out their duties without any reference to the medical condition itself.

5.16 Further delays to the resolution of a given long term absence can also flow from occupational health officers arranging further or periodic review meetings with the member of staff. The impact of this is that assessments in these cases are always essentially interim, making it less likely that a final conclusion will be reached within a reasonable time frame. In the view of the managers this is one reason why long term absences often extend to just before the 6 month stage where the next decisive point in the process takes place, i.e. a reduction in pay. The occupational health service has pointed out that review appointments are only arranged where a diagnosis is not confirmed or where the results of medical investigations are awaited and that it is therefore NHS timeframes that create the problem.

5.17 Whilst limited in scope due to time constraints, this analysis indicates that some changes of emphasis in the process to reinforce the need for managers to make considered judgements could have a positive impact on the management of long term absence. In particular, automatic referral to occupational health, without any consideration of whether it will add value, should be positively discouraged. This could be achieved by introducing a requirement for a) a management decision to be made and b) the reasons for it to be recorded. Allowing an automatic referral would then constitute non-compliance. This would reduce the number of referrals to the occupational health service thus relieving the current backlog and also ensure that value is added in all cases where a referral does takes place.

5.18 There is also scope for clarifying and emphasising the primary role of occupational health which is to prevent work related ill health. Early referral where there is good reason to believe that this will add value should be encouraged; referral at all stages should be avoided where there is no identifiable benefit. In this way the service can be focussed on health surveillance and avoid purely process driven involvement in sickness absence management. In turn this will emphasise the need for informed management judgement to be at the nub of absence management policy and practice.

6. Examples of initiatives from other UK local authorities

6.1 The issues faced by Cardiff in trying to minimise absence levels are the same as those facing every other local authority in the UK. Many have introduced initiatives that go to some of the points brought out in this report. The need for early intervention and support to staff experiencing the two major causes of absence – stress and muscular-skeletal issues are stressed by South Lanarkshire Council for example. Wigan and Stockton Councils are both focussed on recognising and rewarding the positive contribution made by committed members of the workforce.

6.2 Several years ago South Lanarkshire adopted a 'Holistic Approach to Employee Assistance', underpinned by a recognition that 'one size doesn't fit all' and a need for 'a culture of early intervention'. Managers are trained and encouraged to take a pro-active approach to support staff to remain at work on a case by case approach. A range of

interventions such as physiotherapy, counselling and financial advice are available at as early a stage as possible through an employee support team. Physiotherapy appointments are made available within five days and counselling within two weeks. Other elements of the Holistic Employee Assistance Programme include Occupational Health support, discounted complementary therapies, workplace mediation and cognitive behavioural therapy.

6.3 Wigan gained a CIPD Highly Commended award in 2016 for their Be Wigan initiative. The initiative is aimed at building a happy, engaged workforce through a number of reward and recognition programmes, including an attendance and loyalty reward scheme. The initiative incudes high profile involvement from the council's Chief Executive who fronts an informal agreement with members of the workforce setting out what they can expect from the council alongside the council's expectations of them.

6.4 Stockton, inspired by the maxim often attributed to Peter Drucker that, 'Culture eats strategy for breakfast', has also focussed on the culture of the organisation. The work-stream entitled, Shaping a Brighter Future Programme, concentrates on creating a workforce culture that helps the council, 'to attract talented employees who are the right fit for our organisation', 'drives employee engagement and staff retention', 'supports happiness and satisfaction at work' and 'leads to strong performance'.

6.5 These initiatives all operate on the principle that prevention is better than cure. Dealing with the reasons for absence before they become problematic is expected to have a positive impact on sickness levels and contribute to improved overall performance.

6.6 It should be stressed that Cardiff Council is itself highly regarded for its people management practice and has been short listed for the 2017 CIPD Best Employee Engagement Initiative for the Employee Voice project. It is progressing to Silver Level in the Corporate Health Standard - a Welsh Government initiative aimed at supporting employee health and wellbeing. The Council also has a partnership with the Local Health Board to fast track Mental Health referrals which includes CBT as well as EAP service. The challenge, as for all authorities, is to make these initiatives accessible and customised to ensure that the positive engagement culture reaches all sections of the workforce.

7. Conclusions and recommendations

7.3 The data indicate that the nature of sickness absence issues and therefore, the solution to them, is different for different service areas. All three of the focus groups recognised this.

7.4 Absence amongst teachers is particularly significant because of the high proportion of this group within the workforce. Notwithstanding the (unsubstantiated) suggestion made by some that teacher absence may be under-reported, they are statistically the group least likely to take time off sick, indicating that an initiative focussed on them in particular would be unlikely to succeed. Nonetheless, even a 1% reduction in absence levels would be a significant benefit to the overall absence level. The main point arising from the head-teacher focus group in relation to teacher absence was a need to tighten up language used in policy statements and standard letters. The example discussed was

a letter which uses the term 'may lead to…' which would be stronger if it said 'is likely to lead to…'.

7.5 In so far as the rest of the school workforce is concerned, teaching assistants are significantly more likely to be absent than teachers. This may reflect school management priorities or may be related to the nature of the job and needs further exploration. Some people were of the view that teachers are more vocationally attached to their jobs, feel a high degree of responsibility in relation to not letting their pupils down and also have a great deal more to lose than teaching assistants. This was confirmed to an extent by the head-teachers who also pointed out that the nature of the teaching assistant role has changed over recent years to become more professional and for many a step towards becoming a teacher. It is not known whether this is reflected in the data and further drilling down should take place to test this hypothesis.

7.6 A number of participants in the focus groups expressed doubts as to the efficacy of the policy framework in relation to schools, suggesting that some head-teachers may be acting outside the corporate absence management system. The data appear to support this view and some of the head-teachers confirmed that they sometimes made a positive decision to not follow prescribed process. It should also be pointed out that teacher absence is managed differently in some important respects than that of the council staff to reflect differences in national terms and conditions of service.

7.7 Non-school education staff are the departmental workforce that is most likely to take long term sick. This is not however reflected in the overall absence data for the school catering or cleaning workforce, indicating a disproportionate propensity for these groups to take long term, rather than short term, sick leave. The cleaning managers in particular report a very high level of compliance with corporate procedures and this is reflected in the discount data and the comparatively low level of short term absence. It is possible that the disproportionately high level of long term absence also reflects this, supporting the view of a number of people that inflexible management of short term absence is fuelling the increase in long term absence.

7.8 The focus groups threw up some common themes but also some contradictory views. HR officers were of the view that managers are risk averse and inconsistent. Managers felt constrained by process and claimed at times to be unsupported when they thought disciplinary action was warranted. They were of the view that it is HR and the council's senior management that are risk averse. Both groups indicated that a closer, more partnership oriented, approach would be helpful.

7.9 Trade union input to the review has been particularly useful in establishing how policy and processes are perceived by the council workforce. The insight of representatives into the real life experiences of staff members helps to contextualise the sickness absence data and in particular to understand why it is that some occupational groups are inherently more prone to sickness absence than others. Targeting supportive, early intervention initiatives at these groups can have a positive impact on their well-being and help drive down the level of absence.

7.10 The negative perception expressed by some trade union representatives and in particular the view that managers are prone to using the absence management system to the

detriment of individual members of the workforce, is not necessarily supported by evidence. Nonetheless, it indicates a pressing need to emphasise the positive part that the effective management of sickness absence plays in meeting wider obligations with respect to health and safety at work.

7.11 The suggestion, referred to earlier in this report, that managers should be disallowed from making referrals to occupational health following a return to work on the basis of a GP opinion that a person is fit, illustrates how what should be a supportive mechanism could be undermined if these negative perceptions are not allayed.

7.12 Employers are in fact under a positive duty to actively consider whether a person's work is a contributory factor to ill health and must determine whether changes are required. They are also, unlike GPs, required to consider the wider impact on the health and safety of others where the performance of a member of staff is affected by their health. A referral to occupational health can be an important aspect of fulfilling these duties. The Management of Health and Safety at Work Regulations (MHSWR) 1999 (NI MHSWR 2000) refer to this, as guidance from the Health and Safety Executive makes clear[1]:

These regulations set out broad general duties that apply to almost all kinds of work. They place a number of requirements on employers that include:

■ making a suitable and sufficient assessment of the risks to the health and safety of employees in the workplace that could harm the health and safety of their employees and others who may be affected by the work activities;

■ introducing preventive and protective measures to control risks identified by the risk assessment;

■ reviewing and if necessary modifying that assessment and the preventive and protective measures if circumstances change, eg if work could affect the health of an employee returning following sick leave or an employee's health affects the way they perform tasks at work;

■ providing employees with a level of health surveillance (ie watching over their health by various methods) that is appropriate to any risks to their health and safety that are identified by the risk assessment.

7.13 The issue of whether and to what extent managers misuse occupational health referrals should not be allowed to fetter the proper use of this, or any other legitimate management tool. This is not to diminish the importance of tackling poor management practice, indeed it is vital to the integrity of the process that any misuse or abuse of process is identified and dealt with through the appropriate procedures.

---

[1] Managing sickness absence and return to work: An employers' and managers' guide, Health and Safety Executive http://www.hse.gov.uk/pubns/priced/hsg249.pdf

7.14 All focus group participants agreed that there was a backlog in referrals to occupational health and that this was a contributory factor in the increased level of long term absence. There may be a case for increasing occupational health resources but a number of people felt that the automatic referral of cases, regardless of whether occupational health involvement was likely to be of benefit, meant that resources were unnecessarily stretched. This points to a need for a more targeted approach, driven by the judgement of managers rather than automatic referral triggers.

7.15 A limited process mapping exercise indicates that some specific changes in emphasis and process are required at the stage of referral to occupational health. It must however be pointed out that feedback and a meeting with the relatively newly appointed occupational health manager indicate that many of the issues raised through the workshops are being actively addressed. Changes to the way the service works have already been implemented to counter the perception that it adds little value and there is a renewed emphasis on the pro-active, preventative side of occupational health activity.

7.16 The groups all identified negative, unintended consequences of the policy and procedure. It might be considered inevitable that any attempt to systemise absence management will lead to some instances of 'playing the system' and that trigger points will become ceilings in some instances, e.g. long term absence lasting just under six months or short term absence patterns just avoiding trigger points. It is not possible to establish at this stage how significant these are and therefore not possible to come to a definitive view as to the balance between the cost of these and the benefits of operating a systemised, corporate approach. It does however seem that there is some scope for adjusting the balance between adherence to process and the application of informed managerial judgement to ensure that action is not solely driven by the absence management system.

7.17 The analysis suggests the following recommendations:

1. Target and tailor HR support to those managers who most need it – the data and feedback from the focus groups indicate that this could be those managing smaller workforce groups who rarely use the system and find it onerous.

2. Ensure that operational managers understand and are able to follow policy and process consistently and that this is reflected in the performance management process. This will include clarifying the difference between long term and short term absence and ensuring that managers are aware of the advice and support that is available to assist them to make informed decisions.

3. Identify work groups where early intervention and support is most likely to be effective and tailor this to suit specific needs, e.g. early referral to physiotherapy for heavy manual staff and easy access to advice and support for low paid/part time/shift working staff.

4. Further explore the possible relationship between the (over) compliance with process driven short term absence management systems and the increase in long term absence. If there are cases where workers, in conjunction with their doctors, are in effect, choosing long term absence as the least risky option, there may be a case for greater discretion in the way the system operates to ensure that there are no perverse incentives in individual

cases. There may also be potential for strategic level contact with local GPs to ensure awareness of the council's willingness to make adjustments to allow them to choose the 'may be fit' for work option rather than signing people off.

5. Ensure that ubiquity does not create anomalous application of policy and process. Schools in particular would benefit from a tailored approach that emphasises the role of informed, reasonable decision making in the management of both short and long term absence. A positive, evidenced decision to discount an absence for example should not be treated as non-compliant and at certain stages in the process managers should be required to exercise judgement. On the other hand, the reasons for decisions must be recorded and managers held to account where their judgement is flawed or otherwise lacking.

6. The need for supportive management practice should be emphasised and blind process compliance discouraged. Managers should be encouraged to demonstrate in their practice that effective absence management is an important aspect of meeting duty of care requirements as well as compliance with the law governing workplace health and safety.

7. Any allegations of misuse of process by managers should be investigated and dealt with via appropriate procedures.

8. School governors should be provided with regular reports showing levels of absence at the school for which they are responsible, along with comparator data and an estimate of the cost to the school of the absence. This would be an effective way of holding head-teachers to account.

9. The absence data for school based staff should be analysed on a school by school basis to establish whether, as the head teachers believe, there are a small number of schools contributing disproportionately to the overall figures. This would enable support to be targeted at those schools that most require it.

10. Ensure that occupational health resources are available and targeted at cases where they will make a genuine difference. This may mean ending automatic referrals in cases where medical evidence, or the view of service management, indicates that adjustments are unlikely to be feasible or conversely, where they are obvious and do not require the involvement of occupational health. Specifically it is recommended that:

    - A specific requirement be imposed on managers to proactively consider whether referral to occupational health will contribute to the definitive conclusion of a long term absence case before the referral is made. Automatic referral should be regarded as non-compliant.

    - If possible, remove any de facto or actual veto by the subject member of staff on the provision of occupational health reports to managers.

    - Redefine or clarify the mission statement of occupational health to ensure that it is clear to all stakeholders that the primary focus of the service is prevention of ill health.

- Actively discourage follow up reviews where these delay medical redeployment or dismissal by placing a positive requirement on the service to provide definitive advice as soon as is reasonable practicable.

- Ensure that the process for self-referral is fully understood and that managers are aware of the need for them to play a proactive part in ensuring that Occupational Health Resources are not wasted on referrals that will not benefit from the involvement of the service.

11. Early intervention, based on a multi-disciplinary approach, should be accommodated within the policy framework, including where patterns of absence or behaviour are of concern to managers, whether or not these are picked up by the absence management system. Swift and appropriate referrals to a range of support services should aim at helping staff to cope with issues leading to stress and to avoid muscular-skeletal conditions, before these lead to problematic absence levels.

12. Consider what further training is appropriate to assist managers to offer early stage support to workers. As in the South Lanarkshire example, the aim would be to refer to appropriate support, on a case by case basis, with the aim of avoiding the need for later process driven action in response to absence triggers.

13. Further explore potential and options for limiting the impact of non-work related stress. This will require detailed further analysis of complex issues and the establishment of measures capable of demonstrating the impact of workplace initiatives on the wider well-being of those within the workforce who are most at risk. Further information about the impact of the Wigan and Stockton examples may assist with ensuring that the Cardiff Employee Voice Project penetrates the culture of the entire organisation.

14. Investigate work systems and conditions for some members of the workforce to establish whether changes could be made that would reduce propensity for LT sickness. This might include identifying unsafe working practices, revising shift patterns and taking action to ameliorate the impact of lone working, for example.

15. Introduce a case management approach whereby all relevant parties are involved in seeking solutions. Formal, case conference type meetings should be used to implement a positive, solutions focussed approach to difficult cases, with an expectation of multi-disciplinary attendance.

16. Monitor the application of the updated drugs and alcohol policy to ensure that it is effective in supporting staff. A number of authorities, including the UK's largest, Birmingham, have implemented testing regimes, alongside awareness raising, in an effort to eliminate the threat to public safety that affected staff can pose. APSE is able to offer training and access to specialist support in relation to this critical issue if this becomes necessary in the future.

LOCAL SERVICES
LOCAL SOLUTIONS