

Department for Work and Pensions

Research Report No 227

Job Retention and Rehabilitation Pilot: Employers' management of long-term sickness absence

Katharine Nice and Patricia Thornton

A report of research carried out by the Social Policy Research Unit, University of York on behalf of the Department for Work and Pensions

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The Authors

Katharine Nice joined the Social Policy Research Unit as a Research Fellow in November 2003. She has worked on several elements of the qualitative evaluations of the Job Retention and Rehabilitation Pilot and the Incapacity Benefits Pathways to Work pilots commissioned by the Department for Work and Pensions.

Patricia Thornton is a Senior Research Fellow at the Social Policy Research Unit where she has led a programme of research on Jobcentre Plus disability services. Other recent research includes: qualitative elements of the Job Retention and Rehabilitation Pilot; and the New Deal for Disabled People national extension; and comparative studies of policies and practices relating to disability benefits and work.

Abbreviations

DDA	Disability Discrimination Act
DWP	Department for Work and Pensions
GP	General Practitioner
HSE	Health and Safety Executive
JRRP	Job Retention and Rehabilitation Pilot
NHS	National Health Service
SMEs	Small and Medium Sized Enterprises

Summary

The study explored how employers view and deal with sickness absence. It was commissioned by the Department for Work and Pensions to inform work undertaken through the Government's Job Retention and Rehabilitation Pilot (JRRP), which is trialling ways of helping people on sick leave to return to work. In-depth interviews were carried out with 53 representatives with differing roles in 22 public, private and voluntary sectors organisations in four of the six pilot areas. The main aims were to understand how sickness absence policies translate into practice and to investigate any needs for extra help or information to manage sickness absence.

Employers' attitudes to sickness absence

Sickness absence was seen as a problem because of difficulties in providing cover, stress and overload on the workforce, costs, effects on productivity, profitability or competitiveness, and repercussions for customer service.

Among managers there was some lack of sympathy towards days off for 'minor' complaints, suspicions that short-term absences were not always 'genuine' and suggestions that the seven-day self-certification period encouraged illegitimate days off and longer spells than warranted. There were some tensions between human resources staff, who wanted to avoid an overly punitive approach, and managers who wanted to pursue a disciplinary route. Organisations that saw themselves as caring and supportive were keen to identify underlying problems at work and make changes to pre-empt further absences.

There was a widespread desire to retain staff absent with long-term sickness in order to keep specialist skills, maximise investment in training, avoid costs of recruiting and training new staff, circumvent the shortage of new recruits and to give the wider message to staff and job applicants that they are valued.

It was easier to plan work if absence periods and lengths were known in advance, and uncertainty about absences related to mental ill health made work planning harder to manage. There was little evidence of unsympathetic attitudes towards long-term absence, though some scepticism among managers about stress-related

illnesses, and some tendencies to see retirement on health grounds as inevitable where redeployment opportunities were restricted.

Policies for long-term absence were generally thought to be supportive of the individual, except where a disciplinary tone was taken at an early stage.

Apart from in small companies, performance in terms of days or percentages of time lost was generally commented on. Targets appeared to be a spur to improve absence rates, especially where the performances of different parts of the organisation were regularly compared, and reducing long-term absences could have an important affect on ability to meet targets.

Documenting and communicating policies and procedures

According to accounts from study participants, documentation appeared to concentrate on procedures absent employees had to follow and, in unionised organisations, to emphasise formal investigation and grievance procedures. Written guidance on how to apply procedures varied in depth and prescriptiveness. There were examples in large companies of intranet-based information on supports to help people back to work. Some documents stated the rationales for policies; here language and tone was intended to convey values underpinning the approach.

A strong impression emerged of policies and procedures evolving rapidly: being formalised for the first time, rewritten or tightened. Human resources staff brought their professional experiences to policy development, as well as advice from specialist organisations. Policies also had been informed by asking other employers, and there were mentions of emulating 'good practice' employers. Often part of the process were consultations with unions or elected staff representatives and human resources staff. Occupational health staff were sometimes marginal here, and ordinary staff were not necessarily asked.

A noticeable development was changes to short-time absence policies to allow more scope for disciplining staff perceived to take advantage of lax procedures.

Where policies and procedures were kept under review, human resources staff used guidance on employment practice, and the Disability Discrimination Act 1995 was often an impetus to review policies.

Efforts to ensure that policy and procedures were fully understood appeared to be directed more at managers charged with implementing them than at employees subject to them. There was a view that an approach that outlines what the organisation can do for the employee is more helpful than rules on what to do.

Managing short-term absences

The approach to managing short-term absence was typically non-interventionist. While it was widespread practice for the employee to make contact on the first day of absence, only one employer in the study was proactive at this point in that they offered occupational health advice for selected conditions. There was rather little evidence of active management of sickness absence in the first two to three weeks following self-certificated absence, though some large organisations asked employees about whom they had concerns to see the occupational health service for help. Stress, depression, upper limb disorders and recurring illnesses such as asthma were mentioned here. Referral to occupational health typically depended on managers understanding conditions. Exceptionally, occupational health staff monitored medical certificates and applied their expertise in deciding which absent employees to contact.

Return to work interviews, or less formal discussions, were almost universal, but sometimes cursory. The thrust and tone ranged from suspicion of unwarranted absences to demonstrating that the organisation cares. There were beliefs that return to work interviews deterred unwarranted days off, and sometimes those employees about whom managers had suspicions received the most attention. Work pressures meant it could be hard for managers to make time, and systems for checking that return to work interviews were sometimes acknowledged to be inadequate. Sometimes interviews were taken seriously as opportunities to explore work-related causes or hidden problems, and occasionally were thought to have been successful.

Although it was sometimes recognised that repeated short spells of absence, like occasional days off, could be the precursor to prolonged sickness absence, there was a tendency for them to be seen as suspect. In larger organisations with systems to log repeated absences, attendance review meetings could be the first step on a disciplinary route with the requirement imposed to improve attendance. But there were also organisations that investigated and tried to address underlying problems.

Managing long-term absences

Respondents in almost all organisations stated a defined number of days or weeks at which continued absence became regarded as long-term, usually four or three weeks. The earliest thresholds, from ten days, had been chosen as the most appropriate at which to intervene with rehabilitation efforts. Managers tended to be less certain than human resources staff about when activities related to long-term absent employees should begin. Monitoring systems were not always robust, and it was possible for long-term absent employees to be forgotten.

In the period before a continued absence became long-term, the line manager was typically the main actor. In terms of responsibilities for the management of long-term absence, there were five models:

- prime responsibility with departmental or line managers, common in public sector organisations;
- shared between managers and human resources managers;
- led by human resources managers;
- led by the occupational health department, in one organisation;
- shared by human resources, occupational health nurse and line managers.

Some problems were associated with leaving responsibility to managers: other pressures on their time, limited knowledge or skills, and inconsistent treatment. Back up from human resources included more proactive advice giving, and, in large companies, central telephone-based help teams. Managers welcomed directive advice from central or regional human resources staff, and 'hands-on' involvement of locally-based human resources staff. Where human resources took the lead there was scope for consistent practice across the organisation. A 'triangle' of human resources, occupational health nurse and line manager had clearly defined roles.

There was variation in how organisations kept in touch with long-term absent employees, and sometimes differing understandings within an organisation of what should happen and when. Home visits were at regular intervals or discretionary. Human resources staff, and managers themselves, reported some reluctance on the part of line managers to undertake home visits, in part because of wishes to avoid pressuring the person back to work. Staff who made home visits believed they were appreciated, however. Where the employee was invited to see an occupational health professional and line manager regularly, home visits were unusual.

Formal meetings to review prospects for or to plan return to work were carried out at the workplace, and sometimes involved case conferences with the interested parties and action planning

Occupational sick pay provisions were thought to be a disincentive to early return to work and to hinder employer's efforts to facilitate return to work. It is possible that an untrusting approach to managing short-term absence reduces confidence in the organisation's commitment to them on the part of long-term absent employees.

Rehabilitation resources

Use of services for rehabilitation was not strongly evident. Counselling and medical assessments or interventions were the main services purchased on a contractual basis or provided internally to assist a return to work. Counselling services were aimed at assisting both employees and managers, but their effectiveness was often unknown due to confidentiality requirements. Advice on specific issues and health conditions was sought from external sources as the need arose. Services such as physiotherapy, MRI scans and sessions with chiropractors were purchased as individual need arose. Employers reported the value of using public services such as

the Jobcentre Plus Access to Work programme and Disability Services, appreciating their specialist knowledge and expertise, but there were also some frustrations in using them.

Use of occupational health services

Among large organisation, occupational health advice was drawn from in-house occupational physicians and nurses or from contracted providers. Long-term absent staff variously were referred automatically to occupational health at trigger points, strongly encouraged to make contact, referred selectively or referred as a last resort. Managers valued occupational health advice if it indicated a likely return date or added to understanding of the condition and its impact on work. Criticisms included the perceived impracticality of advisers' suggestions, views that occupational health intervention held back speedy return to work, and delays in receiving reports. Human resources staff approved of occupational health advisers who were found to be supportive of the individual. Some human resources staff felt they played an important role in managing tensions with between occupational health and managerial staff's priorities.

Adjustments and adaptations on return to work

In general, employers were willing to consider and make adjustments or adaptations to employees' working conditions and the workplace. A wide variety of modifications were reported including phased returns, altering or reducing hours worked and tasks undertaken, adapting equipment and the place of work, and temporary or permanent redeployment.

The focus was primarily on the employee so that employers were guided by their circumstances and needs as far as possible. The ability to be flexible and imaginative about what could be offered and agreed with an employee was seen as important. Despite a willingness to do what they could to help employees back to work employers faced a number of barriers. The employer's capacity to make modifications was dependent on their size, resources, type of work undertaken and variety of jobs offered. The employee's circumstances could also prove to be an obstacle, such that nothing that the employer could offer or do would facilitate their return to work.

Needs for further support

Employers were asked about their awareness of external services to support return to work other than those they had used. Awareness was greater among dedicated human resources staff and less among staff at smaller private organisations who were not human resources specialists. Specialist employment services, advice bureaux, charities and professional bodies in the medical field were mentioned, as was one private company offering a return to work service. Some felt they did not need to use external support because the services on offer were not suitable for the

work environment, their internal resources were sufficient and valued, or a specific need had not arisen.

Although informants were not questioned directly about the JRRP, larger organisations in particular recalled it as an external service they were aware of and sometimes had experience of. Some had been in contact with JRRP providers on a purely introductory level; some had built on the introduction by collaborating with them for the benefit of an absent employee; others had first-hand experience of working alongside JRRP providers without prior briefings. There were some mixed views about the service, but positive reflections included the ability to be proactive and provide a seamless service. Learning from the pilot included being introduced to making return to work plans.

The idea of best practice guidance was welcome for some: as a source of advice on making adjustments and accessing grants, as a form of moral support, or as a tool for measuring themselves against other organisations. Those whose sickness absence procedures were being updated or were newly installed were particularly keen to access good practice guidance. Otherwise there were doubts among human resources specialists that it could add anything to their own personal experience and organisational resources. While some operational and line managers felt they might benefit, for example from guides to managing stress, they said they lacked time to read them.

Respondents often spoke of the need for changes to existing arrangements, such as long National Health Service waiting lists, certification practices and GP medical reports. People spoke about key elements that they would like to see in service provision such as better communication, faster access and responsiveness to needs. There were some calls for information on what is available to help employers support people back to work. Some respondents could not identify any specific needs but said they would not refuse offers of further assistance and information.

1 Introduction

The Department for Work and Pensions (DWP) commissioned the National Centre for Social Research and the Social Policy Research Unit to carry out an in-depth study with employers on policies and practices in the management of long-term sickness absence. Interviews were conducted over eight weeks from June to August 2004.

This introductory chapter explains the research background and aims (Section 1.1). The research needs were informed by a review of the scope, focus and methods of existing research on the management of sickness absence, summarised briefly in Section 1.2. Section 1.3 specifies the research questions addressed. The design of the study and methods, including the sampling strategy, are described in Section 1.4. The final part of the introduction outlines the structure of the report.

1.1 Research background and aims

The intent was to inform work currently being undertaken in the area of job retention within the Job Retention and Rehabilitation Pilot (JRRP). The pilot is designed to test the relative net impact of the early intervention of a person-centred case management approach that eases and boosts individual access to health care, workplace focused help or a combination of the two to support return to work and job retention. Employed and self-employed people included in the pilot are at risk of job loss because they have been absent from work because of ill health, injury or disability for between six and 26 weeks. Four organisations independent of DWP delivered the pilot in six locations in Great Britain. The pilot began in April 2003 and runs for two years.

This study is one of a series of focused studies that aim to answer questions about specific issues that arise within the context of the pilot. This research aimed to provide a better understanding of the context in which the pilot was operating by exploring employers' current practices in managing sickness absence and return to work, and to give an insight into the potential, and possibly actual, contribution of external job retention services.

The Department's JRRP database was used as a convenient sample frame and interviews were carried out with employer representatives in four of the six JRRP locations. While the study did not set out specifically to explore employers' experiences of the JRRP, the opportunity presented itself to investigate views and experiences where there had been contact, as well as awareness of the pilot amongst other external rehabilitation services. Since the purpose of the research was to explore employers' approaches and their use of services more generally, it was decided that it would not be appropriate to mention the JRRP specifically.

The Department highlighted the need to explore possible gaps between employers' policy and practice in the management of sickness absence, and the study thus sought to investigate how absence management policies were implemented. In addition, following a review of the scope, focus and methods of previous research (see Section 1.2), employers' needs for support in implementing sickness absence policies and return to work was found to be an area where in-depth investigation was required. Given the growing promotion of employers' and managers' guides to managing sickness absence and return to work, such as that developed by the Health and Safety Executive (HSE) (HSE, 2004), the study was an opportunity to explore use of and need for 'good practice' guidance.

Careful consideration was given to the most appropriate aspects of sickness absence management upon which to focus, so as to best inform the JRRP. It was decided to concentrate on the *return to work* of people absent from work due to ill health or impairment rather than on the *prevention* of such absence (prevention is sometimes regarded as an element of the sickness absence management process). It was agreed also that, although the Department's interest was in the management of sickness absence of any duration, the emphasis would be on the management of long-term absence where it was distinguished. It has been found that the employer response to short-term absence, especially repeated absences, is often to take a disciplinary as opposed to a rehabilitative approach (Dibben *et al.*, 2001) and it was thought important to explore this further.

1.2 Research needs identified from a review of existing research

The focus of the research and the study design were informed by a review of the areas of enquiry and methods of the existing research concerning employers and the management of sickness absence.

The bulk of the research literature investigates the form, structure and content of policies and practices. Research has explored whether employers have formal policies in place or informal responses to absence (Trades Union Congress, 2002); and the roots of, and factors influencing, employers' approaches (Thomson *et al.*, 2003). Research evidence on the content of policies has fallen into three main areas: the maintenance of contact with employees, the provision of workplace adjustments, and the provision of rehabilitation services (James *et al.*, 2000).

Limited research has been conducted on how absence management policies are put into practice. In a summary of the existing research evidence James *et al.* (2000) state that whilst there is a general willingness to take action, action is not always taken or taken effectively, since the approach is often an *ad hoc* rather than systematic application of policy. There is therefore a need for more research on issues such as who is involved, what their individual roles are and how people work together to manage sickness absence.

Some studies (Thomson *et al.*, 2003; Trades Union Congress, 2002) have adopted a case study approach in order to identify 'good' or 'best' practice. A recent study for the HSE developed a conceptual framework of best practice and sought verification from 'stakeholders' and experts in the field (James *et al.*, 2003). The last mentioned study is among a few that also spend time investigating factors that influence the effectiveness of best practice policies.

An under-explored area is employers' need for external support in their development of absence management and job retention policies and the provision of rehabilitation in practice. Here, size and sector may be relevant factors, as found in the evaluation of the New Deal for Disabled People Personal Adviser Service pilot (Loumidis *et al.*, 2001).

There is a shortage of research using qualitative methods, seeking to understand whether and how employers manage sickness absence and why they use particular approaches.

1.3 Research questions addressed

The following main research questions were identified.

- What are employers' attitudes to sickness absence and views on how to deal with it?
- What do employers perceive to be the benefits and drawbacks of retaining employees?
- What influences employers in their provision of medical and work-related support for return to work and what are the constraints?
- What, according to employers, are the strengths and weaknesses of their sickness absence policies and practices, including gaps between formal policies and practice?
- What within the organisation helps and hinders the management of sickness absence?
- To what extent are employers aware of good practice guidance and to what extent do they need it?
- What do employers feel they need to support them in managing sickness absence and enabling the return to work of absent workers?

- To what extent are employers aware, and make use, of available support and incentives to retain staff?

Answering these questions necessarily required gathering data on the content of policies and what employers actually do when an employee is absent on sick leave.

The topic guide designed in consultation with the Department to answer these research questions can be found in the appendix to this report.

1.4 Research design and methods

The study was designed to explore how policy transfers into practice within an organisation and to capture more than one perspective on the questions central to the research. The broad aim was for three interviews in large organisations and two in medium-sized organisations to include human resources staff with responsibilities for sickness absence, managers charged with implementing the policy and occupational health staff where they existed. It was not felt appropriate to burden small employers with more than one interview and here the person with personnel responsibilities was targeted. There was scope to be flexible to fit differing situations.

The sample was drawn purposively to include of a range of sizes of employing organisations across the public, private and voluntary sectors and a good representation of industrial sectors.

1.4.1 The purposive sample

The sector of the employing organisation was an important feature of the sampling strategy. It is known from analysis of the Labour Force Survey that sickness absence rates are higher in the public than in the private sector (Barham and Leonard, 2002). There is also an indication from one study that public sector organisations have access to a larger number of sources of expertise than those in the private sector and are much more likely to feel required to consider provision of rehabilitation (Dibben *et al.*, 2001).

Organisational size was also an important consideration. There are indications from employer surveys, such as that carried out by the Confederation for British Industry (CB1, 2004), that absence levels rise with increasing size of organisation. Qualitative research has highlighted the differing needs and levels of self-sufficiency of different sized employers (Loumidis *et al.*, 2001).

The target sample size was 24 employing organisations evenly split into small, medium and large. The aim was to achieve higher representation of public sector organisations than would be the case in a proportionate sample (according to Black *et al.*, (2004) just under one in five jobs are public sector, though this definition excludes some of the educational sector).

The research team drew the sample from the Department's JRRP database. This gave details of volunteers accepted for the research trial and included the names and addresses of their employers, whether they were public or private sector and the employees' descriptions of their business. The extract made available to the researchers did not include the names and personal details of trial participants. To avoid overlap with any simultaneous employer-focused activities on the part of JRRP providers, the sample was based on the earliest JRRP trial participants. Care was taken to exclude employers of JRRP participants who had taken part in the qualitative evaluation of the pilot. To make fieldwork more manageable, employers in only four of the six pilot areas were sampled.

The approach was made by post and email to the address listed on the JRRP database, which was normally the establishment where the trial participant had worked. A named person had first been identified by telephone or Internet search. Which of three versions of the approach letter was sent depended on the apparent size of the organisation based on information in the database and some searches of on-line directories and Internet information about the employers. It was suggested to the largest organisations that someone responsible for human resources or personnel issues, a line manager and perhaps an occupational health nurse or doctor might all take part. The letter to the middle-sized organisations referred only to human resources and occupational health but typically line manager interviews were also requested in the follow-up telephone calls. The third letter was directed to the managing director or chief executive of the smallest organisations. The three letters can be found in the Appendix.

1.4.2 The achieved sample

While there was in general a good response to invitations to take part, difficulties were experienced in recruiting the smallest employers, who were in any case poorly represented in the database, as were medium-sized organisations. By the end of the designated fieldwork period 22 employing organisations had participated, and it was agreed that this represented a sufficient spread in terms of types of activity although there was a shortfall of small and medium-sized organisations.

Of the 22 participating organisations, eight were public sector, 13 private sector and one voluntary sector. The sub-sectors of the public organisations were education, health, fire, police, central government and local government. The activities of the private sector organisations covered financial services, customer services, media, building and related trades, transport, manufacturing and personal services. In terms of occupational composition, there was a spread from employers whose staff chiefly held senior professional, technical and managerial positions to organisations where there was a predominance of elementary or clerical positions.

Information on the JRRP database about size of the overall employing organisation, and of the workplace at which the JRRP participant was employed, was derived from pilot participants' own estimates and sometimes proved to be inaccurate. Some organisations that were sampled as 'small' were discovered at interview to be part of much larger organisations.

Apart from one body with a staff of less than 100, the public sector organisations were all large. The staff sizes of the voluntary sector employer and two private employers were under 50. Two private sector organisations were medium-sized with less than 500 employees. The remaining nine private employers ranged in size from 1,000 to 130,000 nationwide.

It emerged during the analysis that organisational size is not a sufficient way of typifying participating organisations. It was found important to take into account also whether they were organisations with sites throughout the UK or local employers only. On this count less than half were multi-site organisations. Multi-site organisations typically differed from employers that were local only in that the sickness absence policies respondents were expected to implement were handed down from a remote human resources department, which generally guided practice, whereas organisations that were local only had developed their own policies. There was one exception to the rule, where the local operation of a nationwide organisation formulated its own sickness absence and other personnel policies.

Overall, 53 people were interviewed in the 22 organisations, exceeding the target of 48 respondents. The number of interviewees per organisation ranged from one to five as shown in Table 1.1.

Table 1.1 Interview sample

	Number of interviews	Number of organisations
	1	4
	2	9
	3	6
	4	2
	5	1
Totals	53	22

Seven interviews were with people with occupational health roles, whether as an occupational physician, nurse, manager or adviser.

The remaining interviews were divided between:

- *staff with human resources management responsibilities*, that is informants whose primary or only role was human resources management, some specialists in the practice of absence management and staff at the top of small organisations who took responsibility for human resources as well as other functions; and
- *managers*, that is heads of organisations, departmental managers, operational managers and production managers with administrative, supervisory or direct line management responsibilities.

1.4.3 Conduct of interviews

Interviews took place on the employers' premises. In multi-site organisations, interviews typically were conducted at headquarters or regional level as well as at the workplace first approached. Four of the 53 interviews were carried out by telephone, mainly in large organisations where the respondents were located at a considerable distance from the designated fieldwork areas. The quality of the data collected by telephone was comparable to that achieved through face-to-face interviews.

Interviews took approximately one hour. With participants' permission all interviews were tape-recorded. Tapes were transcribed for analysis.

1.4.4 Method of analysis

Based on the verbatim transcripts a detailed content analysis of the data was undertaken using 'Framework', an analytical tool developed by the National Centre for Social Research. This charting system allows for within case analysis, to identify differences between human resources staff, occupational health staff and managers in a single organisation for example, as well as for comparisons across organisations.

1.5 Outline of the report

- Chapter 2 examines employers' attitudes to sickness absence and its management.
- Chapter 3 considers the content of policies and procedures for the management of sickness absence and how they are communicated. It also describes occupational sick pay arrangements.
- Chapter 4 looks at how policies and procedures are put into practice, and the barriers.
- Chapter 5 considers the rehabilitation resources available to employers to support return to work.
- Chapter 6 covers adjustments and adaptations on return to work.
- Chapter 7 considers employers' needs for further support for return to work and managing sickness absence.
- Chapter 8 draws together conclusions from the study.

2 Employers' attitudes to sickness absence

As the organisations had been drawn from the Job Retention and Rehabilitation Pilot (JRRP) database it was to be expected that all had employees who had experienced a recent episode of sickness absence of six weeks or more. This chapter looks first at the reasons for sickness absence being seen as problematic (Section 2.1). Overall, employers said their organisations were keen to reduce sickness absences. There were often differences in attitudes to short-term or sporadic absences versus long-term absences, discussed in Sections 2.2 and 2.3. Concern about sickness absence is reflected in the attention given to measuring absence rates and the existence of targets, which is covered in Section 2.4.

2.1 Why sickness absence is a problem

Not every informant saw sickness absence as a problem for the organisation. However, in all of the organisations studied at least one disadvantage associated with staff being off sick was expressed and frequently several problems emerged.

2.1.1 Difficulties in providing cover for absences

A key problem was ensuring that the tasks normally carried out by the absent employees were completed. Operational managers faced special problems where employees worked on production lines and where specialised tasks could not be reallocated. Managers in small service organisations found it especially hard to juggle staff at short notice, and one informant spoke of '*a domino effect*' as the repercussion of moving one staff member rippled through the workplace.

Where organisations could provide cover it incurred higher than ordinary costs if provided through overtime or a temporary agency. Where it was essential to have a daily back-up labour supply to ensure a reliable service it was frustrating to have to pay staff that were not used when the absence level was less than anticipated.

Some organisations found it hard to recruit temporary replacement staff of the right calibre and agency staff sometimes had been found to be unreliable. If the duration of the absence was uncertain, and it was not essential to have immediate cover, it was hard to decide if going to the trouble and expense of finding temporary replacements was worthwhile. Other organisations were not allowed to recruit staff to fill in, mostly because of the costs involved.

Except for some specialised jobs, it was quite usual for managers to view long-term absences as easier to cover for than occasional days off sick because sick notes usually stated the expected duration of the absence in terms of weeks.

2.1.2 Stress and overload on staff

If temporary cover was not permitted or arranged, other staff had to pick up the extra workload with reported detrimental effects on employee morale and team working. It had been observed that absence increased amongst some staff overloaded by covering for absent colleagues. Deleterious effects on existing staff included being prevented from taking time off themselves. Managers said employees resented others taking time off for suspect reasons, people staying off longer than might seem reasonable given the reported complaint and those who had a higher than average number of spells of absence. Resentment was thought to be more pronounced where team targets and performance-related pay were affected.

There were stresses on managers when they had to juggle staff rotas or sometimes had to step in themselves to ensure that the business was delivered. Where agency cover was arranged, it proved stressful to staff to work with them if they were unfamiliar with the organisation and the needs of its regular users.

2.1.3 Costs

The costs of sick pay, overtime when other staff covered for absent employees and temporary agency fees were highlighted, especially where labour costs were a high proportion of overall costs. Some organisations ran generous sick pay schemes, as discussed in Chapter 3, and prolonged absences could make a significant difference to outlay. Public sector informants placed less emphasis on the costs of sickness absence, though one public sector organisation had a drive to reduce the costs of medical retirements.

The costs of retraining replacement staff if people left employment through sickness were pronounced in specialised fields.

2.1.4 Effects on productivity and profitability

Low morale resulting from stress and overload on staff sometimes was found to lead to lower productivity.

Where absent employees could not be replaced temporarily there were lost opportunities for sales in some parts of the private sector, especially in financial services.

If employees leave as a result of sickness the employer might acquire a reputation for not retaining staff and so find it hard to recruit new staff, with consequences for competitiveness. This effect had been noted in an industry where there was an extreme shortage of skilled labour.

2.1.5 Effects on customer service

Informants in public sector organisations in particular emphasised the difficulties unforeseen absences caused them in providing a reliable, regular or fast response service to the public. They felt they were at risk of failing to meet their responsibilities or duty of care to the public. Similar difficulties were reported by customer-facing private sector employers where the business involved providing an immediate service; customer service standards were jeopardised if staff did not turn up for work.

There could be multiple impacts. For example, a general manager in a private sector service industry talked of absence hurting the organisation's *'pocket'*, overall profitability and performance, hurting its customers, unsettling the workforce and frustrating managers who had to find time to deal with it.

2.2 Attitudes to short-term sickness absence and its management

Among managers who said their attitude always had been to work regardless of illness or injury, and among managers who said they had not themselves experienced ill health, there was a tendency to be unsympathetic towards employees who took days off for what were perceived as minor complaints such as stomach upsets or *'sniffles'*. Among managers, there was some resentment of staff who year on year had larger than average spells of absence.

There were suspicions among managers that days claimed as sickness were not *'genuine'*. There were several references to patterns of absence that implied a wish to extend the weekend and to absences coinciding with major external events. In one private sector organisation some absent employees were thought to be doing other paid work. Lack of commitment to the job was also thought to be a reason for taking days off. Recognition of other reasons for staff claiming sickness absence was unusual but one personnel manager acknowledged that some staff claim sick leave when they have childcare difficulties and suggested that it fell to the organisation to help them find solutions. Here it was argued that the demarcation between *'genuine'* and *'non-genuine'* sickness absence is not helpful. Respondents in a large retail organisation said that they tried to pre-empt absences by showing their willingness to be flexible with working arrangements.

Views were expressed by respondents in two organisations that the seven-day self-certification period encouraged illegitimate days off and longer spells of absence than really necessary, and that attendance would improve if staff were not paid for

the first few days of absence. A manager in another organisation in the past had used his discretion not to pay for absence to set an example.

Incentives to employees to reduce non-genuine absence included attendance bonuses. In one public sector organisation attendance rates had improved in certain manual occupations where attendance was rewarded. It was also commented by managers that weekly team targets were a form of peer pressure on employees not to go absent and so let down the team.

Developments in formal policies to deal with short-term or sporadic absences were in the direction of 'tighter' procedures with more scope to pursue a disciplinary route. Staff with human resources responsibilities spoke of concerns to ensure absence is legitimate and to avoid applying a punitive approach to staff who are genuinely ill, and flexibility in applying the procedures was sometimes advocated. Some tensions were reported when operational managers were perceived by human resources staff as too 'tough' and wanting to invoke disciplinary action in the form of written warnings. On the other hand, some organisational cultures were felt by human resources staff to be too liberal. It was found hard to achieve the right balance between the needs of the individual and the costs to the organisation.

Within organisations there were instances where operational and line managers were less open to recognising underlying causes of sporadic absences than human resources or occupational health staff. Close working in the management of absences helped to reduce the difference: one operational manager spoke approvingly of how an occupational health nurse had educated him on why one employee was frequently absent for a day at a time.

By no means all organisations emphasised illegitimate absences and punitive approaches. Across sectors there were organisations that saw themselves as caring and supportive, keen to identify underlying problems at work and willing to make changes to pre-empt further absences. Some human resources staff said they deliberately avoided talking about absence in a punitive way: having dedicated human resources staff based in the workplace appeared to help inculcate a positive and supportive attitude amongst operational managers. Tolerance was less in evidence where the absence management function was carried out principally by operational managers who had to deal with the consequences for their business of high absence levels.

2.3 Attitudes to long-term sickness absence and its management

While there was widespread recognition of problems associated with sickness absence, not all of those outlined in Section 2.1 above were necessarily driving the active management of *long-term* sickness absence. The imperatives to contain the costs of sick pay and replacement labour and to keep up productivity were plain but so was the desire to retain staff.

Reasons given for retaining staff were:

- retaining specialised knowledge or skills in a competitive market; skilled trades people, for example, being hard to come by;
- maximising investment in their past training and recruitment;
- the high costs of training new recruits;
- shortages of applicants for vacancies in a buoyant employment market;
- protecting the viability of a possibly endangered site of a multi-national company by sustaining the workforce;
- demonstrating to staff that the organisation cares about, values and supports its employees;
- boosting the caring image of the organisation to attract job applicants;
- particularly in small organisations, acknowledging the commitment and contribution to the organisation on the part of long-standing employees who become sick.

Participants in the study often spoke of trying to retain staff as long as possible. There was some limited evidence that organisations might work harder to retain those staff members who made the most valuable contributions to the business, such as those with strong relationships with customers. One manager said they exercised discretion in deciding whether to retain staff, taking into account their absence records and past performance. There were constraints on retention too: for example, it was noted in the rapidly moving financial services industry that the individual's job might no longer exist when they were ready to return to work.

Attitudes towards long-term sickness absence were considerably less negative than views on short and sporadic spells of time off. From the point of view of operational managers it was easier to plan work if periods of absence and their lengths were known ahead of time; a parallel was drawn with covering for maternity leave. Here it was important to have good channels of communication with the sick employee to understand the prognosis and likely period off work. Because duration typically was uncertain, absences related to mental ill health were considered trickier to plan around than time-limited absences for surgery or to recover from small injuries.

There was limited evidence of unsympathetic attitudes towards long-term sick employees. There was scepticism about stress-related illnesses on the part of some. A manager from an organisation with an acknowledged poor absence rate said they '*challenged*' staff members' claims that stress was the reason for absence even when certificated by a General Practitioner (GP). On the other hand, other managers emphasised that they were especially sensitive to the needs of people with depression or stress. There was some recognition of work-related contributors to stress on the part of managers who themselves worked in pressured environments, and call centre work, dangerous jobs and target-driven occupations were singled out as stressful. Staff shortages due to sickness absence were seen as contributing to stressful working conditions, which in turn led to absence.

In organisations where there had previously been intolerance of long-term absences, human resources staff said they were trying to change the culture towards being more supportive by sending out the message that they cared for their employees and wanted to treat them fairly. The message could be hard to get across to operational managers focused on productivity targets.

Policies for long-term absence were generally said to be supportive. One large public sector organisation, however, warned people who had been absent for four weeks that their future with the organisation would be considered if absence continued. It had instituted a procedure at eight months of absence under which dismissal was one option considered if no return date was indicated. There was agreement among the interviewees in that organisation that this disciplinary approach was unduly harsh, upset staff and worked against investment to support return to work.

While organisations had procedures to allow for retirement on ill-health grounds these commonly were said to apply many months down the line in cases of terminal or very severe illness or after efforts to get the person back to work had failed. Exceptions were where the job involved manual labour and redeployment to desk-based work was considered unworkable; here people with heart conditions, for example, were pushed towards medical retirement and state benefits. Dismissal on grounds of capacity seemed to be rarely used, and it was said that employees tended to retire on health grounds before that point was reached. Managers wished to avoid the unpleasantness of dismissing staff and feeling they had let them down.

2.4 Measuring absence rates and targets

Smaller private sector organisations did not measure sickness absence rates. Such organisations were small enough for owners and managers to gauge whether the amount of sickness absence was a problem without the need to record and measure it. One larger trade organisation with comparatively less well-developed policies for managing sickness absence also did not measure absence rates.

An organisation or department's performance was commonly reported in terms of days or percentages of time lost through sickness absence. What was considered to be a good or acceptable rate varied. For a vehicle servicing and retail firm 4.5 to 5 per

cent was considered high while a call centre viewed a similar rate as good for their industry. At another call centre a six per cent rate was not viewed as problematic.

Where rates over time were reported they had fallen more than gone up. Periods of poor industrial relations, redundancies and reorganisations had been found to contribute to high absence rates in the past.

Smaller private sector employers where sickness absence was not thought especially problematic had no targets to work towards. There were also no targets among large organisations with high levels of absence, however. Some organisations measured their performance against industry standards and these served as notional targets. Some organisations had to meet specified targets. One local authority spoke of a Best Value target. In some multi-site organisations, both public and private, sickness absence rates were compared across sites and managers reported pressure to perform well in what were sometimes described as 'league tables'. Absence rates sometimes were compared across departments and poorer performance was investigated. Some people talked of 'key result' or 'performance' areas – relative to performance of other sites or internal only. The extent to which comparisons engendered a sense of competition varied but generally managers felt that poor performance would reflect badly on them. Small departments within organisations were sometimes felt to be unfairly disadvantaged if one or two people were off long-term sick.

Within organisations in the study there was generally consistency in understanding of targets among those interviewed. However, there were occasional examples of managers from different parts of an organisation stating different targets. In these instances the absence rates reported were considerably higher than the targets mentioned, suggesting that the targets were notional only.

The existence of targets, or industry standards to work towards, did appear to affect the management of long-term sickness absence. It was pointed out that long-term absences affected how far targets and expectations could be met: sometimes just three or four people on long-term sick leave could skew the overall rate, and it was sometimes impossible to improve performance if the absent employees had suffered injuries, such as a broken back, which took a very long time to recover from.

3 Content of procedures and policies and their communication

All organisations in the study, except one, had documented procedures in relation to sickness absence and some also had written guidance for its active management. A few had statements of the policy underpinning their procedures. This chapter first describes the content and scope of the documentation. Section 3.2 looks at the origins and development of procedures and policies. Section 3.3 looks at how procedures and policies were communicated. Views on the adequacy of the documentation are reported in Section 3.4. Sick pay arrangements are reported in the final section.

3.1 Content and scope

As the researchers did not request any documentation, although accepted it when offered, this review of content and scope relies mainly on informants' reports.

There was heavy concentration on procedures for notification and certification, and attendance at return to work interviews and absence review meetings where they applied. In organisations with no dedicated human resources staff, documentation typically was restricted to these procedural aspects aimed at employees and there was rather less evidence of guidance to managers, which was sometimes acknowledged as a gap. In unionised organisations there was often an emphasis on procedures for formal investigation of absences and for dealing with grievances.

Some organisations, particularly in financial services, provided managers with guidelines and models on what to do and who to contact. There were some examples, across the private, public and voluntary sectors, which included guidance for managers on dealing with long-term absence. One local public sector organisation had separate policies for frequent and long-term absence, with guidance notes for both managers and staff.

The depth of guidance appeared to vary. One human resources officer based in a large private organisation believed that it was not possible to document aspects of the practice of managing absences, such as how to behave with the individual. Rather, it was felt, line managers should be supported to develop good management practice generally. Non-rigid interpretation within clear guidelines was thought to constitute good practice in some large private sector organisations. Where guidance was not very prescriptive managers in one large private organisation made use of a centralised human resources advisory centre for advice. Elsewhere, especially in organisations with a more pronounced disciplinary approach, written guidance on exactly what to do was thought by managers to be essential.

In some financial services industries, guidance included suggestions on how to access occupational health, the employee assistance programme and Internet sites. Here it had been considered important to bring together into one place on the intranet, and make visible to employees and line managers, information on the range of supports available including medical help and making adjustments. This shift was intended to convey the message that the policy was about supporting people back to work.

Some documents contained statements of policy as well as procedures. These aimed to explain the rationale for procedures and sometimes the values underpinning them. One message was that taking sick leave had both cost and management impacts on the organisation and thus staff had responsibilities to attend the workplace. Language and tone were thought by human resources staff to be important ways of conveying the policy approach, reflecting values such as fairness, that the organisation cared about its employees, and that support to return to work was fundamental to the approach.

3.2 Origins and development

A strong impression emerged of policies and procedures evolving rapidly. There were examples of policies being formalised for the first time, revamped or tightened up. Organisations that underwent mergers needed to harmonise policies and procedures. New managing directors were said to have called for changes, and new human resources staff brought useful experience. Typically, policies were under continuous review.

Policies and procedures had been written in the past few years in some smaller organisations, in some trade and manufacturing sectors and in local authorities. The impetus for their introduction included formalising a raft of personnel policies to achieve Investors in People accreditation, the desire to be proactive, local pressures to improve attendance rates and recognition that performance compared badly with that of other parts of the wider organisation. An organisation-wide performance assessment had pointed to weaknesses in one department's procedures, such as poor record keeping and no return to work interviews.

A reported impetus for improving policies was increasing occurrence of stress-related illnesses. One local public sector organisation had introduced a work-life balance initiative on managing stress that influenced its sickness absence management policies.

A noticeable development was changing short-term sickness absence policies and procedures to allow more scope for disciplining staff who were perceived to take advantage of lax procedures, or at least to impress on them the importance to the organisation of their presence at work.

If policies and procedures were long-standing, staff with human resources responsibilities who were relatively new to the organisation were not in a position to say what had influenced their form. Otherwise it was reported that content was informed by previous professional experiences of human resources officers, including post-graduate training; prior experience as an employee; asking organisations in the same line of work and umbrella organisations for ideas; and searching on the Internet.

Where policies and procedures were kept under review, human resources staff variously adopted what they felt was suitable to their context from practice guidance from bodies such as ACAS (Advisory, Conciliation and Arbitration Service), the Department for Trade and Industry and umbrella organisations; or they brought in consultants from independent employment advice firms. Reviews were important to make sure that procedures did not fall foul of legislative changes and especially the Disability Discrimination Act (DDA) 1995. Amongst organisations with dedicated human resources staff the DDA often was an impetus to review policies.

There were some mentions of borrowing policies and procedures from '*good practice*' employers, and membership of a national retail consortium allowed comparison with others' practices. One large employer's decisions about timings of actions were drawn from unspecified '*good practice guidance*'.

Discussions with human resources staff and negotiations with unions, or elected staff representatives in non-unionised organisations, were often part of the process. There were some views on the part of occupational health staff that the potential to tap their experience on the ground had been overlooked in the development of policies. Consultations with ordinary staff were mentioned infrequently, and in one small organisation a manager had seen some resistance amongst staff to a set of rules imposed on them.

3.3 Communication

In some organisations, staff responsible for the formulation of policies and procedures were charged with their implementation but, as discussed further in Chapter 4, responsibility was commonly devolved to managers. It appeared that communication of the content of guidance documents was directed more at those who implemented them than at those who were subject to them. There were many reports of manuals,

guidance notes, briefings, handouts, email messages and intranet sources for managers.

Managers seemed to learn by doing and by consulting manuals and so on. There were less frequent references to training for managers. One industrial organisation that had introduced a fresh policy had held workshops, which all line managers had been required to attend, involving role-playing.

Means of informing staff, mainly of procedures, were:

- information in staff handbooks;
- the intranet;
- notification of terms and conditions of employment, with variations sometimes signed to acknowledge receipt;
- talks or written information handed out during inductions to the job;
- talks to all staff to explain changes in procedures.

This study of course did not explore with staff who took sick leave how far they made use of these sources of information but employer representatives sometimes commented on their ineffectiveness. For instance, it was recognised that staff handbooks were not consulted and that employees might not read variations on terms of employment.

3.4 Satisfaction with how policies and procedures are documented

It is perhaps not surprising that interviewees with responsibilities for formulation or oversight of implementation of policies and procedures offered few critical comments on what was laid down in writing. Indeed, among human resources staff of large retail and financial services organisations there was some pride in their written policies and there were aspirations to be publicly acknowledged as a good employer.

There were, however, some critical comments from managers. There were some beliefs that providing staff with a set of rules was not an effective way of getting across the organisation's expectations and that a 'PR' approach that promoted what the organisation can do for the employee might be more helpful. Here it was felt that employees would comply more willingly with procedures for reporting sickness absence if the documentation, and its promotion, were angled towards convincing staff of the advantages to them of doing so.

Some representatives from smaller private sector firms acknowledged deficits in what was documented. For example, it was sometimes felt that documentation outlining the procedures staff had to follow needed to be supplemented by guidance on how to manage sickness absence. On the other hand, there were views among smaller employers that practice was just 'good sense'.

3.5 Occupational sick pay and other financial provisions

Perhaps unsurprisingly there were some discrepancies between informants in the factual information given about sick pay provisions. This perhaps signals that provisions were not well known, remembered or understood by all the informants.

Fixed occupational sick pay provisions were almost universal. One very small employer said they could not afford to pay sick pay. Sick pay at one local firm was entirely at the discretion of the manager, in discussion with human resources. Here, the manager would decide whether the employee should be paid full pay or statutory sick pay based on a number of factors including the individual's length of service, performance at work, likely duration of absence, and the manager's desire to demonstrate compassion for the workforce. At two large public service organisations, and one medium-sized single-site organisation, managers or higher-ranking officers had the option of extending the occupational sick pay period. This was only available in special cases, such as where the employee was injured at work, or for certain staff, and was sometimes based on recommendations from human resources. In one large private organisation extension of the sick pay period, known as an income protection scheme, was part of longer-serving staff members' contracts.

Typically, occupational sick pay was graduated according to length of service, although two employers also took into account factors such as the type of job and the number of days of sickness absence taken in the past. The most generous schemes started at a minimum of ten days or one month service, and could provide a maximum of 12 months on full pay after seven or ten years' service. However, for most the maximum entitlement was six months full pay followed by the same period on half pay and was dependent on five or more years' service. In a nationwide public sector organisation occupational sick pay entitlement was not graduated and was affected by the individual's absence in the preceding four years. Here, if past absences meant they had depleted their entitlement they were encouraged to apply for Incapacity Benefit or received 'sick pay at pension rate'.

In addition to sick pay provisions, some larger public and private sector organisations gave benefits to selected employees or offered reduced rates on private health insurance. Managers above a certain level qualified for medical insurance as part of their contract. A large financial institution was exceptional in providing a sickness and accident benefit on a discretionary basis to employees who could not return imminently but were expected to recover at some future date. The benefit was paid as a percentage of their salary for a fixed period when a medical review would assess their capabilities. At other organisations, discounted private medical insurance was open to selected employees or the entire workforce with the hope that a shorter route to medical treatment would reduce sickness absence levels.

4 Managing employees' absences

This chapter looks at how sickness absence is managed at different points in the absence trajectory up to the point where the individual is ready to return to work. The focus here is on the absence management activities of internal actors: human resources staff, managers and in-house occupational health staff. The resources available to organisations for advice and rehabilitation are examined in Chapter 5.

Occasional or repeated days off work can be the precursor to prolonged absence, and how they are treated may affect the likelihood of long-term absence. The chapter begins by considering how short-term absences are responded to (Section 4.1). Section 4.2 looks at how employers respond to repeated short spells of absence. Section 4.3 is devoted to an analysis of how long-term absence is treated. It begins by looking at how it is defined and the rationales underpinning definitions. Obstacles in monitoring long-term absence are then briefly discussed. This section then examines where responsibility for managing long-term sickness absence is located and the advantages and disadvantages associated with the models identified. Section 4.4 looks at arrangements for keeping in touch with absent employees and planning return to work. The final section (Section 4.5) considers barriers to return to work efforts.

4.1 Responses to short-term absences

This section looks at procedures in the short-term, from the first day of absence onwards, and at the return to work interview which was used as a tool for managing short-term absence.

4.1.1 Early contact points

The first point at which there is scope for invention is the first day off sick. Standard practice, seemingly widely adhered to, was for the employee to phone in within one or two hours after they were expected at work but in one instance before their shift

started. Typically they were expected to speak directly to their immediate line manager or supervisor. In some, mainly larger, organisations the call was taken at a central point and the line manager was subsequently informed of the absence, and there were some procedures that expected the line manager to call the employee back.

Employers' interests at this point focused mainly on the management of the day-to-day business and filling the gap presented, assessing how long the absence might last and logging the absence. These were not the only concerns, however, and particularly where 'call-back' arrangements were in place line managers were expected to enquire about the person's well being and ask if there was anything the organisation might do to help. While there was no direct evidence that a sympathetic seeming approach like this encouraged quicker return to work, and of course employees' views were not explored in this study, it seems that it set the tone for any future enquiries into the person's sickness absence.

One large company stood out from others in the study in acting on the first day of absence. Cautious about how conditions develop, it referred people with depression, stress or an upper limb disorder to its centralised human resources service and then to occupational health. There was also a concern here to monitor the reasons for stress and depression.

During the seven days of self-certificated sickness absence employees typically were expected to follow procedure, or more informal expectations, and keep their managers informed of their condition and when they were likely to return to work. Except in small workplaces described as being like a '*family*', managers rarely initiated contact in this period.

As explained in Section 4.2, procedures for dealing with prolonged absences generally began at around three to four weeks. Rather little evidence was forthcoming of active management in the period of around two to three weeks between a non-certificated absence ending and the point at which a certificated absence began to be treated as long term. The main impression is that employees were expected to keep the organisation informed rather than that the organisation routinely initiated contact. Again, managers' main concerns focused on workforce planning. There appeared to be few formal procedures at this stage other than requiring prompt submission of sick notes. It was once commented that this stage was the hardest to deal with, it seems because of uncertainty about what the organisation could do.

There were, however, some large organisations that monitored reasons for absence and asked those absent employees about whom they had worries to see the occupational health service for help. Among the concerns mentioned were stress, depression, upper limb disorders and recurring illnesses such as asthma. Here, referral to occupational health was typically at managers' discretion and depended on them understanding conditions and their effects. By contrast, an in-house occupational health nurse in the private sector monitored medical certificates and used her expertise to decide which absent employees to contact. Some large

organisations treated repeated absence for a single reason in the same way as they managed long-term absence, and this is covered in Section 4.3.

4.1.2 Return to work interviews

Return to work interviews took place once the employee had restarted work. They were intended to apply regardless of the duration of absence but most informants focused in their descriptions on the process that applied after short spells of time off work. Prior contacts, or meetings at which arrangements for being back at work were discussed (see Section 4.4), appear to reduce the relevance of return to work interviews after long-term absence.

Return to work interviews were almost universal, although employers in very small organisations did not use the term to describe how they explored with returning employees their reasons for being off. Exceptions were found in a small trade organisation that had no formal procedures but intimate knowledge of most employees, and in a medium-sized local firm that was considering introducing return to work interviews on the grounds that they would discourage odd days off for illegitimate reasons. There were more general beliefs that return to work interviews made people think twice about taking time off and prevented misuse of sick notes, and one organisation reported a drop in the number of occasional days off since it had introduced return to work interviews. In one industry with a high proportion of manual workers, pay for the days absent was withheld if the person did not take part in the interview.

The thrust and tone of the return to work interviews, as described to the researchers, ranged from suspicion over potentially illegitimate absences, and in one instance pointing out the costs the organisation had incurred, to showing that the organisation 'cares' and, unusually, exploring ways of supporting the staff back at work. In a large company that aspired to recognition as one of the country's top good practice employers it was presented as a chance to check that the employee was fit to return, to welcome them back, to highlight their importance to the company and to emphasise the importance of them attending.

It was felt best for return to work interviews to be carried out by someone who knew the employee's work and home circumstances, and responsibility typically rested with the line manager or with the staff member with personnel responsibilities in small workplaces. While all employees were required to undergo an interview on the first day back at work, sometimes it was those about whom managers had suspicions who received the most attention compared with others who were believed to have been genuinely ill or who had a doctor's sick note.

Some return interviews were described as very brief, a few minutes 'chat', or just of 'going through the motions' or signing off a form recording the reason for absence. cursory interview practice and informality were sometimes intentional but more often were thought by both human resources staff and managers interviewed to be signs that managers were not carrying out their responsibilities properly. Both

human resources staff and managers recognised the business pressures that restricted managers' time to carry out interviews thoroughly.

Interviews that were taken seriously and seen as an opportunity to explore any work-related causes or hidden health or personal problems sometimes were thought by managers to have been successful. For example, a manager had uncovered stress where the employee had claimed a back problem. This offered the opportunity to signpost the person to a counselling service. If managers knew about patterns of absence and their causes, and especially if there was a system in place to equip the manager with the necessary information in advance, the return to work interview presented an opportunity to identify ill health that could be a precursor to long-term absence.

Managers did not always have guidelines to follow in carrying out return to work interviews but in one services sector company detailed guidance on content and structure written on the form was thought valuable in ensuring that the interview was orientated towards the individual's needs.

Both human resources staff and managers acknowledged that return to work interviews did not always happen. They commented that some managers were more conscientious than others. The requirement to carry out return to work interviews was understood, it was believed, but it was felt that it could be hard for managers to make time when they had pressing demands to deliver an immediate service to customers or production lines to keep going. Training and reminders were not always effective, according to both human resources staff and managers. One large company had perfected a system to spot missed return to work interviews quickly and to make the managers at fault carry them out.

4.2 Dealing with repeated episodes of sickness absence

Repeated absences, especially those consisting of one or a few days in each spell, were a general concern.

Managers of small companies said they knew their staff well enough to notice and respond to repeated episodes of sickness absence and saw no need for formal recording systems or procedures. The company managers spoke to the staff members involved at a point when they saw repeated absence having a negative impact on the business or when they suspected malingering. A difficulty for some larger organisations was that their information systems were not sophisticated enough to identify patterns of absence. In an unionised organisation there was a concern that staff were not being treated equitably when it was left to individual managers to respond to patterns of absence. Large organisations typically had computerised, or sometimes paper, systems and formal procedures at given 'trigger' points at which the individual would be called to a meeting.

There was a tendency for repeated absences to be viewed as suspect. Meetings were sometimes the first stage on a disciplinary route. One policy gave a large public sector employer discretion to request a medical certificate for every day of absence after three spells of absence, or two weeks absence, in three months. This appears to have been intended to deter unwarranted absences. Some organisations, however, saw meetings as an opportunity to uncover problems they might help to resolve.

Organisations that had rigorous attendance management procedures identified employees who had reached a ceiling of sick leave (such as eight days in a rolling year or three absences without a doctor's certificate in three months), challenged them on their record and invoked disciplinary action. The outcome of warning meetings was a plan to improve attendance, and breaches led to further steps on the disciplinary path. There was sometimes scope for managers to use their discretion in such strict systems. For example, they might exempt someone who had suffered a fracture. It was argued by one manager that warning meetings provided opportunities for good managers to identify and address underlying problems. On the other hand it was acknowledged that the employee might not be so receptive to attempts at support in a disciplinary context.

Other organisations carried out attendance reviews but took a less hard-line approach. For example, the 'trigger' was more generous, such as three absences in a rolling six-month period or three occasions in a year. In some organisations attendance review meetings occurred routinely after a set number of absences or days off in a short period, and 'improvement plans' were also a possible outcome, but the tone seemed more supportive and the process less threatening with disciplinary action well down the line. A small workplace used a proforma of questions to look at underlying causes, any issues relating to the job or working environment and what they could do to help. One organisation referred employees to its own occupational health department when they had been absent on three occasions in a rolling four-month period. The occupational health department report then formed the basis of a discussion with the employee on how the organisation could help.

In some organisations provision to hold an attendance review was used only rarely. For example, a manager in a company with a relatively low absence rate said that only persistent patterns, such as taking off Mondays or Fridays, might trigger an attendance review at his discretion but this rarely happened.

Detailed monitoring of short-term and intermittent absences was regarded as critical to the success of efforts to identify at the early stages problems that would develop into a long-term absence. It is clear that care needs to be taken in defining trigger points: if the period being monitored is long – six months or a year were reported – then the opportunity for helpful intervention may be unduly delayed. It also seems important to take account of the reasons for absences when considering early intervention. One policy distinguished short-term intermittent absences with an underlying condition from those that did not.

4.3 Responding to long-term absences

In all of the organisations, study participants conceived of long-term absence as presenting different problems and challenges than absences of short durations.

4.3.1 Defining long-term absence

Apart from in one very small company, respondents in all organisations were able to state a defined number of days or weeks at which continued absence came to be regarded as long term. Four weeks was usual, and three weeks quite commonly mentioned, but the range was from ten days in one instance to eight weeks in another.

In some organisations there was complete clarity about the long-term absence threshold, found where action swung into place automatically, for example to begin a series of home visits at specified intervals, to call the person in to see a company doctor or to hold a review meeting.

On the other hand, particularly among large local public sector employers, but not exclusively so, there was some uncertainty among managers and also conflicting views among people spoken to in different points in the organisation. Here there were examples of occupational health or human resources staff firmly stating trigger points but confusion or lack of awareness among line managers. It was sometimes pointed out that the policy was unhelpfully vague or that managers were encouraged to use their discretion on when to first take action. But otherwise it was clear that the definition of long-term absence was not adequately communicated to managers. There were also some misunderstandings within organisations about which long-term absent employees were subject to policies: one manager felt it was probably only those where there was no defined end to the absence duration.

There were also some threshold differences within an organisation depending on the type of action to be taken. In one instance, there was a trigger point for referral to occupational health but discretion for managers to choose when to contact the absent employee.

Staff with human resources management responsibilities were not always in a position to explain why particular absence durations had been chosen. As noted in Chapter 3, some had inherited policies from their predecessors, and some in multi-site organisations were carrying out policies locally that had been designed centrally. Where reasons were known, a building firm mentioned following the duration laid down in their national industry standard, and some human resources officers who had been involved in the development of their organisation's policy had drawn on external advice from a contracted employment advice firm or their professional association.

Unusually, it was the financial impact on small companies that determined the point at which some action was required. They needed to decide if paying agency fees was sustainable or whether to give the employee sick pay or statutory sick pay.

Another rationale, among some large service-providing companies, was that the timing was the most appropriate to begin rehabilitation efforts, and the importance of early intervention was stressed. Thresholds had sometimes been changed to enable earlier identification of problems.

4.3.2 Monitoring long-term absence

It appears that systems for monitoring long-term absence were not always robust and that it was possible for people to be forgotten. For this reason one private employer had employed someone to monitor long-term absence. Manual systems run by managers depended on them remembering to input the information, though in large organisations there was the back up of the centralised recording system from which to request information. One large company recognised the need to improve a back-up system that identified cases that managers had not acted on only when sick pay expired, which could be as late as six months after the absence began.

4.3.3 Locus of responsibility

The line manager was typically the main actor up to the point at which a continued absence became defined as long term. Except in small organisations where the responsibility lay with the managing director or the person with a human resources management role, the absent employee communicated with the line manager during short-term absence. Human resources staff appeared to be involved little, if at all, in the early stages of absence. If concerns had been identified about patterns of absence it was usually the line manager who initiated action such as calling an absence review meeting or suggesting referral to an occupational health service.

A complex picture emerges when responsibilities for the management of long-term absence are examined. The key actors are departmental or line managers, human resources staff and in-house occupational health staff. Five models emerged from the analysis. The divides between them are not always clear-cut, however, and there were some differences in understandings among respondents within an organisation. The five management models are outlined below along with informants' comments on their effectiveness. The models are presented here as a by-product of the study, and there is no attempt to use them to structure the analysis and reporting.

Departmental or line managers have prime responsibility

One model was for departmental or line managers to have prime responsibility throughout the period of absence. Here managers were expected to keep in touch with the individual by phone or via home visits, monitor their situation in relation to returning to work and manage the return to work. Prime responsibility given to managers was found amongst the public sector organisations in the study: some already worked in this way while others recently introduced such practices. It was less usual among large private sector organisations in the study, though one large multi-site private company had recently devolved responsibility to immediate line managers (while another was moving in the opposite direction towards involving human resources staff).

Some problems with this model were identified. Some managers said they lacked time and gave low priority to managing absence, especially where there were pressures to supply an immediate customer service, and the associated paperwork caused some frustration. There were some comments from human resources staff and managers that line managers could lack '*people skills*', find it hard to take on a role perceived as counselling and have limited knowledge of ill health conditions. There was a worry among human resources staff and departmental managers that policies could be carried out inconsistently across the organisation where line managers had discretion on how to act, leading to some absent employees being treated less fairly than others. Being accused of inconsistency was a particular concern in organisations where unions watched closely how procedures were put into practice.

Departmental or line managers and human resources share management

The role of dedicated human resources staff ranged from being available if line managers chose to ask them for advice, to steering them on how to deal with more complex cases, to taking on the cases and coaching managers through handling them.

The more intensive forms of support from human resources departments worked in different ways. There were examples within multi-site private sector organisations of centralised human resources advisory centres, which managers were expected to contact before acting or for advice on issues they had identified. Central telephone-based help teams could keep in touch with the absent person and manage a '*rehabilitation programme*', though this was described as helping the manager to manage rather than the team taking the lead. Such centralised services were characterised as '*reactive*' and depended on managers taking the initiative to contact them. But there was also discretion for such services to monitor and pick up cases themselves.

A proactive approach on the part of human resources, which monitored cases of long-term absence or made specific suggestions to line managers on appropriate actions, appeared to reduce some of the obstacles found when managers had to cope alone but the problem could remain of line managers not prioritising absence management and lacking time. There was a report from a human resources staff member that a new policy for them and local managers to discuss absence cases at the four weeks point had '*helped enormously*' in the management of sickness absence and that managers now felt more confident being told what to do. Elsewhere it was clear from managers' accounts that they welcomed directed advice from human resources staff and that written guidance, however extensive, was not sufficient when dealing with idiosyncratic situations.

Most active involvement of human resources staff was behind the scenes, and often at a central or regional office rather than at the workplace level. Where human resources staff members were based locally, there were examples of them sharing with departmental or line managers 'hands-on' roles including joint home visits and subsequent discussions on the way forward.

Human resources *managers take the lead*

A further model was for human resources managers to take lead responsibility for the management of long-term sickness absence. A prominent example was designated absence management staff in a large public sector organisation. It was found too in a local public sector organisation and some trades and industries. The model was found also in organisations not large enough for devolved responsibility to line managers to be viable. Line managers were kept informed of developments and likely return to work dates, the main point being to help them in their management of the business. If managers had a special relationship with the absent employee they sometime kept in contact with them.

Reported advantages of this approach include relieving managers of the time and paperwork, and consistent practice across the organisation. A human resources manager in a local company suggested she was more supportive of the individual and their return to work than managers who might feel they could carry on with temporary labour.

It should be noted that in one instance the human resources manager's account of taking the lead did not accord with that of the manager on the ground. Conversely, one manager thought human resources managed sickness absence while the human resources participant saw the role as a sounding board for managers. In these examples there was no face-to-face contact.

Occupational health takes the lead

There was one instance, in the public sector, of the in-house occupational health department having responsibility for case managing long-term absence.

Human resources, occupational health nurse and line managers share management

Where human resources staff, occupational health nurses and line managers worked in the same location there were examples of shared absence management. In one company a '*triangle*' of human resources, occupational health nurse and line manager managed a case, with meetings between the absent employee, the line manager and human resources, and between the occupational health nurse and the employee. The line manager received information updates from the nurse to inform the planning of the business. This arrangement was thought to be very effective.

It seems important to have clearly defined roles properly carried out when three parties are involved with the employee. In one organisation, the onus on occupational health to manage the case increased if managers avoided their responsibility to maintain contact with the person.

One organisation involved the on-site occupational health nurse in case conferences, and managers were being encouraged by the human resources department to hold monthly meetings with the nurse.

4.4 Keeping in touch and planning return to work

Although models of locus of responsibility for managing long-term absence have emerged, there were sometimes disparate accounts from respondents with differing roles in an organisation of what was supposed to happen or its timing. Here staff with human resources management or occupational health roles, perhaps not surprisingly, tended to be clearer than managers about expectations. Some human resources staff acknowledged that policies were '*muddy*' or did not adequately define who should do what and when.

Respondents' accounts of managing long-term sickness absence tended to focus on how organisations kept in touch with absent employees and formal meetings where return to work is discussed. This subsection concentrates on the processes for keeping in touch and arrangements for planning return to work.

The two broad approaches involved visiting the home and calling the absent employee into the workplace where they were able to do so. The two approaches were not mutually exclusive; one organisation, for example, said that four-weekly review meetings could be held on site or in the home.

4.4.1 Home visits

There were views that visiting the absent employee at home, or away from workplace, constituted good practice. Visiting the home allowed more flexibility to be responsive to the person than a scheduled appointment in the workplace. It was also felt to signal that the organisation '*cares*' about the employee.

Home visits were carried out variously by departmental or line managers alone or in pairs, jointly with a human resources staff member either routinely or if the manager put in a request, and by a dedicated absence manager or personnel officer.

Home visits were described as ways of keeping the person in touch with what had been happening at work and a chance to discuss practical matters such as sick pay arrangements and when return was likely. The aims were generally said to be to '*find out how they are*' and '*ask if the organisation can do anything to help*'. One human resources manager referred to home visits by managers as an opportunity to identify the causes of absence, especially in the case of stress, but it appears that generally enquiries about health and welfare were not necessarily in-depth and that specific ways of helping were not always in mind. One member of a human resources department employed to carry out home visits saw her role as akin to counselling, however. In addition, use of the organisation's contracted counselling service and occupational health service was encouraged here, as was contact with the Job Retention and Rehabilitation Pilot (JRRP) (see Chapter 7).

In terms of how home visit policy was implemented, organisations fell into four groups. Some large organisations strictly adhered to rules to carry out home visits after a defined period of absence, and often also at defined intervals thereafter. Others were more flexible about the timing but did make sure that visits were carried

out. In the third group, home visits were carried out at managers' discretion despite the human resources department's expectation to the contrary. In the fourth group, home visits took place only as felt appropriate, for example where employees had stress or terminal illness, or were avoided where people were recuperating from surgery and a return to work date was known.

Some opinions were offered on how absent employees react to the organisation keeping in touch by phone or through meeting at home or elsewhere off the premises. Amongst the staff who made the contacts themselves, it was generally felt that people appreciated '*the human touch*', liked knowing that the employer was concerned about them and felt valued, less excluded and not '*spied upon*'. There were, however, some concerns among some staff overseeing the policy to avoid accusations from absent employees and unions of harassment, and for this reason, caution in making unscheduled phone calls was advocated. Where a new policy to be more proactive was being introduced, there was a reported conflict with previous guidance not to intrude on privacy. It was acknowledged that some employees did not want their line manager to keep in touch. One large public organisation in such cases aimed to work through staff associations.

Reluctance on the part of managers to make phone calls or discretionary home visits was sometimes attributed to a concern to avoid the person feeling '*hounded*' or pressured back to work, a point made by both human resources staff and managers. But it was also felt by human resources staff that resistance was '*cultural*' where there was no history of managers taking on such roles, and that the perception of the managerial role needed to change.

4.4.2 Calling the person to the workplace

In some large organisations, the employee was asked to attend the site to see the occupational health doctor or nurse and would meet with the line manager at that point. Home visits were unusual when such arrangements were in place. Workplace meetings with managers were not usually conceived of as part of a process of re-familiarisation with work. Managers sometimes saw benefits to the absent employee in coming to the place of work and seeing colleagues, but disbenefits to the organisation in terms of disruption to productive activities were pointed to.

Regular formal review meetings with human resources staff and line managers quite commonly took place at the workplace. A manager at a local organisation talked about discretionary '*absence counselling sessions*' in addition to home visits. Where they happened, formal meetings to plan return to work as described in the following subsection took place in the workplace.

4.4.3 Planning return to work

The smaller private organisations in particular did not appear to include a time when they planned how to help employees make their return. Aside from these organisations were those who either had a definite obligation, and perhaps time, to hold a formal planning meeting with the employee, or made plans on an informal level when the

right time arose. The idea of planning for a return was more pronounced where employers were helping employees make gradual returns to work, as this provision seemed to necessitate careful forethought.

Formal planning

Larger organisations with central human resources provision had formal meetings built into their sickness absence management procedures. These meetings were a forum for discussing the employee's circumstances and aims; the likelihood and circumstances of making a return to work, including a likely timescale; and the types of support needed, or that could be offered, in order to facilitate a return. A variety of interested parties were invited to attend or consulted about decisions made, including the employee, line manager, human resources staff, occupational health, and an employee representative such as a union representative or friend. Such meetings were further characterised by the documenting of the discussions held and decisions made, for example in action plans, and for some the plan laid out the way ahead and acted as a reference tool along the way. Some meetings were held in a disciplinary context, as explained above.

The formality of this planning stage was sometimes made more apparent by holding meetings at defined times or periods, such as every four weeks, though others were led by individuals' circumstances and progress.

As described in Chapter 7, some smaller organisations without distinct or dedicated human resources specialists, but also a manager at a large public organisation with local human resources support for return to work, had first experienced making action plans when they had worked with a JRRP provider to help an employee back to work.

Informal planning

Decision making and planning was done on an informal level too. This tended to be conversations between the employee and their manager at a time when the employee had indicated that they were ready to return. Again, the circumstances and needs of the individual dominated the topics of conversation, but documentation of decisions made did not appear to be important. If carried out on home visits, informal planning tended to focus on the timing, and sometimes the phasing in, of the return.

4.5 Barriers to return to work efforts

There were assumptions that occupational sick pay provisions could operate as an incentive not to return to work or to delay the return. It was believed that staff who could perhaps have returned earlier, often returned to work when their entitlement to sick pay had ended or when they were about to drop down to half pay after receipt of full pay. It was supposed that insurance schemes operated as a disincentive in the same way. Employers believed that employees might have prolonged their

absence by returning to work when their entitlement to sick pay ran out, working for a period long enough to renew their entitlement and then entering another period of absence. An organisation that paid sick pay on a discretionary basis did so to prevent employees from believing they had an entitlement to a period of sick leave and, thus, avoid it becoming a disincentive to work. It is perhaps unsurprising, therefore, that some informants regarded sick pay provisions as a significant hindrance to the effectiveness of their sickness absence management provisions. Where entitlements were generous they undermined other efforts employers made to facilitate a return to work.

It is also worth noting that the end of the occupational sick pay period was sometimes seen to spur people to return to work before they were fit because they needed the income.

A further possible barrier to success in encouraging absent employees to return to work, occasionally recognised by study participants, is an overly disciplinary approach to dealing with occasional and repeated absence. It is possible that an untrusting approach to short-term absence reduces confidence in the organisation's commitment to them on the part of long-term absent employees.

5 Rehabilitation resources

Employers rarely used the term 'rehabilitation' in the context of internal and external support services at their disposal. It is, nevertheless, a term that helps to distinguish between processes for the management of sickness absence, as described in the last chapter, and support services or interventions. This short chapter first describes the kinds of health-related services and sources of advice respondents spoke of (Section 5.1). It then looks specifically at the contribution of occupational health services (Section 5.2).

5.1 Health and disability-related services

It is useful to distinguish internal services, services purchased under contract from external providers, and public and other services.

5.1.1 Internal services

Some large public organisations, and a large single-site private organisation, provided counselling, medical assessment and physiotherapy internally. Counselling and hypnotherapy were available on-site from a range of specialists including a freelance psychologist, psychiatrist, occupational health nurse and counsellor. A back care adviser working alongside an NHS physiotherapist treated musculoskeletal conditions on behalf of one local public employer. A national rehabilitation complex and other off-site residential facilities providing physiotherapy and psychological support were available in addition to on-site services to employees of two of the public organisations. Counselling had proved valuable in helping employees recover fully from traumatic experiences.

5.1.2 Purchased external services

Services purchased by employers from external sources were mainly medical assessments and counselling. Other service contracts included physiotherapy and a health helpline.

Medical assessments were purchased, where occupational health services were not available, to investigate the condition named on a GP's medical certificate and its implications for return to work where GP certificates were found to be insufficiently clear or detailed. There were some comments on the value of medical assessments in helping managers to decide what the person was capable of at work but there was comparatively little evidence of such assessments leading to interventions such as enhanced, or earlier, medical treatment.

Larger organisations from both public and private sectors had contracts with employee counselling services, and a small voluntary organisation purchased it as the need arose. Some human resources staff said they strongly recommended the counselling service to staff on long-term absence. Counselling was also valued as a service available whether absent from work or not. There were some views among managers, however, that staff might question the confidentiality of the service if a manager promoted its use too overtly. Some question marks were raised amongst managers about the effectiveness of counselling provision, since the confidential nature of the service prohibited feedback. Some counselling programmes were also designed to assist managers, who may seek advice about managing specific and sensitive issues, such as alcohol abuse and bulimia. This type of service was particularly useful to managers at a large private organisation who found that their occupational health provision could not meet their demands as the company grew.

There were examples from public sector and large private organisations of purchasing, as the need arose, physiotherapy, treatment from a chiropractor and osteopath, and medical interventions including surgery and MRI scans. One large private employer with an internal occupational health service preferred their arrangement to refer patients to a physiotherapist as required, as they had been concerned that in-house provision would dominate their service and that they would lose control of its use. There were a few examples of earmarked funds to aid recuperation and to speed up treatments.

5.1.3 Public and other services

Some smaller employers chose to approach external organisations for advice on specific issues as the need arose. For example, advice on working with people with serious mental health issues was sought from voluntary organisations; a solicitor's helpline was used during a crisis involving a mentally ill employee; and a local disability group was drafted in to advise on appropriate support for an employee who used a wheelchair temporarily.

Larger organisations, in particular, volunteered experience of the Jobcentre Plus Disability Services advice and funding of workplace adaptations, and guidance and practical help from Jobcentre Plus Disability Services relating to training and redeployment. Employers appreciated having access to specialist knowledge and expertise but there were some frustrations. It was frustrating for employers when the service could not be accessed by the employer but was reliant on an employee making contact. Service delivery could be subject to delays and the level of service

was felt to be inconsistent throughout the UK if services' capacity did not match the demands made on them by an increasing recognition of their availability among employers. One concern was that the availability of further services had become apparent only after the employer had made contact, prompting the suggestion that information on available support should be better disseminated.

5.2 Occupational health services

Among large organisations, occupational health advice was drawn from in-house occupational health physicians and nurses or from contracted providers.

There was wide variation in how and when their services were accessed. Human resources departments often were involved in recommending that a long-term absent employee see an occupational health physician or nurse. There were also organisations where managers were expected to make referrals without input from human resources staff, but where occupational health staff thought they were failing to do so. Some respondents spoke of automatic referrals for long-term absences at trigger points. Automatic referral after a set number of days of absence was not helpful in the eyes of some occupational health nurses. They would have liked to exercise discretion over whom to see and when, with sufficient information provided about the person to make the decision. Other respondents said they strongly encouraged long-term absent employees to make contact, some were selective in whom they referred and one said they used contracted occupational health advice only when at a loss as to what to do. Earlier points of referral in illness trajectories also varied: for example, when absence with stress, depression or upper limb disorders was first identified; and when conditions, such as asthma, were notified after eight days of absence. Once back at work, employees in many large organisations could call upon occupational health specialists for help and advice.

It was mentioned that one occupational health specialist gave physiotherapy sessions. Some occupational health respondents emphasised their assessment and advice-giving role to prevent injuries and sickness. Otherwise, much of the discussion of occupational health support focused on its role in the management of sickness absence. Managers particularly valued occupational health advice if it gave an indication of the likely return date and if it added to their understanding of the absent employee's medical condition and its impact on their work. Managers spoke of receiving useful advice on the employee's capacity to do certain jobs but there were some criticisms of the advice they received. For example, occupational health advisers were sometimes thought to make impractical suggestions for adaptations, redeployment and light duties.

Managers sometimes found reports hard to understand. Some human resources staff believed they played an important 'link' role in interpreting reports for managers but managers sometimes valued direct contact with occupational health nurses based on the premises. There was some criticism of delays in receiving reports. One large contracted provider averaged eight weeks and some of its reports

took three months to arrive. Waiting for the report meant that contact with the absent employee was put on hold.

There was a recurrent view among managers that occupational health advisers '*sided*' with the absent employee, did not see the manager's point of view and resisted managers' needs to get the person back to work as quickly as possible. One manager had a contrary view, however: their company's contracted occupational health physician was considered good at getting people back to work speedily. Human resources staff sometimes spoke approvingly of occupational health advisers who were found to be very supportive of the individual. It appeared to be important to have human resources' involvement to manage such tensions.

6 Adjustments, adaptations and personal support on return to work from long-term absence

This chapter reports on the support considered, or put in place, for long-term absent employees on their return to the work and obstacles employers encountered. The main focus is on practical adjustments. Support from other staff, while not usually a planned element of organisations' provision, is also considered.

6.1 Attitudes to making adjustments and adaptations

Across and within the study organisations, informants were willing to consider and make adjustments or adaptations to employees' working conditions and the workplace. This willingness appeared to be limitless for some, such that they were prepared to do whatever was required. Others were aware that their willingness to follow procedure would not always result in an employee's return. There were situations when they knew employees would not return but had still gone '*through the motions*' by attempting to make reasonable adjustments in line with the Disability Discrimination Act (DDA) 1995 and company policy. Adjustments needed to be 'reasonable' for one employer, doing no more than simply enabling workers to return. It was thought to make business sense for people to be actively employed in some part of the organisation than not at all, even if employers had to retain extra staff temporarily and employ staff only part-time in the first instance. It was thought important to be flexible and imaginative about what could be offered and agreed with an employee, and above all to be guided by the individual needs of the employee. Being proactive was also deemed beneficial as it was thought that employees were more likely to return permanently if they returned sooner.

Some employers, with primarily physically demanding jobs, explained how their attitude to making modifications had changed over time. In the past they may have been uniformly unwilling to consider certain adjustments, such as restricted duties, and not considered each individual case in turn. They would now conduct risk and workplace assessments allowing them to be more responsive to individual needs. Occupational health staff talked of having struggled, with some perceived success, to change managers' attitudes to taking back employees who were not yet fully fit.

6.2 Decision making

Typically, it was line managers who were charged with making decisions about whether to make adjustments and what adjustments to make, in consultation with the employee, although in one large private organisation the internal occupational health service had case management duties. However, managers were often guided by others with specialist knowledge and expertise. They called for advice on individual employees' capabilities and on choosing appropriate modifications from human resources specialists, health and safety officers and external professionals such as GPs and physiotherapists. Assessments such as ergonomic, risk and personal capability assessments were also conducted by external specialists or internal occupational health services, though this tended to happen in the larger organisations with greater resources. A medium-sized organisation without a human resources specialist based on-site, made workstation assessments by asking employees to complete a self-assessment form and by following guidelines laid down by the central health and safety department.

Employees' individual circumstances and needs, employers' capacity to make adjustments and adaptations, and external considerations all needed to be taken into account when deciding whether to make modifications and what those modifications would be. It often seemed to be a delicate balancing act between employers' willingness to do what they could to meet individual needs and meet legal requirements, and the restrictions placed on them by internal capacity and resources.

Employers wanted to focus on the employee and be guided by their circumstances and needs as far as possible. Personal capability and workplace assessments helped to inform decision-makers of what was possible. The requirement to comply with the duties laid down in the DDA was noted by occupational health and safety officers and managers at some large public and private organisations. Together with the desire to avoid being taken to an industrial tribunal, the legal requirement added weight to the argument to accommodate individuals, to the extent that some organisations found that they had created jobs for which they had no budget.

Despite these factors working in favour of the employee's return, the employee's circumstances could sometimes prove to be the biggest barrier. For example, one informant felt it would be difficult to help employees where changes would need to be made outside the workplace, such as those who suffered stress due to home-

related problems. Facilitating a return was also problematical or unfeasible where the employee's health condition was felt to be too severe or to place heavy restrictions on their capacity to work at any level or in any role.

Where employees were waiting for medical tests or treatment, employers responded in varying ways. Some invited the employee to return by making interim adjustments. In contrast, a large private organisation was prepared to wait for the employee to receive treatment before they returned to their job. One large private organisation chose to pay for early medical interventions but only in exceptional cases where employees had valued skills.

Most alterations appeared to be permanent where employees had permanent health problems or injuries and were unlikely to be able to return to full duties. Such alterations could be offered as a trial in the first instance. In general, temporary adjustments contributed to a phased return to work and were used where employees were recovering from illness, and full recovery, or returning to full working capacity, was expected. Temporary adjustments also occurred where a phased return had not been planned specifically. Some small organisations had taken full-time staff back on an initial part-time basis, perhaps without making plans and setting defined time periods and relying more on managerial discretion.

Employers' capacity to accommodate a return to the workplace could be restricted by their size, location, resources, the type of work carried out, and the variety of jobs offered. Issues concerning employers' capacity are explored in greater depth in the following section, within the context of adjustments and adaptations made.

6.3 Types of adjustments and adaptations

Employers had considered or made a range of adjustments and adaptations: phased return, alterations to working hours, altered job tasks and reduced duties, redeployment, and physical and environmental adaptations.

6.3.1 Phased returns

There was widespread use of phased or graduated return to work, which could entail returning to work on reduced hours, reduced duties, or a combination of the two, gradually building up to full capacity over a period of time. It was reported that people could return for as little as an hour a day, and gradually increase to work full-time hours. These phase-in periods were designed as a time to become accustomed to the working environment, to build confidence or morale and to become reacquainted with the business.

Some large organisations said it was their policy to offer phased return to everyone coming back from long-term sickness absence and that its use was common. This provision was known to some as a formal rehabilitation programme, where plans were made and reviewed by line managers in consultation with the employee and perhaps human resources and occupational health specialists. One large company

used its training facilities to provide extra support for employees who needed to reacquaint themselves with their work.

Successful use of the graduated return was reported. Offering a gradual return often meant employees came back earlier and back to full capacity more quickly. It was also thought to be a useful tool for communicating a message to employees that the organisation cared about them and wanted them back.

Initiating a graduated return could depend on the employee's role, skill level and their willingness to return on an initially reduced basis. It was found to be easier to alter the tasks and build up the workload of managerial staff who had been absent, because they enjoyed flexibility and variety in their work. There were, however, barriers to the temporary reduction of tasks. Where tasks could not be amended, for example where employees had contact with the public, graduated return was limited to the number of hours worked. Similarly, one operational manager with strategic responsibilities explained that, whilst reduced hours were available, reduced duties were avoided because employees had legal rights to continue temporary duties on a permanent basis. Reduced duties, even on a temporary basis, could not be considered for employees with physically demanding operational roles due to concerns about health and safety. In this case, they may complete a phased return in a non-operational role before transferring to full-time operational duties again. Informants said that some managers put up barriers to phased returns by asserting that they were prepared to welcome employees only if they worked to full capacity.

It was believed by some, that returning on anything less than full pay was not always financially viable for employees. Two organisations paid full salaries; a third paid for hours worked with non-working hours paid at sick pay rate (which could be nil, however); and a fourth revealed that managers were working outside company policy by making discretionary payments to staff to give them an incentive to return.

6.3.2 Alterations to working hours

Alterations to working hours included reducing hours to part-time, changes to avoid the rush hour, to match child care responsibilities or to give a more manageable shift pattern, and flexible arrangements to take more breaks at work.

There were few barriers preventing alterations to working hours, though there were difficulties where changes to shifts would create childcare problems or where a set number of positions needed to be filled for each shift.

6.3.3 Altered job tasks and reduced duties

Changes to job roles were easier for employers who could offer a wide range of tasks in various locations and requiring a variety of skills. For example, an employee could be given the task of coaching fellow workers to do a certain job when they could no longer do the job themselves. In another organisation, a receptionist was able to catch up with some reading and work away from the front desk whilst she felt

unable to deal with the public. Other employees continued in largely the same role but with extra responsibilities, such as the pastoral care of others, removed.

Managers perceived there to be limited opportunities for light duties for manual workers. As a consequence, one manager felt they were in conflict with the occupational health and human resources personnel who had recommended such action. The option to undertake reduced duties was also thought to be open to abuse by employees, such that they could use sickness absence as a way to pick and choose more favourable tasks. Reduced duties could not be considered for employees with operational roles that demanded physical fitness due to concerns about health and safety.

6.3.4 Redeployment

Despite employers' support for the concept of redeployment, the likelihood of it becoming a reality and being successful often appeared to depend on employers' capacity to accommodate it and employees' willingness to participate. In general, informants from the same organisation gave similar accounts of the attitude towards redeployment and the process involved. However there was a notable discrepancy in one large organisation where the human resources and occupational health personnel said employees were redeployed wherever possible and a manager reported that redeployment occurred in exceptional cases. A possible reason for the discrepancy could be that the manager was not closely involved in individual cases, as responsibility for this lay with a lower tier of team managers. Human resources and occupational health may be better placed to provide an overall view of the organisation's management of sickness absence.

The organisation itself – through its size, available resources, location and type of work undertaken – could often dictate the possibilities for redeployment. Employers with greater resources of time, facilities and money, and with the potential to expand, were keen to invest in employees by developing their skills on a temporary redeployment, or by retraining them for permanent redeployment. Elsewhere, temporary redeployment was also used in a more discriminating way for employees who already possessed the appropriate skills.

Medium to large public and private organisations with a central human resources facility operated internal job vacancy systems. They were often better placed to offer a greater number and broader range of jobs and, therefore, to match up the skills and capabilities of the employee with those demanded by vacant posts. New vacancies appeared regularly and employees wishing to be redeployed were required to enter an application process, though their competition was limited to others on the redeployment list. Those employees left less physically fit by their sickness or disability, were sometimes introduced to non-operational or administrative roles where these were available, sometimes being promoted.

For multi-site organisations, relocation to a new site was an option for those suffering stress caused by the workplace. However, some said that the availability of

vacancies could be affected by location, so that redeployment was more difficult in rural sites. Redeployment also became difficult where jobs were fairly homogenous; where the number of jobs, and, thus, vacancies, had reduced over time; and where physical fitness was essential, since alternative non-operational roles did not exist or were limited in number and popular.

Redeployment could be conditional on the skills, circumstances and wishes of the employee. Although some people said they would always try and redeploy employees, it was also thought that some employees were more easily redeployed than others. For example, it is difficult to redeploy those employed at a higher level, since they themselves have more specialised expertise and vacancies demand specific skills that may not match. Informants spoke of employees who had not wished to be redeployed because they felt they did not have the skills, that they were too old to retrain or were so accustomed to their long-standing role that they could not contemplate doing anything else. Only one employer said that redeployment was conditional on the past performance and present behaviour of the sick employee.

The success of redeployment was thought to be largely dependent on the employee's perceived ability to adjust to an alien role, particularly where the individual concerned had held their old post for many years and possessed a narrow set of skills. For one informant, whose organisation was split into several directorates each with their own budget, successful redeployment meant passing the responsibility of paying an employee's wage to another directorate and ending the cost of keeping the absent employee on as well as paying for their replacement.

6.3.5 Physical and environmental adaptations

Examples were given of adapting equipment such as providing split keyboards for computers, providing new equipment such as a suitable chair, and improving access to the workplace. The introduction of equipment could mean an employee was able to continue undertaking certain tasks, such as using a Dictaphone to compose reports. An informant from a small private organisation said that the organisation would pay for physical adjustments as they were unsure whether funding was available to them. Others spoke of the help in terms of both funding and specialist advice that they received from external services such as the Jobcentre Plus Disability Services.

Some workplaces were already more amenable to disabled employees or able to be adapted. A large private organisation recognised that whilst it could accommodate disabled employees at its larger sites, it would be more difficult to make environmental adaptations at its smaller sites. The possibility of physical adaptations was thought to be limited due to legal restrictions, such as where the building was listed or where the building did not belong to the organisation using it as a base. There were some examples of changed arrangements to enable working from home or working in another part of the workplace, such as on the ground floor.

6.4 Personal support in the workplace

Where people were apprehensive about returning to work, informal visits to the workplace would be encouraged in the lead up to the return date, so that the individual could talk to colleagues and catch up on developments. It was said that employees did not always feel able to accept such offers, especially where they had been absent with mental health problems.

As reported in Chapter 4, many organisations endeavoured to maintain regular contact with the individual to check on their welfare during their absence, and this could continue for a period once they returned. Some employers had already picked out 'mentors' and 'buddies' who were asked to maintain contact or help people to adjust to the working environment. In an exceptional case, a human resources staff member had taken responsibility for personally supporting individuals and building a rapport with them, perhaps putting more effort into this part of the role than was expected by managers. Some managers continued to meet with the individual, some on a daily basis, to monitor their reorientation. Line managers spoke of personally supporting employees in other ways too, such as providing lifts to work.

7 The need for further support to enable a return to work and to manage sickness absence

So far the report has discussed organisations' use of internal and external resources for managing sickness absence and rehabilitation. This chapter considers perceived needs for further support. Employers' awareness of external services to support return to work, other than the Job Retention and Rehabilitation Pilot (JRRP), is reported in Section 7.1. Section 7.2 looks in detail at understanding of the JRRP amongst those employers who knew of it, and views on its value amongst those who had experience of employees in contact with a JRRP provider. Employers' views on the need for written good practice guidance are discussed in Section 7.3. Section 7.4 concludes the chapter with employers' reflections on problems with external and internal provision and improvements needed.

7.1 Employers' awareness of external services to support return to work

Respondents were asked if they knew of any sources of external support to help to get people back to work. The concept of an outside service to help people get back to work from sickness absence was not familiar to all respondents and it was sometimes necessary for the interviewer to prompt with examples (without naming specific services) or to give further explanation.

There was greater awareness of external supports among dedicated human resources staff than among line managers, and less among smaller private companies. There were views among operational and line managers that knowing about outside support was the role of human resources staff rather than part of their own

remit. Consequently, awareness was often limited to those services they had experience of using in the past. In general, human resources staff knew about services beyond those their organisation had used, including Jobcentre Plus services such as 'PACT' (the precursor to Disability Services) and Disability Employment Advisers; voluntary sector bodies such as the Royal National Institute for the Blind, Citizens Advice Bureaux and Macmillan Cancer Relief; and professional bodies such as the Royal College of Nursing. Some also had contact details for helplines and self-help groups.

Smaller private organisations without human resources provision were less aware of external support, perhaps recalling the names of one or two services. They explained that they would only become aware of services that approached them first or that their awareness was limited because sources of external support were directed at employees, who were often thought to be reluctant to use them.

Outside support known about was not used if it did not appear to suit the organisation, if no specific need had occurred, or if internal services and expertise were thought to be good. Support was thought to be inappropriate when it did not suit the characteristics of the business, such as a private service aiming to find employees alternative roles in a business with a limited range of jobs that had approached one private sector employer. For some, the decision to use external services was dependent on first receiving a recommendation, where the service was new, or guidance from sources such as occupational health. Some showed an intention or willingness to use external support in the future.

7.2 The Job Retention and Rehabilitation Pilot

As explained in Chapter 1, the participating organisations were drawn from the Department's database for the JRRP. The database was a useful sampling frame, and using it had the secondary advantage of allowing for exploration of experience of the JRRP should informants mention it. Respondents were not asked directly about the JRRP. Some, however, recalled it as an illustration of external support of which they were aware of and sometimes had experience. Their understanding of what the JRRP does sheds light on the effectiveness of promotion of external services, and their experiences show what is, or is not, valued.

7.2.1 Awareness of the JRRP

Awareness of the pilot was higher among larger organisations. The pilot was not well known amongst the smaller private sector organisations, which either made no reference to it or had experienced little or no contact. It is worth remembering that whilst employers were drawn from the JRRP database and, thus, had at least one employee who had participated in the trial, the employee in question may have been part of the control group, reducing the likelihood of the employer's awareness of the JRRP. It is also possible that others in the organisation, rather than those interviewed, were the principal contacts for JRRP providers.

Organisations had first become aware of the pilot through a variety of means, including reading about it in a local authority magazine distributed to every household; reading a provider's leaflet; being approached by the provider, given a staff presentation and visiting the provider's premises; and through an employee's, though not necessarily their own, contact with the pilot. Unusually, a large organisation saw itself as a part of the pilot.

7.2.2 Contact with JRRP providers

Larger organisations spoke of how they had been in contact with the pilot provider and the relationship they had established as a result. For some, contact was made on a purely introductory level, where JRRP providers had visited the workplace, given presentations or briefings to line managers and supplied them with leaflets so that they could raise awareness amongst their staff. In this way employers took on the role of directing employees to JRRP services. This contact was extended where the employer was involved first-hand in the JRRP provider's support of an individual employee, such as meeting to discuss return to work plans or when the provider conducted an on-site workstation assessment. On these occasions employers were able to obtain advice from the provider and reports on an employee's capability. Not all those who worked with the provider in this way had received prior introduction to the scheme.

Some employers promoted the use of the JRRP to their employees. Informants who knew about the JRRP were generally clear that they could not directly refer absent employees to the provider but some were willing to bring it to the attention of employees by, for example, writing about it in a staff newsletter and handing out leaflets to all who might be eligible for the service. Those employers most willing to encourage the use of the JRRP were those who had first-hand contact with the provider, either through briefing sessions or collaboration regarding an individual employee, especially where they had good experiences of the service. It was felt that cursory knowledge needed to be backed by more detailed information before promoting it to staff. In one organisation, long-term absent employees were encouraged to contact the pilot if it was felt that relevant services would be provided; in another, everyone dealt with was encouraged to take part.

7.2.3 Employers' understanding of the JRRP

The level of understanding of JRRP services was influenced by experiences, such that those in greater contact with the pilot, possessed greater and more accurate knowledge. However, there were some misunderstandings. Not surprisingly given the nature of the JRRP trial, with separate health and workplace intervention groups as well as a combined group, respondents whose employees had joined the JRRP often had narrow interpretations of its target groups or service components. For example, it was seen as a service for people with mental health problems or for people with specific illnesses, to be focused on health interventions or primarily fast-tracking medical interventions. There were also some misunderstandings among respondents with first hand experience of the service but who had not been briefed

about the service by the providers themselves; for example, it was viewed as a counselling service although the provider had worked with the respondent to design a return to work plan. Respondents who had been given presentations or whose organisation was closely associated with the pilot had a fuller understanding, including the pilot's rationale, the eligibility criteria, the different pilot groups and the types of services available such as workplace assessments. One such respondent believed the JRRP is a service for employers, however.

7.2.4 Reflections on the value of JRRP services

At the time the study was carried out, there had been no reporting on the effectiveness of the pilot and some respondents mentioned the lack of feedback on the service outcomes. Thus, some were unwilling to comment on its value. Where they did, however, a variety of opinions was forthcoming.

Positive reflections

The JRRP provider service was valued for the way it had benefited individual employees and, in turn, themselves as an employer, by helping employees return to work sooner than if they had waited for NHS treatment, such as some who received quicker access and an enhanced provision of physiotherapy. In bringing about this result, particular elements of the provider's approach were praised, including:

- a prompt and proactive approach both in seeking participants and in responding to their needs;
- the ability to conduct assessments;
- working with the employer on back-to-work plans, in one case introducing the respondent to the idea;
- the facilities and range of services available, meeting a variety of needs such as physical and emotional problems;
- a seamless service centred on a support worker, in contrast to some employers' experiences of having to pull in provision from a range of sources.

Some highlighted the positives of the programme by comparing it with the internal provision of support. JRRP providers were able to provide services that line managers did not have time to consider, such as providing in-work support by conducting regular checks on the employee. The JRRP was perceived as giving a superior service to the internal occupational health service in one organisation, and more generally, was able to supplement scarce internal resources.

Mixed views and limitations

Mixed views came from those who thought the pilot was a good idea in principle but had not been matched by their experiences, such as respondents that felt the provider had failed to promote their services effectively and recruit sufficient numbers of clients. There were views that the providers had interfered unhelpfully

and had taken away employers' control of the situation. A small employer felt that the agreement of a return to work programme caused disruption to the workplace that had time, cost and productivity implications. There was also a feeling that the Government money supporting the pilot would be better targeted at cutting NHS waiting lists, meeting the problem at its source.

A perceived limitation of the service was that it was unable to offer help with some health conditions, such as sleep apnoea and angina. Constraints imposed by the service's trial status, such as gaining access to support on the basis of random selection rather than individual needs, had also led to frustrations and disappointment. In one case, however, the initial disappointment following an employee's assignment to the workplace intervention group gave way to surprise when the interventions used were thought to have been successful.

Suggested improvements

Suggested improvements to the operation of the service were centred on better communication and timing. Marketing could be improved and it would be beneficial to encourage more communication between the employer and service provider, an example of which would be to allow employers to refer those employees they felt were suitable. It would also be useful to seek advice (about adjustments, for example) earlier in the course of an employee's illness, before leave from work was taken.

7.3 Awareness and use of external guidance on managing sickness absence

One aim of the study was to explore the need for, and usefulness of, external guidance on managing sickness absence. As explained in Chapter 1, Government departments are promulgating good practice guides.

Some human resources respondents were aware of potential sources of good practice guidance, such as professional bodies, Government initiatives and briefings, handbooks and Internet websites. Some chose to keep up to date with developments by becoming members of a professional body, subscribing to professional journals or health and safety bulletins and receiving automatic updates by email. Other sources of guidance included consultations with an employment advice organisation and guidance issued by regulatory bodies

In general, external guidance was used more to inform policy than to assist with practical absence management. Some managers and human resources specialists were more active in using such sources where they were motivated by changes in legislation, or concerns about their compliance with the law, or were in the process of establishing and developing new policies and practices in managing absence.

As noted in Chapter 3, other organisations' arrangements for managing sickness absence were particularly useful as a framework for those updating procedures or

starting anew. Private organisations, in particular, were concerned to measure their practice against that of competitors by taking part in industry forums, such as the British Retail Consortium, or taking note of those deemed to be leading employers by external awards.

A reluctance to use external guidance on managing sickness absence amongst human resources specialists was explained by doubts that it could add anything to their own personal experience and organisational resources. While some operational and line managers felt they might benefit, for example from guides to managing stress, they lacked time to read them and there was a worry that what they read might be outdated. A risk of inconsistent practice across the organisation was an objection raised by human resources staff to the idea of managers accessing external good practice guidance on managing absence.

A vague willingness to use advisory support in the future was forthcoming from respondents who were not aware of its availability; or who did not feel they needed it at present but were open to its potential usefulness. There was a feeling that they did not want to turn down any help or become isolated, and that the thinking on what works best in managing sickness absence was a fluid exercise.

In summary, there were mixed views on the need for good practice guidance. Some welcomed this kind of guidance: as a source of advice on making adjustments and accessing grants, and as a form of moral support or as a tool for measuring themselves against other organisations. Some demonstrated their desire to contribute to the development of good practice guidance and to gain access to it by their keenness to take part in this research study and their interest in obtaining the summary report. Those whose sickness absence procedures were being updated or were newly installed were particularly keen to access good practice guidance. They were critical of their organisation's less developed practices and felt unsupported.

7.4 Problems with existing provision and needs for further help

Within larger organisations, problems and needs were identified more readily by on-site or central human resources and strategic staff, rather than by line managers. There was an expectation among line managers that internal human resources or occupational health staff would have the requisite expertise to tackle problems themselves and managers were happy with this support. They also expected human resources or occupational health to identify any gaps in provision and seek help from outside the organisation where it was needed. Respondents with a strategic or central role, and in a position to get an overview of the whole establishment or organisation, seemed better able to appreciate the wider needs of their line managers and employees. Some respondents who could not identify specific needs stated that they would not refuse offers of assistance or further information where it was forthcoming.

7.4.1 Problems with external services

When asked whether they felt the need for further assistance in enabling return to work respondents often spoke of problems associated with the use of existing external services and their wishes for improvements.

Long National Health Service (NHS) waiting lists were a particular cause of frustration to employers as they could be the only barriers to employees returning to work. Some large private employers had considered funding private treatment but there were objections to subsidising the NHS and concerns about setting a precedent within the organisation. For a large public sector organisation, fast tracking through private provision was too political a decision to be taken.

Problems with sickness absence certification were identified and there was some dissatisfaction with General Practitioner (GP) sick notes and medical reports. One respondent from a small organisation that did not apply disciplinary procedures for short-term or sporadic absences believed that some staff took unfair advantage of what was thought to be an overlong seven-day self-certification period. It was felt that GPs could certify absences too readily; with the effect that people could believe they had a right to be off work and were not encouraged to return. Their sick notes were also found to be unhelpfully imprecise. It was particularly hard on employers wanting to plan workforce deployment if certification gave no clues as to when an employee might be expected to return to work. Medical reports requested from GPs were sometimes hard to understand or insufficiently informative about the employee's situation and prognosis; a small organisation without access to an occupational health provider was exploring the alternative of using independent medical assessments for such reasons. On the other hand, one human resources manager praised GP reports. When used, company doctors or occupational health services were thought to helpfully supplement information from GPs but delays in getting reports from GPs and occupational health were mentioned.

7.4.2 Needs for external support

The needs identified by employers were often couched in terms of assistance for themselves, rather than directly for the employee, although there were suggestions of better counselling provision and an advice hotline to direct employees to appropriate services. It was stressed by one respondent that any external agency must be committed to helping employees back to work, not just to support the individual.

Need for information and advice

Some needs identified were for information and advice. Employers with few links to external support wanted to know what was available to them. A respondent from a large private organisation suggested a 'one-stop-shop' providing specialist advice on how to get people back to work would be particularly useful for small-medium employers (SMEs) with insufficient internal resources. Independent consultants were advocated in cases where managers felt their views on getting employees back

to work were in conflict with those of their human resources department. Information and advice was also needed on specific matters such as details of self-help groups, help for those with depressive illnesses, entitlements to state welfare benefits, employment law, making physical adjustments and providing alternative work for employees.

Key elements looked for in service provision

Beyond their calls for further information, respondents also spoke about key elements they would like to see in services helping to rehabilitate workers, such as better communication, faster access and responsiveness to needs. Occupational health services would be more valuable if they shared an understanding of the organisation's specific background and characteristics. An external agency purely providing funding for faster medical treatment when required was welcome. Some were in favour of improving existing services such as the NHS, by developing its links with employers. A facility whereby internal occupational health services could refer patients to the NHS for quicker investigation and diagnosis was advocated, as was a more active role for GPs in helping people back to work. 'Community physiotherapists' could form a direct link between occupational health and the health centre to which they are attached, giving faster access to treatment. It would also be advantageous if the NHS sought to rehabilitate people specifically for work and not just for daily living.

Specialist services

The small subset of informants who spoke of favourable experiences of JRRP services were keen to see the service replicated to the wider population and to a broader spectrum of employees. A specialist organisation that would be able to devote time and skills to concentrate on specific needs and issues, and yet have the capacity to deliver a range of services to meet a wide range of needs, was desirable. Such a service, desirably, would also provide a fast track to diagnosis and treatment.

7.4.3 Internal needs

Aside from discussions on enhancing external support, employers also spoke of improving their internal resources. More money was required to offset the costs to the organisation of sickness absence, and to provide financial assistance to employees making a gradual return to work. Some thought they could reduce the demands on line managers by recruiting specialists, such as occupational health nurses, or members of staff dedicated to managing absence. Extensions to occupational health provision, to include counselling for example, were also considered. It was suggested that occupational health could take a lead role in sickness certification and medical assessment where it was felt the service from GPs was deficient.

8 Key conclusions

The background to the study reported here was the Government's recognition of the need to improve return to work support for people at risk of leaving employment following sick leave. The Job Retention and Rehabilitation Pilot (JRRP) services have pursued a person-centred case management approach for eligible volunteers off work through sickness for between six weeks and six months.

This research, like previous studies of sickness absence management, has centred on what employers themselves do to manage sickness absence and return to work. It reports on the actions, experiences and perspectives of staff with differing roles within the employing organisation. Employees would need to be brought into the frame in order to obtain a full picture of the implementation and effectiveness of employers' sickness absence management and return to work policies and practices. Indeed, research focusing on the '*dynamic interplay*' between all the 'actors' involved represents the largest gap in the research literature in this area (Cunningham and James, 2000; James *et al.*, 2003).

Bearing that limitation in mind, this study has furthered understanding not just of the content of policies and the details of procedures but also of what employers actually do when an employee is absent on sick leave. It has illuminated how employers view and treat short-term, repeated and prolonged sickness absence in different ways; what they see as the benefits of retaining staff; what they have available to them to support return to work; and views on need for further support.

The Summary at the beginning of this report encapsulates its content. Here we draw out key findings in relation to the research questions we set out in Section 1.3.

- There were striking differences in attitudes to, and management of, short-term and long-term absence, confirming findings in previous research. Procedures were being tightened to deter 'non-genuine' days off, sometimes with threats of disciplinary action. There was some recognition that repeated short spells of sickness absence had underlying causes, with detection systems leading to the use of occupational health resources or the introduction of flexible working arrangements. But more often repeated absences were seen as a disciplinary matter.

- Employers generally appeared sympathetic towards people off long-term sick and keen to have them back at their work, influenced by the business advantages of retention. The Disability Discrimination Act (DDA) 1995 acted as an extra pressure to do everything possible to facilitate return to work, especially with regard to adjustments and adaptations.
- Perceived weaknesses in the implementation of sickness absence policies included difficulties in the way of line managers carrying out sickness absence management responsibilities fully and consistently. It was said that it could be hard for busy managers to set aside enough time, that there was some reluctance to take on new and sometimes alien-seeming roles, and that internal documentation did not necessarily help line managers in dealing with individual circumstances as opposed to following procedures. Conversely, dedicated human resources or in-house occupational health advice to managers, tailored around the individual's circumstances, were thought helpful in large organisations with such resources. Arrangements where dedicated human resources or occupational health nurses took on case management roles and liaised with managers were thought to have the advantage of allowing managers to concentrate on workload planning concerns.
- The structure of occupational sick pay was identified as hindering the management of long-term sickness, people having been observed returning to work at the point when sick pay ended or dropped to half pay. A perceived external barrier was long National Health Service (NHS) waiting lists.
- Much of the practice described in relation to long-term sickness absence related to keeping in touch with the person and reviewing the prospects for, and likely timing of, their return to work. Two organisations spoke of a 'rehabilitation plan', and there were also examples of return to work plans centring on phased returns and adjustments required. There was some limited evidence of organisations boosting medical intervention or treatment, getting ergonomic assessments, and using worksite-related advice from occupational health staff.
- The concept of external services to support return to work from sickness absence tended not to be immediately recognised by study participants. One implication of the study findings is that responsiveness to external services, such as those provided in the JRRP, may depend on having evidence of their effectiveness as well as a full understanding of what they do. There were attractions in seamless services, contrasted with experiences of having to seek out different types of support from a range of sources.

Employers wanted more information on what is available to support them in absence management and return to work efforts. There are indications that practice guidance has most potential usefulness when a specific need arises.

Appendix

Research instruments

Letter 1

May 2004

Dear

We are writing to ask for your help with an important research study focusing on employers' experiences of sickness absence amongst staff. The Department for Work and Pensions (DWP) has commissioned the research as part of a wider study investigating effective ways of helping employees to return to work after a period of sickness absence. We would like to talk to you about what happens in your organisation when an employee is on sick leave, and to discuss your views on sickness absence and the return to work.

The Social Policy Research Unit at the University of York and the National Centre for Social Research, both independent research organisations, have been commissioned by DWP to carry out interviews with selected employers. The research will be entirely confidential – we will not name any organisation or participating individual in any research reports – and participation is voluntary.

A researcher from [*research organisation*] will contact you shortly to invite you to take part in an interview. They will outline the purpose of the interview and be able to answer any questions you have about the study. If you are willing to participate they will arrange to hold the interview at a time and place convenient to you. The interview will last approximately 60 minutes.

If you have any queries about the research please contact me [*contact name*] on [*phone no.*], or Leah Harris in the Social Research Division of DWP on 0207 712 2327, email Leah.Harris@dwp.gsi.gov.uk

We hope that you will be able to take part in this important study. Your contribution would be greatly valued.

Yours sincerely

Letter 2

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A researcher from [*research organisation*] will contact you shortly to invite you to contribute to this study. They will outline the purpose of the interview and be able to answer any questions you have about the study. We are also interested in talking to a second member of staff at your organisation who has experience of employee sickness absence, perhaps someone responsible for human resources or personnel issues, and would be grateful if you could identify an appropriate person. If you are willing to participate, the researcher will arrange to carry out these interviews at a time and place convenient to you. Each interview will last approximately 60 minutes.

If you have any queries about the research please contact me [*contact name*] on [*phone no.*] or Leah Harris in the Social Research Division of DWP on 0207 712 2327, email Leah.Harris@dwp.gsi.gov.uk

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A researcher from [*research organisation*] will contact you shortly to invite you to contribute to this study. They will outline the purpose of the interviews and be able to answer any questions you have about the study. We are interested in talking to three members of staff at your organisation who have experience or knowledge of employee sickness absence, and would be grateful if you could identify the appropriate people. We envisage that they may be someone responsible for human resources or personnel issues, a line manager, and perhaps an occupational health nurse or doctor if you use their services. If you are willing to participate the researcher will arrange to conduct interviews with the people identified at a time and place convenient to them. Each interview will last approximately 60 minutes.

If you have any queries about the research please contact me [*contact name*] on [*phone no.*] or Leah Harris in the Social Research Division of DWP on 0207 712 2327, email Leah.Harris@dwp.gsi.gov.uk

We hope that you will be able to take part in this important study. Your contribution would be greatly valued.

Yours sincerely

Employers' management of sickness absence

Interview Topic Guide

- *Introduce self and research organisations involved (NatCen, SPRU). Explain are independent research organisations. We have been commissioned by DWP to carry out the research.*
- *DWP has commissioned this research as part of a wider study investigating effective ways of helping employees to return to work after a period of sickness or disability.*
This interview will focus on views about sickness absence; what the organisation does when some one is off sick, and what influences that; and awareness of and any need for external sources of support.
- *Explain about confidentiality. We will write a report for DWP. We will not name any organisation or participating individual in the research report.*
- *A copy of the summary of the research report will be available to all who take part.*
- *Where relevant, explain that we are also speaking to other members of staff at the organisation: this is to get the perspectives of people with differing roles. Stress that we will treat what they say with confidence and will not discuss it with any other staff member.*
- *Explain about tape recording: tapes treated confidentially and stress no tapes will be passed to DWP. Confirm length of discussion (60 mins). Seek permission to record.*
- *Invite questions.*

A. BACKGROUND

FOR RESPONDENTS WHO ARE EMPLOYEES OF SAMPLED EMPLOYER:

1(i). I would like to begin by asking for some basic information about yourself and your organisation

Job title and main responsibilities

Length of service at organisation

Main tasks/business of the establishment (and organisation if appropriate)

Size and structure of organisation (multi-national, national, multi/single site)

Number of employees

– in establishment/department

– in organisation as a whole in UK

How long organisation has been established

How HR function is organised (any specialist posts)

FOR RESPONDENTS WHO ARE CONTRACTED TO SAMPLED EMPLOYER:**1(ii). I would like to begin by asking for some basic information about yourself and the work you do with [named establishment/organisation].**

Job title and main responsibilities

Relationship with establishment/organisation

Duration of relationship

Number of clients they work with

Areas they work in

B. MANAGING LONG-TERM SICKNESS ABSENCE: POLICIES AND PRACTICES**2. Can you describe what has actually happened when an employee was absent from work due to sickness or disability?**

Are there any differences depending on how long someone has been off sick?

? Probe any demarcations between short-term and long-term absence and any definition of 'long-term'

Explain research focus on longer-term absences (4-6 weeks + if no definition used)

How was the long-term absent employee identified?

? Any arrangements for monitoring sickness absence

When (timescale of actions)?

What kind of support was available?

- Personal contact (telephone, home visits, return to work interviews)
- Medical support (eg private medical insurance, assessments/treatment with a health professional, physiotherapy, counselling)
- Work-related support (eg functional evaluations, retraining, environmental adaptations, altered job tasks /roles/hours)
- Financial support (sick pay duration)

Balance of personal contacts, medical and work-related support

Compulsory and voluntary aspects

Who was involved and their roles, eg

- Managing Director
- Human resources specialists

- Line managers
- Occupational Health doctors and nurses
- GPs/other external health professionals
- Trade Unions
- Employee

Training/preparation for and supervision of their roles (availability, adequacy, helpfulness)

Extent to which action is coordinated

How typical is what has been described?

? Explore whether absence is handled differently depending on factors such as:

- length of service
- skills
- health condition

3. Do you have any guidelines to follow?

Are policies formal/informal; written/unwritten?

? Probe for whether provision as a whole is:

- systematic/ad hoc
- integrated/mishmash
- discretionary/mandatory
- applicable to whole organisation/restricted to establishment

? Probe for reasons

How long have guidelines been in place?

Where did they come from?

How have guidelines changed/developed over the years?

- Any methods for reviewing guidelines?
- Any arrangements to see how far guidelines are followed?

4. Are there any differences between what is set out in the guidelines and what has happened in practice?

? Probe fully for reasons (eg, policies too demanding; line managers' attitudes or awareness)

? Probe for thoughts on how to fill gaps between policy and practice (eg monitoring implementation)

C. EVALUATION OF POLICIES AND PRACTICES

5. Has what has happened in practice been effective from your point of view?

Strengths in current practices

Weaknesses in current practices

Ideas for improvements/filling gaps

6. Do you think the guidelines are effective?

Strengths in current guidelines

Weaknesses in current guidelines

Ideas for improvements/filling gaps

7. What factors influence the effectiveness of sickness absence management?

What helps?

What hinders?

? Probe for reasons

? Probe for thoughts on the key factors that secure a successful return to work

Example(s) of employees' successful return to work – and why effective

8. Are there situations where people do not return to work?

? Probe for circumstances and reasons (eg, termination of contract)

? Probe for circumstances where it is easier for an employee not to return

Example(s) of employees' non-return

? Probe for respondent's attitudes to non-return

? Probe whether more/less effort is put into return of certain employees

9. What are the advantages of staff returning to work or not?

Benefits of retaining staff (eg, retain skills and experience, avoid training replacements, seen to comply with law)

? Probe for reasons

Drawbacks (eg lost productivity, cost of hiring temporary replacements, unable to shed labour)

? Probe for reasons

D. ESTABLISHING AND DEVELOPING POLICY

10. What factors have influenced the establishment/development of your sickness absence management policies and practices?

Influences on type of provision (i.e. medical, vocation, financial)

Influences on level of provision

? Probe fully for reasons

11. Has external good practice guidance played a role?

Extent of awareness of such guidance

Extent guidance has been adopted

? Probe fully for reasons

? Probe for thoughts on the adequacy and value of good practice guidance

E. AWARENESS AND USE OF EXTERNAL SUPPORT FOR EMPLOYERS IN MANAGING SICKNESS ABSENCE

12. I'd like to ask some questions about external support to help employers in getting people back to work. Do you know of any sources of external support that might be available to you?

What type of support?

possible responses: do not prompt by programme/service name

- JRRP providers
 - Access to Work
 - DEAs
- Occupational Psychologists
- Specialists in adaptations (e.g. IT)
- Employers' Forum on Disability
- Voluntary organisations (e.g. RNIB)
- WorkStep (offer incentives for employers)
 - How did you become aware of it?

13. Have you used any available support?

When. How often (ongoing relationship or one-off)?

How contact was made

What kind of support was offered? What support did you receive?

Example(s) of involvement with external support – successful and unsuccessful

? Probe for reasons for seeking help

? Probe for thoughts on adequacy, value and effectiveness of support

FOR THOSE WHO HAVE USED EXTERNAL SOURCES OF SUPPORT:**14. How do you work with/alongside the external service?**

? Probe for details on the nature of the relationship with each service (eg, employer referrals to the external service; consultancy/advice, inc workplace visits by external service)

How relationship was established

? Probe for what facilitates/impedes the establishment of the relationship

? Probe for what facilitates/impedes the operation of the relationship

? Probe for whether and how this relationship could be improved or extended?

15. Would you welcome (more) support in developing ways of managing sickness absence and putting it into practice?

What kind of support would be beneficial, internal or external?

? Probe for reasons

? Probe for ideas about possible sources of support (general and/or specific examples)

? Probe for ideas on establishing and conducting effective working relationships with external services

16. Finally, do you have any other thoughts, comments or suggestions that you would like to offer?

Thank you very much

Remind about confidentiality and use of the data.

Check if interested in receiving summary of the research report.

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