NORTH LANARKSHIRE COUNCIL

REPORT

AGENDA ITEM No. 12

To: SOCIAL WORK COMMITTEE	Subject: STUDY OF ABSENCE
From: DIRECTOR OF SOCIAL WORK	
Date: 5 JUNE 2003 Ref: JS	

1. PURPOSE OF REPORT / INTRODUCTION

1.1 The purpose of this report is to advise Committee of the findings of a study into absence within Social Work.

2. BACKGROUND

2.1 Absence is an issue of concern across the Council. In 2002, permission was granted by Committee to commission a study into absence across the Council.

2.2 The study was undertaken by the Scottish Local Authority Management Centre (SLAM)

2.3 The main findings and plan for action are noted below.

3. FINDINGS AND ACTION

3.1 The study found that:

46% of staff have no absence

Short-term absence is well controlled.

The pattern of absence for Social Work in North Lanarkshire is reflected throughout the country i.e. that Social Work / Social Services tends to have a higher level of absence than other Departments

A small number of staff - less than 100 from a total staff group of 3700 - on long term absence, comprise the bulk of days lost

The majority of those on long term absence are over 50, with stress the major factor in absence for APT and C staff and muscular – skeletal problems the major factor in absence for manual staff. The Absence Management System within the Council does not distinguish between work-related stress and non-work related factors.

The absence management system tends to be indiscriminate, targeting all staff. It needs to be more clearly focused on those areas where intervention can lead to change.

There is evidence of drift in supporting the return to work of those on long term absence

Staff are disappointed that good attendance is not well recognised.

3.2 Proposals for action include:

The creation of an Absence Management Team to improve targetting and help line managers to support more effectively the small number of staff who comprise the majority of days lost.

The development of a more effective relationship with SALUS to support the work of the Absence Management Team.

The re-launch of the scheme and retraining of managers to ensure full implementation of the Absence Management System, incorporating changes initiated by the Corporate Best Value Group on Absence Management.

Produce more detailed management information to allow informed and targeted decision-making. This will include a communications framework to keep employees informed of absence levels.

Recognition of good levels of attendance, consistent with the outcomes of the Corporate Best Value Group.

Promote the development of policies which lead to good health.

Identify services, which could be provided to facilitate early return to work. It is anticipated that this will include changes introduced by the Best Value Group to improve access to physiotherapy services to support treatment for muscular-skeletal injury.

The improvement of staffing levels within Social Work. See separate report on recruitment prepared for Committee.

3.3 A copy of the Executive Summary of the Study has been placed in the Members' library.

4. FINANCIAL / PERSONNEL / LEGAL / POLICY IMPLICATIONS

4.1 Current staff will deal with the work outlined above. No additional resources or costs are required.

5. RECOMMENDATIONS

5.1 Committee is asked to:

(2) Note the outcome of the Study and approve the actions noted above.
(1) Remit this item to the Policy and Resources (Personnel) Sub Committee for its interest.

Jim Dickie
Director of Social Work
May 12th 2003

For further information on this report please contact John Scott, Manager of Resources and Information (TEL: 01698 332037)

Executive Summary

(1) The analysis of sickness absence and absence management in this report is based on four studies: A statistical study based on the departments absence management and personnel data sets; a focus group study with 100 managers from all sections and all levels of the department; a focus group study with 100 staff of the department; and a questionnaire survey of all staff and managers of the department.

(2) The statistical study established a number of major findings which can be summarised as follows:

- There is an inverse relationship between episodes of sickness absence and days lost and though short term absence accounts for the overwhelming majority of episodes it accounts for a relatively small proportion of days lost. Episodes of 1 – 5 days account for around 75% of all episodes of absence but for only 18% of days lost. Episodes of more than two months duration account for around 3% of episodes but almost 40% of days lost.

- A small number of long term absences account for a disproportionate number of days lost. 100 cases accounted for over 45% of all days lost in the years examined and 4 cases of very long term absence accounted for more days lost than all episodes of absence of a single day's duration.

- Two causes of absence were disproportionately associated with long term absence and substantial days lost. Stress and mental health problems and muscular skeletal problems. The former accounts for only 7% of episodes but 25% of days lost, the latter for 5% of episodes but over 12% of days lost.

- Although the departmental data shows substantial disparities in absence rates between different services, categories of worker, and work locations when we controlled for size of workforce (ie days available) and long term absence (over 60 days) the disparities vanish. Again, a small number of long term cases explain the differences in reported absence rates.

- Return to work after sickness absence exhibits a very stable pattern. For short term absence peak return points are after 1, 5, 10 and 15 days suggesting a kind of quota system that may reflect medical practice. For long term absence the peak points are at 3, 6 and 9 months suggesting a "drift" pattern exists. In longer term absences, the pattern is particularly pronounced for stress and mental health related absence suggesting that focused "return to work" support at an earlier stage would be useful.

- There is a strong age relationship in long term absence. 38% of the 100 longest absences were among staff over 50, a much higher proportion than would be expected given the departments age profile, and 6 out of the 10 longest absences

were among this age group. People over 50 account for almost one third of all days lost across the department, but account for under one fifth of the workforce. Stress related absence is also higher amongst this age group.

- The largest absence category among departmental staff is those with no absence at all in a given year: around 45% of all staff.

(3) The major conclusions that follow are that short term absence is relatively small scale and that the major factor in days lost is a small number of very long term cases that are often stress and mental health related, or linked to muscular skeletal problems. The key absence management issues relate to prevention and rehabilitation (return to work) rather than control and discipline. Although prevention and rehabilitation are provided for in current policy, current mechanisms appear to be ineffective in dealing with the scale of the problem.

The Focus Groups with Managers

(4) The key findings of the focus groups with managers can be summarised as follows:

- Managers view the existing system as insufficiently focussed and burdensome. Particularly, the requirement for return to work interviews after every absence is seen as unnecessary and time consuming against the other demands on managers time. A system more focussed on cases of real concern would be welcomed.

- Managers have received training on absence management but still think disproportionately in terms of control and discipline with respect to short term absence. On discipline, many managers have a confused understanding of the existing legal and policy framework, and see it as requiring that the grounds for sickness absence stated by a member of staff are proved to be invalid. There is also a widespread belief that neither the Department nor members are willing to robustly use discipline, and ultimately dismissal, as sanctions with respect to sickness absence. We were recurrently told that no dismissals for abuse of the absence system had ever occurred within the Department. The perceived requirement to refer cases where disciplinary action is contemplated to the Department centrally reinforced this view.

- For long term cases managers saw themselves as poorly supported. Many had worries and reservations about making home visits which might be seen as intrusive or alarming by staff and felt that the use of personnel qualified staff might be more appropriate. Specialist occupational health input from SALUS was seen to be slow in access, and of often very limited utility (eg failing to resolve issues of capacity or likely return to work dates). A number of examples were cited of appointments with SALUS being achieved after the member of staff had been back to work for some time.

- The key difficulty cited by managers was that absence potentially created disruption of service and their priority had to be ensuring that service requirements were covered. The limited nature of existing cover arrangements were emphasised strongly and for smaller service units particularly could result in the manager themselves covering the work of absent staff. Active management of long term cases was seen as very difficult under these circumstances and, again, greater input from personnel was seen as desirable.

- It was noted also that long term absence seriously exacerbated existing workload pressures on other staff and could itself impact on their health and wellbeing. This was particularly emphasised in small service delivery units such as those in residential care. Limited core staffing against workload was seen to a significant factor in stress related absence.

- Enhanced preventative provision was seen to be desirable. Improved core staffing and cover arrangements were seen as the most important preventative measures but on site access to back clinics, physiotherapy and stress management support were seen as desirable. Better special leave provision for staff with child or adult care responsibilities, or flexible working arrangements to accommodate them, were also seen as desirable.

- Overall, managers saw the current absence management system as lacking real sanctions or rewards, and the recognition and reward of those with good attendance was seen to a desirable development. However, divergent views existed as to what type of reward would be appropriate. Financial, additional leave and access to leisure rewards were all canvassed.

(5) The major conclusions from this study are that managers themselves feel overburdened and poorly supported in their absence management role, and have little optimism that the current absence management framework will reduce current absence rates. Significant misunderstandings of the legal and policy framework exist, and managers are much more focused on issues around short term absence than they are on long term absence. The burdens long term absence places on service management were emphasised, but little belief existed that line managers could do much to resolve it. The key steps to improvement emphasised were improved core staffing and absence cover arrangements, a better resourced and proactive preventative approach, and a reward system for good attendance.

Staff Focus Groups and Survey

(6) The staff focus groups and surveys, not unexpectedly, identified many of the issues raised in the management survey. The major additional findings are highlighted below:

- A uniform approach to all cases of absence is seen as indiscriminate and failing to focus on serious cases within the system. There is a widespread perception that only a very small number of staff abuse the system but everybody gets caught up

in a system designed to prevent this. There was, however, strong support for robust action against people who abuse the system, but the system was seen to lack effective sanctions at present.

- Despite the point above, 70% of staff who had been absent were unaware of having had a return to work interview despite the relevant paperwork being completed.

- A significant majority of staff who had had long term absences welcomed contact with their managers during absence and saw it as supportive. A small minority (under 10%) found it intrusive or intimidatory. The bigger complaint was from people who had had little contact during absence or who saw their manager as "going through the motions"

- The factors seen as affecting absence were the pace of change affecting services, rising workloads against constrained staffing levels, and the nature of the work itself resulting in greater exposure to health risks.

- As with managers, there was strong support for enhanced in house preventative provision and a wide range of services were suggested (from physiotherapy to aromatherapy and yoga). Improved core staffing and greater recognition of staff members care commitments outside work were also seen as important elements of a preventative approach. It was obvious also that many staff are unclear about provision already made for special leave, and the need for more effective communication with staff was emphasised.

- There was strong support for rewards for good attendance although again divergent views existed about type of rewards. Suggestions tend to divide between direct financial rewards and additional leave or enhanced flexi-time.

(7) Overall, the staff groups and survey reinforce major issues arising from the management survey. The current system is seen as indiscriminate, the system is perceived to lack effective sanctions and rewards, and preventative provision is seen as important but underdeveloped. As with managers, core staffing and workload pressures are seen as having a major impact that needs to be addressed. A key conclusion is that staff and managers are unaware of the actual pattern of absence across the department, and the huge effect a small number of cases have on overall days lost. Absence management is still largely seen as focused on controlling the level of short term and recurrent short term absence, while "return to work" measures for long term absence were less understood or valued.

Conclusions and Recommendations

Conclusions

1) The pattern of sickness absence and days lost in the department needs to be the basis for focussing the absence management system. The statistical evidence shows that very short term and short term absence is relatively well controlled and that the biggest impact on days lost comes from a small number of very long term cases of sickness absence.

2) Current thinking about absence in the department tends to be focussed on short term absence and the issues of discipline and control it raises. There is no case for complacency here, and there is confusion about the bases for discipline and control, but much more attention, effort and resource needs to go into preventative and rehabilitative work to minimise longer term absence. The links between stress and mental health problems, muscular skeletal problems and long term absence suggests that preventative and rehabilitative approaches could have high returns in reducing days lost.

3) If a more targeted system of absence management is to be introduced, as all management and staff respondents suggest, it needs to be based on a clear and consistent stance by the Department. At present, there is widespread disbelief in the willingness of Departmental managers and members to pursue issues of discipline with respect to sickness absence, and preventative and rehabilitative approaches are seen to be underdeveloped and weak. A better targeted system needs to offer clear guidance and effective mechanisms, for addressing discipline, prevention and rehabilitation.

4) Discipline needs to be clearly linked to the pattern of absence an employee has, the impact of that absence on the departments work, and screening for underlying welfare or chronicle illness issues. If an employee's pattern of absence is atypical for their category of worker, unrelated to identifiable welfare or illness issues, and disrupts service provision, then focussed activity to achieve improvement, including disciplinary measures, are warranted. The validity of the stated grounds for sickness absence are not something that needs pursued: it is the pattern and the impact that justifies action.

5) Preventative measures need strengthened and better communicated to staff. We think line managers are key first line identifiers of staff who may be developing health or welfare problems that exhibit themselves in changed behaviour or performance. However, such identification could never be complete and only makes sense if a wider array of preventative support services are available. The overwhelming view of managers and staff are that a wider range of in house services should be available to staff. This might usefully be done in conjunction with NHS Lanarkshire, the Council's partner in community planning and health improvement.

6) Rehabilitative capacity needs strengthened and better resourced. As longer term cases are the major source of days lost, developing capacity for early intervention and supported return to work is critical. At present, in house expertise and SALUS are

deployed on a case by case basis but the speed and outcomes of this process are to no one's satisfaction. Although we accept that line managers need to remain the key link with long term absence cases, we also accept that they need far better supported to be effective in this role. Particularly, if drift is not to occur in the management of long term cases, the speed of expert input to assessing capacity and supported return to work options needs improved.

7) A targeted system needs to encourage managers to focus effort on serious cases, rather than treat all cases equivalently. To us this implies a focus on cases of recurrent short term absence that indicate potential issues of capacity or conduct, and particularly on cases of long term absence. In essence, we think an "accounts management" approach where more attention is given to the larger "absence accounts" and less to the smaller is necessary. Clearly all absence needs appropriately reported and recorded but not all requires active absence management.

8) The recording and reporting of absence needs improved. The current illness classification used is ridiculously elaborate and assumes that those recording are capable of refined judgement based on full information. In reality, administrative assistants are using the "pick list" on the basis of the very limited information provided by a GP Sickline. The reporting of absence is overaggregrated, misleading and needs addressed.

Recommendations

1) We recommend that the department relaunch its absence management approach with a clear statement of its stance on matters of conduct and discipline, prevention and welfare, and rehabilitation and return to work support.

- On Conduct and Discipline We recommend that the criteria noted above are emphasised: the atypicality of the employees pattern of absence; the impact of that pattern of absence on the departments work and screening to ensure that capacity and welfare issues are identified where they arise. Where no such issues exist, improvement plans should be agreed with staff, and staff should be informed of the likelihood of disciplinary action if improvement does not occur.

- On Prevention and Welfare We recommend that in house provision of physiotherapy, stress counselling and management and enhanced welfare advice and support be examined. We also recommend that the potential of clinic sessions in different areas in rotation be explored to facilitate ease of access. We further recommend that staff entitlement to leave of absence for child or adult care, or other family purposes, be printed on a laminate card and issued to all staff as many staff are unaware or confused about such entitlements.

- On Rehabilitation and Return to Work We recommend that a multidisciplinary team, to be called the "return to work" team be formed to provide and co-ordinate expert input in cases of long term absence. All cases of over 4 weeks duration should be notified to this team and all cases of over 8 weeks in duration should have its active involvement. The core aim of this team will be to co-ordinate diagnostic and prognostic inputs to address issues of capacity, and to identify and support practical arrangements that will facilitate the earliest possible return to work. They should work closely with SALUS.

2) The relaunched system should be firmly based on the principle of targeting and we recommend that "absence accounts" be prepared for all members of staff. This would provide a record of episodes, duration and pattern of absence since 1998 when the current recording system was adopted or since the member of staff joined the department in the case of newer employees. These would provide the basis for a future "accounts management" approach by line managers and be updated over time. They would also provide a basis for initial discussions with members of staff with poor absence status to identify improvement steps, and support, that may be necessary. Any case of sickness absence of over 4 weeks would automatically attract priority within the "accounts management system" and be notified to the "return to work" team.

3) To facilitate a more effective targeting of serious cases, we recommend that return to work interviews and records of interview should not be required for absences of 3 days or under unless it is the third, or more than third episode of absence

within an absence year. This would very significantly reduce the demand on line managers.

4) We recommend that in each area an "area absence management team" be created to monitor absence and absence management in their area. This should be focused on cases where improvement plans have been agreed with staff; cases where a second or subsequent disciplinary warning is being considered; and long term cases referred to the "return to work" team to ensure that its recommendations are fully implemented. The monitoring role is not a decision making one, but one ensuring that decisions made elsewhere are appropriate and are implemented. Area teams would also monitor absence trends and issues more general within their area. To show commitment and partnership with the workforce, we recommend that each area absence team should include a senior departmental manager and a trade union representative as well as an area manager and a personnel officer.

5) We recommend that in all cases the line manager should be the lead officer in the absence management of their staff but that in cases where a second or subsequent disciplinary warning is considered or an attendance improvement plans has been agreed with a member of staff these would be reported to and monitored by the area absence management team. All cases of four weeks or more duration should be reported to the "return to work" team and in all cases of eight weeks or more duration the team should provide active support to the line manager in facilitating return to work.

6) We recommend that the relaunch of the absence management system be underpinned by a coherent communication and training strategy. The communications strategy should encompass the key findings of the studies reported above, the principles and practices of the adapted system, and reiterate the impact that absence has on workload pressures. It should positively emphasise the preventative and "return to work" measures the department intends to adopt and encourage staff to make full use of them. Training on the principles and practice of the adapted system should be given to all managers with absence management responsibilities and the opportunity to attend training should be given to all trade union representatives.

7) We recommend that a reward system for good attendance be considered. We are convinced that financial rewards for good attendance are both politically inappropriate and, from research evidence, of at best short term benefit. Additional annual leave or enhanced flexi-time runs the risk of increasing workload pressures on other staff and therefore being counter productive. We recommend therefore that rewards should be free access to the Council's leisure facilities. A layered system of reward from perfect attendance to 3-5 days absence might be appropriate. The system currently employed in Community Services should be considered. An addition, which would have a preventative

dimension, would be to offer all other staff enhanced discounts for leisure access to encourage healthier lifestyles and relaxation outwith work.

8) The recording and reporting of absence are currently inadequate and detailed recommendations for improvement are suggested in the conclusion to Appendix I of the report. As these relate to the accuracy of recording, the integrity and consistency of databases, and the usefulness of reported data in giving members an accurate understanding of the absence issues they fare, we strongly recommend they are considered and acted upon.