

Health and Safety Executive Board Paper		HSE/07/62	
Meeting Date:	6 June 2007	FOI Status:	Fully open
Type of Paper:	Above the line	Trim Reference:	2007/12281
Exemptions:	Post-meeting		

HEALTH AND SAFETY EXECUTIVE - The HSE Board

Health & safety in HSE - Review of sickness absence management

A Paper by Tim Beaumont

Advisor(s): Peter Brown, PG; Peter Brown, HRD; Statistics Branch; Business Partners

Cleared by Justin McCracken & Vivienne Dews on 1 June 2007

Issue

1. The strategy and way forward for sickness absence management in HSE. This paper looks at reporting, policy and future developments in the area in the light of current headline sickness absence statistics in HSE. The paper looks at why we are not seeing a reduction in absences, what the current statistics tell us and what we know of experience at ground level.

Timing

2. For discussion at this Board meeting

Recommendation

3. The Board may wish to discuss the broad conclusions of this paper shared by HRD & PG that our policy & procedures meet current best practice, but more needs to be done to ensure these are applied consistently. Board members may want to reflect on how best to achieve this in their own areas. In addition the Board may wish to agree:
 - to merge well being initiatives with sickness absence strategy;
 - new sickness absence performance indicators including extending the target of 6.2 days absent/staff member to 2010; and
 - to support the proposal that line managers, HRD & HSE's occupational health service work together to act on the findings of the statistical analysis of sickness absence in HSE.
 - that the findings of the statistical analysis in the paper be fed back to Directorates and taken into account in revision of stress action plans.

Background

4. HSE's Managing Attendance Strategy was re-launched in April 2006. This places an even greater emphasis on rehabilitation and early management intervention in line with Cabinet Office recommendations and accepted good practice. In support, revised Managing Attendance policy and procedures were published on the Intranet, an interactive e-learning training package was launched, e-HR has provided simplified and real time sickness absence reporting and enhanced management information; and refresher training workshops have been rolled out across the country to all line managers.

5. Feedback from the Managing Attendance courses has been very encouraging and they have been well attended, including by our senior managers. They have provided useful refreshers to line managers increasing confidence and reassurance in their rights and responsibilities when managing and communicating with staff before potential and during actual absences; as well in other areas of devolved management. Some areas of guidance have been updated and clarified in response to points raised; and managers have welcomed the face to face contact with HR and the opportunity to discuss real issues and cases. HRD plans to maintain this momentum by conducting proactive interventions into all our remaining long term sickness absence cases.
6. Other recent developments include a briefing to the Civil Service Steering Board (CSSB) which suggested merging the work streams on sickness absence and well being (see para 16 below)

Argument

7. Overall HSE target: For details on the production of this target see Annex 2. **It is proposed that HSE retains 6.2 as its sickness absence target to be achieved by 2009/10 with appropriate interim annual targets.**
8. Indicators for regular reporting: See Annex 2 for details. Overall this paper recommends that the Board adopts the following performance indicators:
 - **A three-monthly, annualised, rolling indicator of absence - presented in the monthly health & safety report.**
 - **The projected year end absence rate, based on days lost in the year to date - presented in the balanced scorecard with RAG rating.**
9. Analysis of absence in HSE: Annex 3 is an analysis of absence in 2006/07. It identifies points of particular interest:
 - i. Sickness absence in is higher in older age groups
 - ii. Women are more likely to be absent, particularly in the long term and through stress
 - iii. Reducing sickness absence at Bands 5 & 6 would be most effective in overall absence rate; reducing absence at Bands 2 & 3 would be most effective in reducing overall costs of absence
 - iv. Many absences are recorded as 'Symptoms ill defined' on e-HR
 - v. Significant levels of short term absence relate to minor illnesses
 - vi. There are localised absence issues around the country and within Directorates

Addressing the issues raised by i-v will need a blend of national and local approaches. Item vi. requires action by local senior management based on advice from OHS and HRD.

10. Benchmarking: Assessing how much sickness absence an organisation like HSE should expect – benchmarking with similar organisations, or looking at internal demographics and extrapolate likely levels of absence.
11. There are a number of industry comparisons of sickness absence. One of the more recent is produced by the CIPD for absence in 2006:

Category	Rate	Category	Rate
Manufacturing	8	Local Govt	11
Construction	8.3	Central Govt	10.5
Call centres	9.1	HSE	8.9
Agriculture	9	Public services	9.9
Financial services	5.6	Survey average	8

HSE is below the average for central government and public services but above the survey average and the average for financial services.

12. In 2005 Statistics Branch commissioned a survey of sickness absence known as 'SWASH'¹. This found that when other factors were eliminated the difference between public and private sectors were actually not great. The biggest predictors for sickness absence were size of organisation, gender and age. Large organisations employing more women than men and more people in older age ranges would have higher rates of sickness absence.
13. HSE demographics are included in Annex 3. HSE's male/female ratio is closer to the private sector than the public sector averages. HSE has a slightly higher than average percentage of staff in older age ranges and is an organisation of more than 250 staff. When these factors are taken into account the SWASH analysis suggests HSE has more absence than should be expected. Specifically female absence is particularly high. However the SWASH report did not consider some factors such as time in post which is believed to push up absence.
14. Some background demographic figures may also affect absences. For example there are marked regional variations in cardiovascular disease. When considering localised interventions these background factors will need to be considered.
15. *Policy issues*: In March 2006 and again in early 2007, the Board considered a menu of more innovative actions recommended in certain circumstances by the Cabinet Office Ministerial Task Force (which HSE led on developing). On both occasions, the Board recognised that many measures had already been adopted in HSE and that both the more extreme punitive and "reward" options did not fit with HSE's circumstances and culture. In the April 2007 meeting, the Board concluded that the Managing Attendance Policy was robust and that the focus now needed to be on joining up our thinking across sickness absence and wellbeing.
16. Annex 1 sets out the CSSB checklist for Departmental and Agency Boards on handling sickness absence and improving employee well being, with a commentary on HSE's position. Of the 23 recommendations in the Annex, only 8 possibly require extra action by HSE. These relate not to changing policy but to greater accountability and targeting of absences, particularly through the management chain and improved joined up working on health & well being.
17. However, although there is some evidence that long term absences are beginning to reduce, better intelligence and monitoring of the levels of adherence to the policy in the business is required. Arrangements are being put in place by the HR Service Centre and Business Partners, through statistics and on the ground evidence, to identify absence hot spots and reasons behind them, levels

¹ See www.hse.gov.uk/sicknessabsence/swash2005.pdf for a summary report from the survey

of compliance and adoption of the new culture, levels of management accountability, and example of good and bad practice. Initial feedback from Business Partners from the Directorates is provided in Annex 4.

18. The sickness absence practice is also being audited to assess the level of compliance across the organisation. This audit is due to report back in the next few months. The findings should help identify if practice needs to be brought in line with policies.
19. *Well being agenda*: The health, work and well being strategy was launched in 2005. So far HSE has some high level activity: e.g. the work of the stress working group, health screening for the over 50s and therapeutic interventions. There are also some examples of local activity - health seminars, ad hoc well being requests. The 'Caring for the Future'² document requires government to set an example and HSE as one of the drivers of this work must be sure it is leading the way.
20. The main change required in HSE is to mesh the work on sickness absence with well being and to maximise the impact this work has on HSE staff. Work also needs to be targeted where sickness absence is highest. Well planned health initiatives need to complement effective people management to achieve the maximum impact on absence levels. The first step of this meshing is to set up a sickness absence task group made up of relevant staff from HRD and representatives from Directorates. This group will help coordinate the work across the organisation.
21. Targeted interventions need to be part of this strategy. The statistics analysis in this paper show that screening for the over 50s is a sensible move given the higher levels of absences found in that age group. The analysis suggests that future well being initiatives need to look at women's health, particularly stress and depression to try and reduce the levels of long term absence in this area. There are some areas where a shorter term localised initiative may be suitable.
22. The new occupational health contract can accommodate this activity. In addition to the existing onsite work, HSE has factored into the contract 80 days pre year of OHA on-site time dedicated to health promotion and well being. How best to use these days will be the focus of the first contract meeting with Capita on 15 June 2007. Capita can offer a range of solutions, including targeted localised initiatives based on absence/incident data. A fuller description of Capita's services is in Annex 5.
23. Planned interventions are only part of the picture. The well being agenda requires HSE to consider issues like motivation and staff engagement. The findings of the recent staff survey complement the statistics set out in this paper. The findings of the analysis need to be fed back to Directorates to allow them to review and update their existing stress action plans.

Consultation

24. Statistics Branch; Human Resources Division – Service Centre, Strategy & Policy, Process Information & Reporting Team & Business Partners; Policy Group – Health & Work Division

² See www.dwp.gov.uk/publications/dwp/2005/health_and_wellbeing.pdf

Presentation

25. This is an important reputational issue for HSE. We need to have clear consistent messages about our targets and our actions. Sickness absence management and well being need to be seen positively within the organisation. The benefits to culture and credibility of low absence levels need to be part of what is said to staff. Our communications need to emphasise our determination to tackle absence by focusing on improving well being, while being willing to take a tough approach to any unjustified absence.

Costs and Benefits

26. It is estimated that sickness absence cost HSE £3,957,845³ in 2006/07. Assuming that absence is reduced in a proportional way across job bands then reducing annual sickness absence to our target level of 6.2 could save HSE £1,212,848. On this basis each reduction in the annual absence rate of 1.0 releases savings of £449,203.

Financial/Resource Implications for HSE

27. This paper proposes no extra expenditure. There is already money in the occupational health budget for well being activities. The work of the absence task group will identify if there is any need for extra expenditure in this area. If this is the case then the matter will be presented to the Board with a full cost analysis.

28. Extra emphasis on sickness absence will mean that HS needs to look carefully at priorities in other parts of the work-stream. HRD and the Board Champion for Health & Safety will carry out this work. This paper makes a strong financial argument that sickness absence should be the top health and safety priority for the organisation.

Action

29. This paper marks a significant change in the sickness absence story in HSE. HR has brought the policy up to date and has provided training for managers. Once the Board has agreed the recommendations in the paper the action shifts to the Directorates. HR will support the Board decisions and lead on coordinating delivery in the organisation. Part of this will involve the regular meeting of the recently established sickness absence task force which will involve HR Business Partners. This will be the main way that Directorates will start to take more ownership of delivering improvements in sickness absence. Directorates will also need to ensure that absence performance is included in performance agreements.

30. These are significant changes for HSE. Seeing a reduction in sickness absence is one of the main priorities for HRD in the coming work year, but it can't be done unless Directorates are fully involved.

³ Costs are direct salary costs only.

Annex 1 - A healthy and productive work force - Checklist of good practice for boards

This is not yet compulsory guidance but compliance with it will give us an indication of the extent to which we adhere to what we tell other companies to do.

*The current situation in HSE is highlighted throughout. When HSE already adheres to the CSSB guidance the commentary is in **green**. When HSE partly adheres the commentary is in **amber**. Where there is significant discrepancy between the CSSB guidelines and HSE practice this is highlighted in **red**.*

Introduction

There is much good practice across the civil service and wider public sector on how to handle sickness absence, and improve employee well-being and motivation. It is important that Departments and agencies think carefully about their own circumstances and strategies. But the following checklist is intended to support Boards in this task. We suggest that all Boards benchmark their current procedures and systems against it.

Checklist

Monitoring, Measuring and Understanding

Boards should ensure that they have:

1 **Good information systems** on absence management. An effective flow of information on sickness absence will include:

- The overall number of days lost to absence;
- The costs (money and productivity) of absence to the organisation;
- Absence broken down by region, department and workforce demographics;
- duration, so that a clear distinction can be drawn between long-term and short-term absence;
- Analysis by type of absence.

GREEN - Most of this data is supplied in the monthly statistics report that goes to Board. This paper contains a fuller analysis of data (see Annex 3).

2 **Clear policies and procedures** on who is responsible for recording the absence of their staff and assuring the quality of data. Best practice is for line managers to be responsible for absence reporting.

GREEN - This takes place in HSE. The process is set out in HR guidance associated with e-HR.

3 **Set Targets** that reflect real circumstances, levels and causes of short-term and long-term absence and whether the absence is work related. Managers at all levels need different targets that reflect performance, the nature of the work and the mix of grades and gender.

AMBER - HSE has an overall headline target. There is no consistent picture of interim targets or directorate/divisional targets are set.

4 **Clear lines of accountability** – so it is clear who is responsible for the delivery of targets and to whom they are accountable. Performance management systems need to make sure that managers are assessed against their absence targets. A Board member should have specific responsibility for attendance management. Non-executive directors or the audit committees need to be asked to give reassurance that policies and controls reflect operational and reputational risks;

AMBER - Accountability for absence performance is only beginning to take place in HSE. HSE does have a Board champion for absence (Vivienne Dews) and an assessment against sickness absence policy is in progress.

5 **Effective Analysis and diagnosis** - information systems need to be designed so that the boards and managers can interpret the data and monitor levels or types of absence, demographic factors and trends. There is greater scope for benchmarking against comparable private and public sector organisations;

GREEN - The introduction of e-HR allows HSE to comply with this recommendation

6 **An understanding of costs** – Boards need to measure the costs of absence costs by department/operational unit and the impact of days lost on performance and productivity.

GREEN - This is part of the information that e-HR can provide the Board and Directorates with.

Managing Absence When it Happens

Boards should ensure that they have procedures in place so that:

7 Staff **contact** their line manager on each day of self-certificated absence;

GREEN - Contained in HSE sickness absence policy

8 **Informal return to work interviews** happen after every period of short-term absence, and that **formal, documented**, return to work interviews happen where absence is over seven days;

GREEN - Contained in HSE sickness absence policy

9 **Certification** is required if the number of short-term absences exceeds (e.g.) five in twelve months;

GREEN - Contained in HSE sickness absence policy

10 **Reference to occupational health** is compulsory in cases where absence reaches a “trigger” level in a twelve month period, to pick up early signs of longer term problems and issues;

GREEN - Contained in HSE sickness absence policy. Referrals are also required when the absence relates to musculo-skeletal problems or stress.

11 **Persistent Monday or Friday** absences are flagged up to managers;

AMBER - This is possible but not proactively carried out centrally. The requirement is for managers to spot any absence trends in their own staff.

12 **Pay effects** are considered for staff who fail to certificate after absences of more than five working days;

GREEN - Unauthorised actions are already deducted from pay. The issue is how frequently this occurs.

12 **Clear case management** structures are in place for long term cases.

GREEN - Part of existing sickness absence policy.

13 **Line managers** have very precise guidance, and the necessary training, to know what they are meant to do in response to sickness.

GREEN - Part of existing sickness absence policy. The recent round of managing attendance seminars have given extra training to managers.

Promoting a Healthy Environment and Culture

Boards should ensure that they have:

14 **Diagnosed** the problems and developed responses. By measuring the kinds of illness that are contributing to absence levels, Boards should devise specific actions to reduce the incidence of such illnesses, with advice from occupational health specialists about action to reduce health risks.

AMBER - Stress has long been recognised as the major cause of absence and this paper backs up that view. HSE has specific workstreams already in place looking at stress and musculo-skeletal disorders. There are ways to improve. There are still a high proportion of 'symptoms ill defined' absences which could be reduced giving better understanding of why people are going off. Also localised targeting of intelligence has yet to take place.

15 **People strategies** that take account of the health of the workforce as a factor in strategic management thinking;

AMBER - This does take place to some extent. Office moves and the role out of IT systems do consider staff health. However the level to which this takes place across all management decisions and the impact this has on the ground may be mixed. For example health was considered during the COIN project but after launch it was clear that there were health concerns about the new system.

16 **Health promotion strategies in place** - Employers have a duty of care to minimise risks to health in the workplace. Boards need to be visible in promoting workplace health through initiatives to reduce the incidence of smoking, obesity and diet and increase exercise, as well as specific actions to address stress and musculo skeletal problems.

AMBER - There are a number of health and wellbeing strategies in place aside from day to day management of all health issues, including specific stress and musculo-skeletal activities. The over 50s health screening, smoking cessation, well men and women seminars and some other ad hoc initiatives have all taken place across the country. These need to be joined up into an overall strategy that is properly targeted where sickness absence is at its worst. Diet and exercise have not recently been specifically targeted.

17 **Considered the impact** of specific measures on health and absence:

- Assessments of workplace comfort and the appropriateness of workstations;

GREEN - Extensive DSE assessment process already in place

- Action to make reasonable adjustments to comply with the Disability Discrimination Act;

GREEN - Reasonable adjustments part of the OH strand of work

- Action to improve the mental health of the workforce;

AMBER - Action on work related stress in place and availability of a staff counsellor but no further work yet done on wider mental health issues.

- Programmes to encourage health checks and guidance on healthy lifestyles – “well man” and “well woman” clinics;

GREEN - These have taken place, but see the response at paragraph 16

- Action to make managers more aware of the factors that drive absence and the steps they must take to manage this effectively – especially in times of rapid change.

AMBER - More management awareness of likely absences at time of change needed.

18 **Considered change management** approaches that

- i. give staff have a voice in the process and explore the scope for giving staff more varied work, extending their responsibilities to make work more interesting and improving productivity;

GREEN - This perspective is within HSE policies but there may be debate over the extent to which this takes place in reality.

- give staff more control over the pace of their work and the opportunity to influence decisions that affect them directly.

GREEN - Staff consultation does take place about work across the organisation.

Annex 2 – Sickness absence statistics

1 – Headline target for HSE

HSE has a long standing target on sickness absence – 6.2 days/staff member. The target pre-dates the Cabinet Office report ‘Managing sickness absence in the public sector’ which was published in November 2004. The target first appears in mid-2004 where it is included as part of the range of efficiency activities set out in Commission paper HSC/04/087 & annex. These efficiencies relate to the savings required by the 2004 Spending Review. The target of 6.2 equates to a 25% reduction on 2004 figures.

There is a target in the Cabinet Office publication of 2004 at paragraph 1.16 of reducing

‘the number of working days lost per 100,000 workers by 30% by 2010. This is in line with the targets agreed after the 1998 study and would represent, on average, around 7.5 of days of sickness absence per person.’

This target relates to the Revitalising target of reducing days lost to work-related ill health & injuries by 30% from 1999/00 to 2010. If HSE was to use 1999/00 as a base line then a 30% reduction in absence would be 6.5 days per person by 2010. A 30% reduction of absence as recorded in 2004 equates to 5.81 days, a low level for any sector.

Barring exceptional circumstances it is unlikely that HSE will achieve absence levels of 6.2 days by the end of this year. This means that we would not have achieved some of the efficiency savings we were hoping to. Furthermore the target has no validity after the end of the year. It was introduced as part of a time bound efficiency package which ends this year. HSE needs a new clearly focused and defensible sickness absence target for the start of the next work year.

Cabinet Office is looking for a 30% reduction by 2010 which equates to 7.5 for the civil service and 6.5 for HSE specifically. The data from the SWASH survey supports this. The prediction from this data is that HSE could expect a sickness absence level of around 6.5. This indicates that a target of 6.2 is reasonable for HSE to aim for. However to bring it into line with the original Revitalising premise behind it, it is proposed that HSE aims to achieve this annual rate by 2010. Given that absence for all of 2006/07 was 8.9 HSE needs to see an annual reduction of 0.9 in absence rate each year between now and 2009/10.

To summarise the annual targets for absence should be:

Year	Absence rate
2006/07	8.9 (actual)
2007/08	8.0 (target)
2008/09	7.1
2009/10	6.2

2 - Proposed new indicators – monthly & balanced scorecard

a) Current situation

The Board receives two sources of information on sickness absence performance in HSE – monthly Board health & safety statistics report and the balanced scorecard. These reports contain a mixture of ‘snap-shot’ information and ‘indicator’ information. The snap shot information is intended to highlight to Board members absence hotspots that require action. Indicator information is intended to give the Board a feel for what the overall, headline performance is on sickness absence in HSE. These proposals refer to changes in the indicator information.

There are two main indicators:

i) Twelve monthly rolling indicator – This is calculated as:

$$\frac{\text{(Total days absence over previous 12 months)}}{\text{(Average staff in post over previous 12 months)}}$$

This indicator smooths out seasonal variations but concerns have been raised by Statistics Branch over its validity as an indicator. The reporting of this indicator should be based on the midpoint of the 12 months rather than the final month. This would mean that indicator would always refer to a time period six months prior to the reporting date. This would not satisfy the requirement that the Board has of an up to date headline piece of information.

ii) Balanced scorecard indicator – This is calculated as:

$$\left(\frac{\text{(Total absence over three months)}}{\text{(Average staff in post WTE over three months)}} \right) \times 4$$

There was a difference in the raw data used for this indicator from that used for the 12 month rolling indicator. This was only resolved in 2006 so only recent balanced scorecard results can be compared to the rolling indicator. ‘RAG ratings’ have not been routinely set for this indicator. Furthermore it does not relate to the overall position for the year, merely what the levels have been in a particular quarter. This does not help the Board get a feel for whether HSE is on target or not.

b) Recommendations

i) Monthly indicator

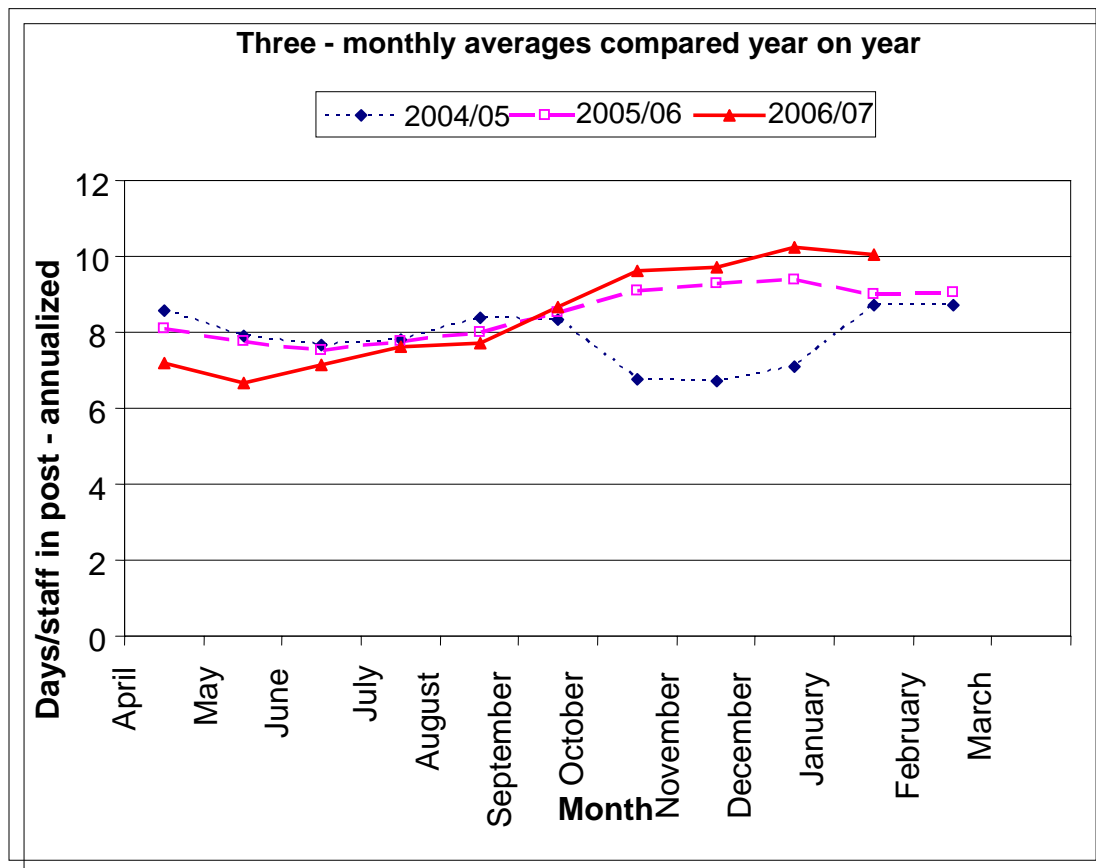
This paper recommends that the Board sees a three-monthly, annualised, rolling indicator. This indicator would be an average of the absence in the previous three months which have reliable data available (i.e. late reports have been submitted). The absence levels would be multiplied by 4 to give an annual level of absence.

Board members would also be able to spot improvements by comparing the current year with previous. As sickness absence comes down the current year indicator should be below the previous years. The problem of centring is also resolved as the data can be presented with the average centred on the previous month, the mid point of the collection period.

An example graph using this year’s data is given on the next page. In effect the most recent data point (February 2007) is the rolling average of January, February and March 2007, centred on February.

The graph shows that by the year end 2006/07 is considerably worse than previous years with sickness absence rising. This presentation would show the Board that a

problem was emerging in October 06. The current 12 monthly indicator didn't show any emerging problems until January 07.



ii) Balanced scorecard figure.

This paper proposes that the BSC contains a figure that allows the Board to see whether HSE is on target or not. The figure should show what the likely year end absence rate would be, should days lost continue at the rate found within the year to date. This way the Board will be able to recognise whether HSE is running 'hot' for absence early on and direct their attentions to the problem. It will also be possible to RAG rate the figure using the proposed target of 6.2.

The following example should illustrate. Assuming staffing remains at approximately 3,700 then in order to achieve an end year rate of 6.2 days per staff member, HSE could expect to have around 1900 days absent per month. If this has been achieved in the year to date at the end of the each quarter then the BSC would have a rate of 6.2 and a RAG rating of green/amber. This differs from the current BSC which only reports on what the absence rate was in each quarter rather than linking the quarter's performance with the year as a whole.

Seasonality would need to be considered in this. The main peaks of absence are found in the 3rd to 4th quarters so the absence spread over the year could be adjusted accordingly.

Annex 3 – Snap shot of sickness absence in HSE at end of 2006/07

1. A detailed review of sickness absence in HSE was requested by the Board. Using data mined from e-HR and a piece of software known as Business Warehouse, it has been possible to look at absence in some detail. The data given in the following graphs is taken for the whole of 2006/07. It gives a detailed break down of where the absence hot spots were in the organisation.

2. Detailed breakdown:

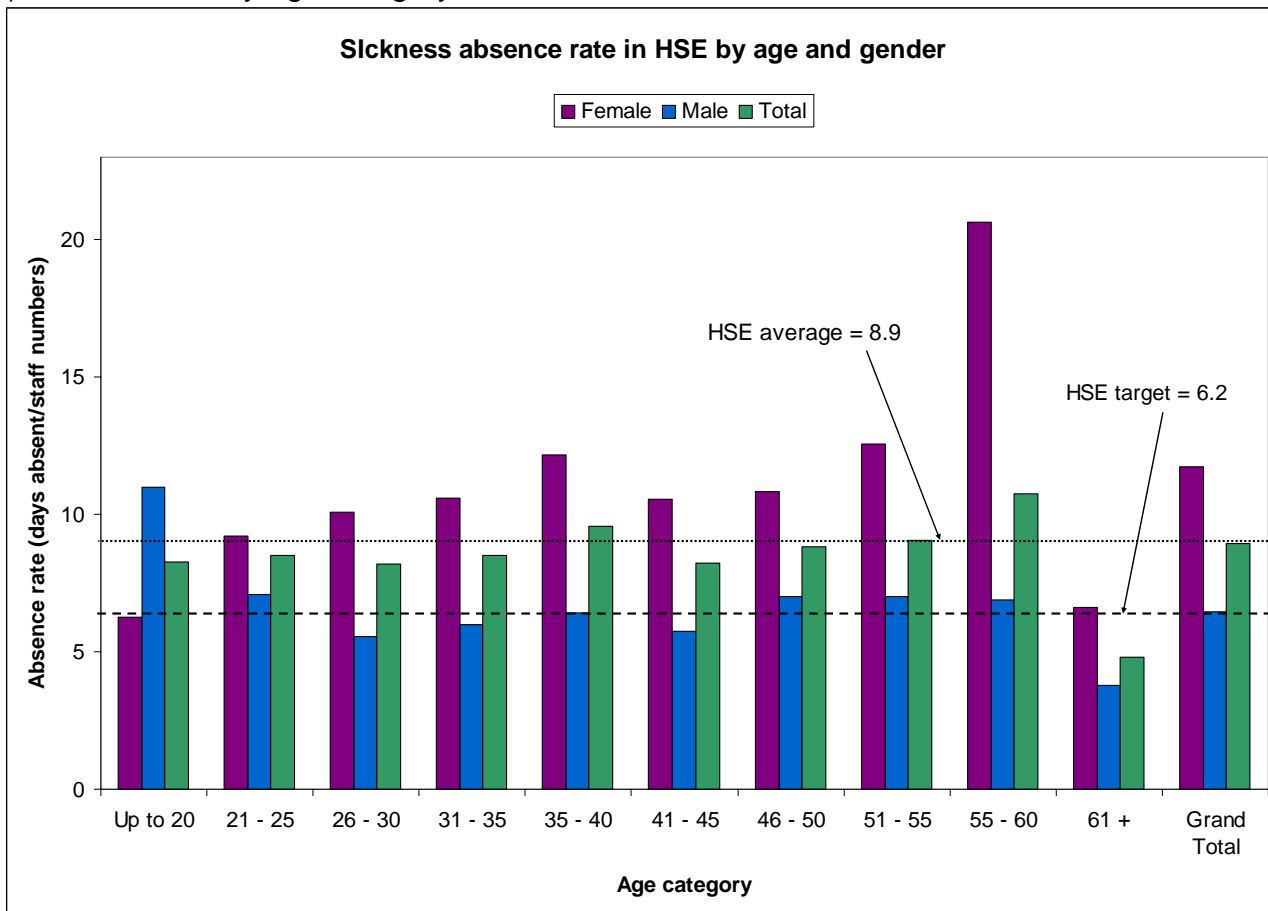
3. For 2006/07 the headline details are in the table below:

2006/07 Year end figures	Female	%	Male	%	Total
Staff in Post	1790	47.0	2022	53.0	3812
Days absent	21018	61.7	13059	38.3	34077
Absence rate	11.7		6.5		8.9
Cost ⁴	£1,303,201	53.2	£1,147,410	46.8	£2,450,611

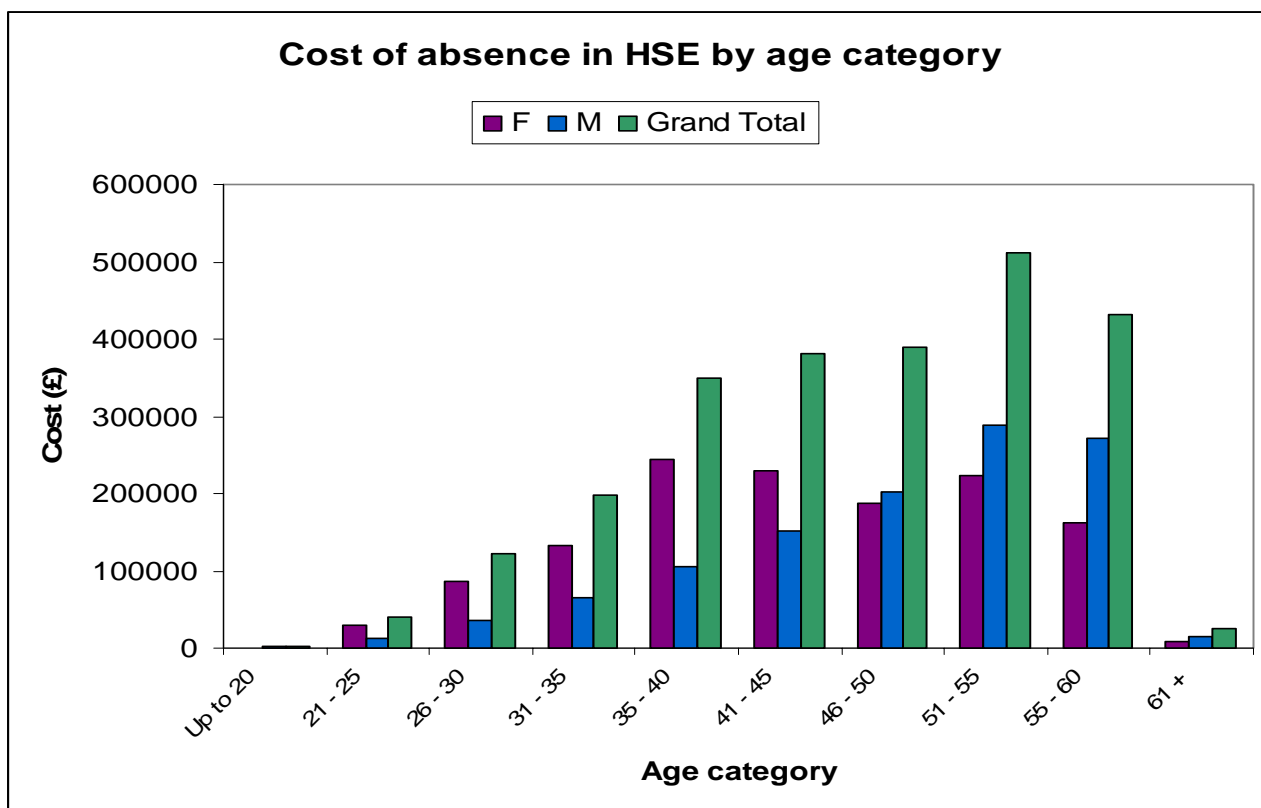
4. The point to note is that female absence exceeds male absence considerably, although HSE has proportionally more men on staff. The cost of the absence is slightly more balanced.

⁴ Costs calculated from direct salary cost of job band.
Page 13 of 29

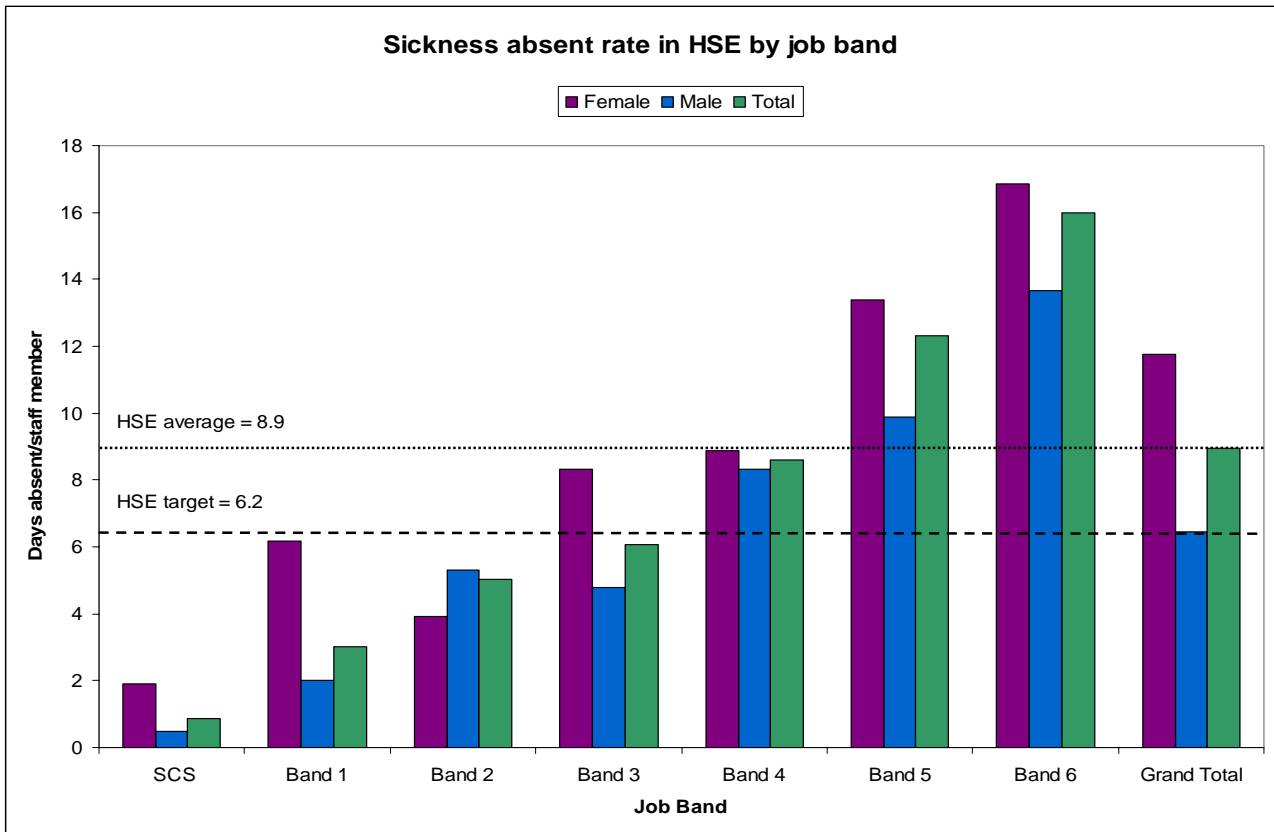
i) Absence rate by age category



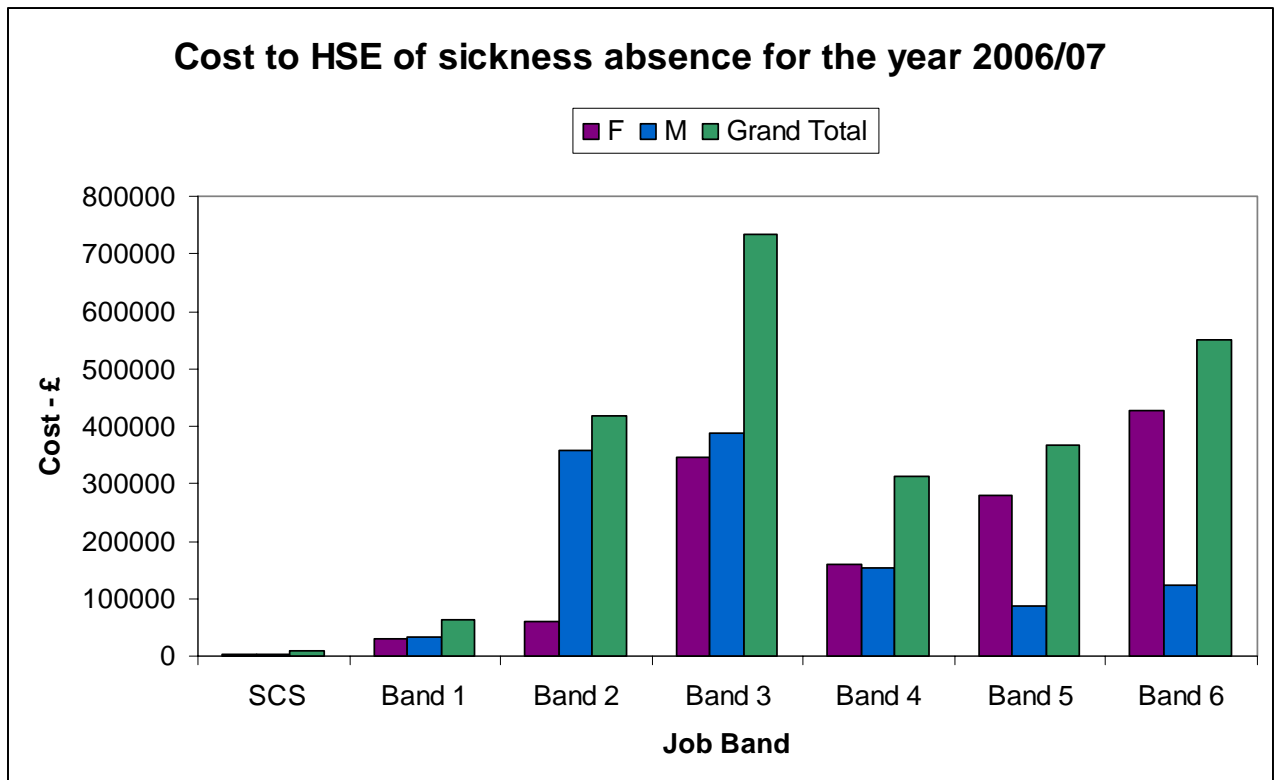
ii) Cost of absence by age category



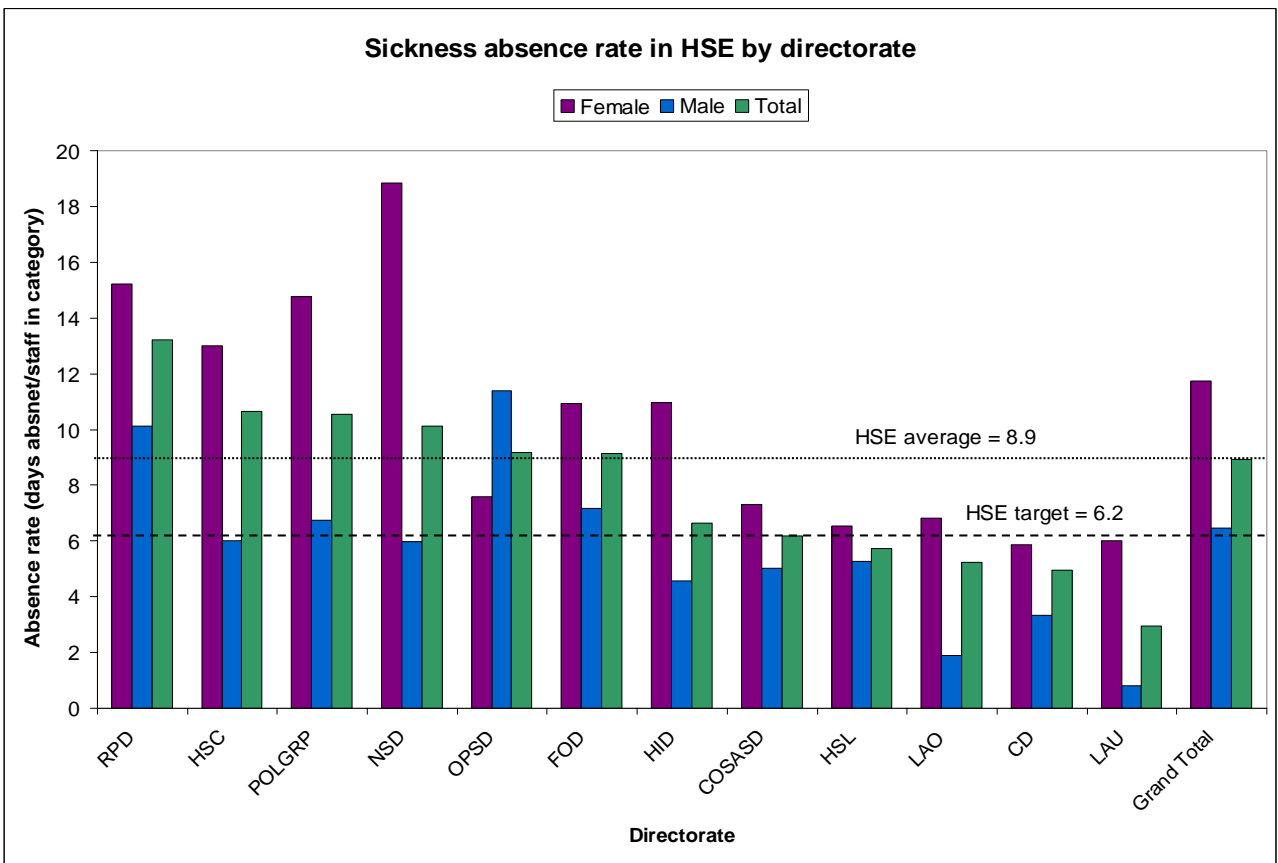
iii) Absence rate by job band



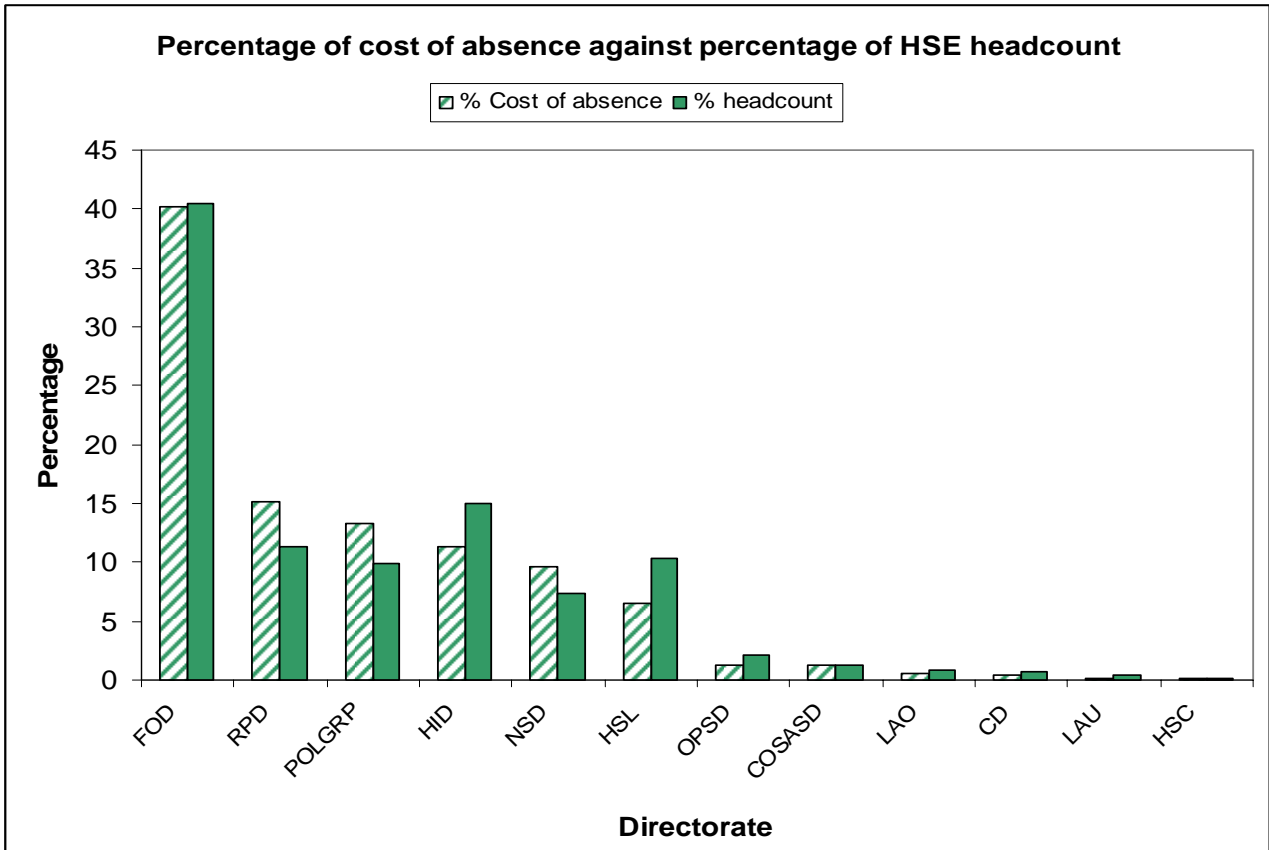
iv) Cost of absence by Job band



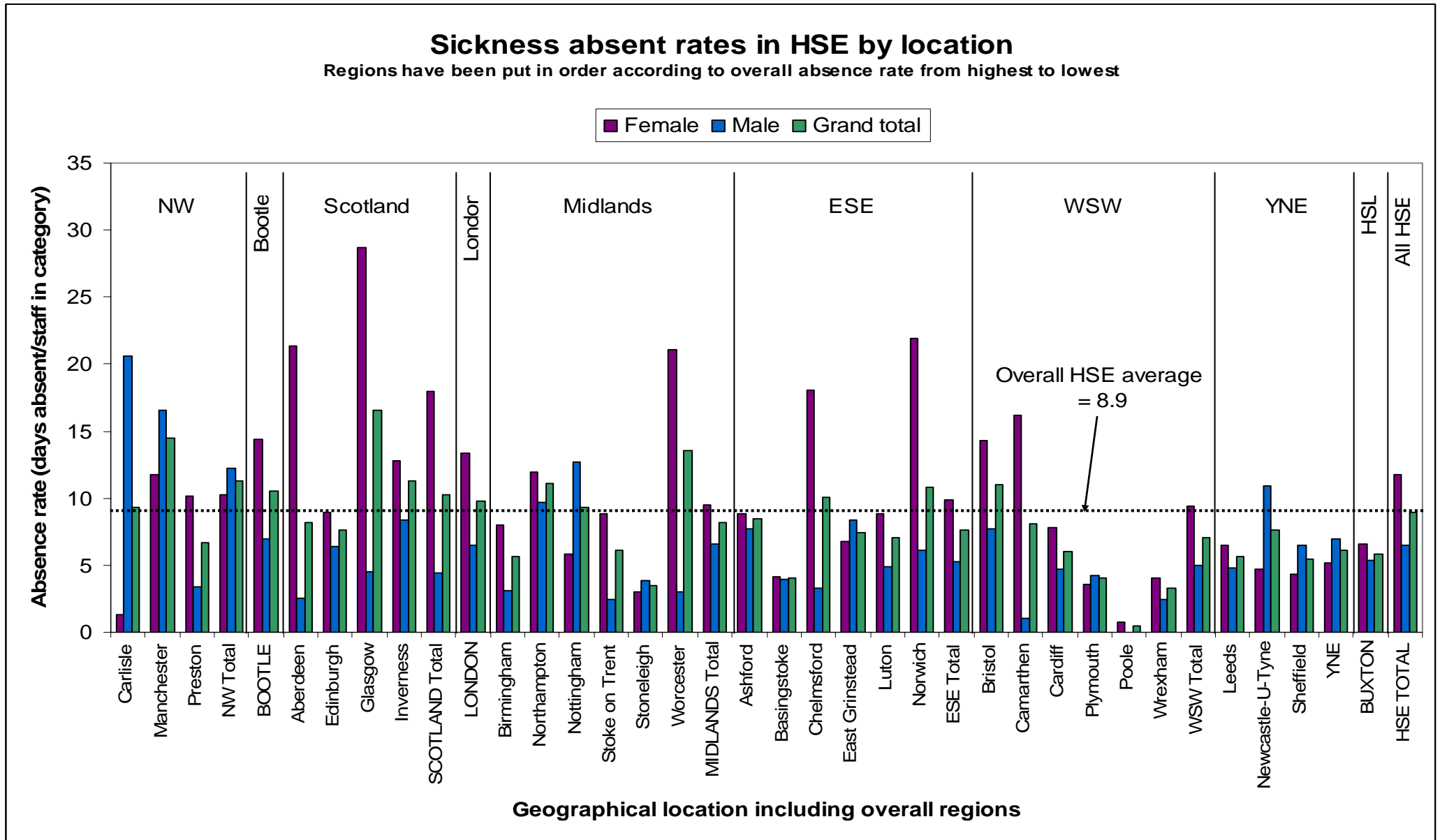
v) Absence rate by directorate



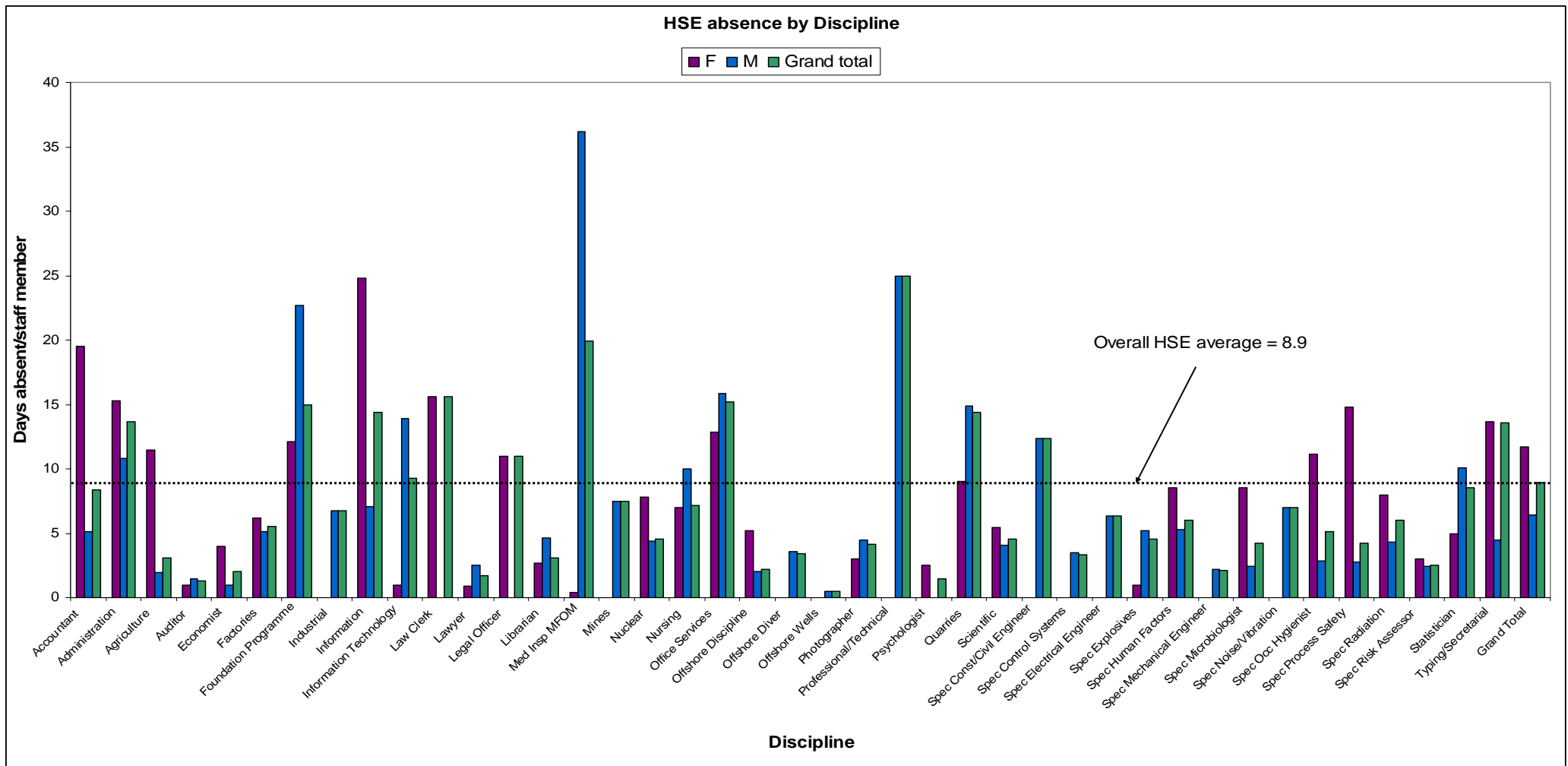
vi) Percentage cost of absence by Directorate



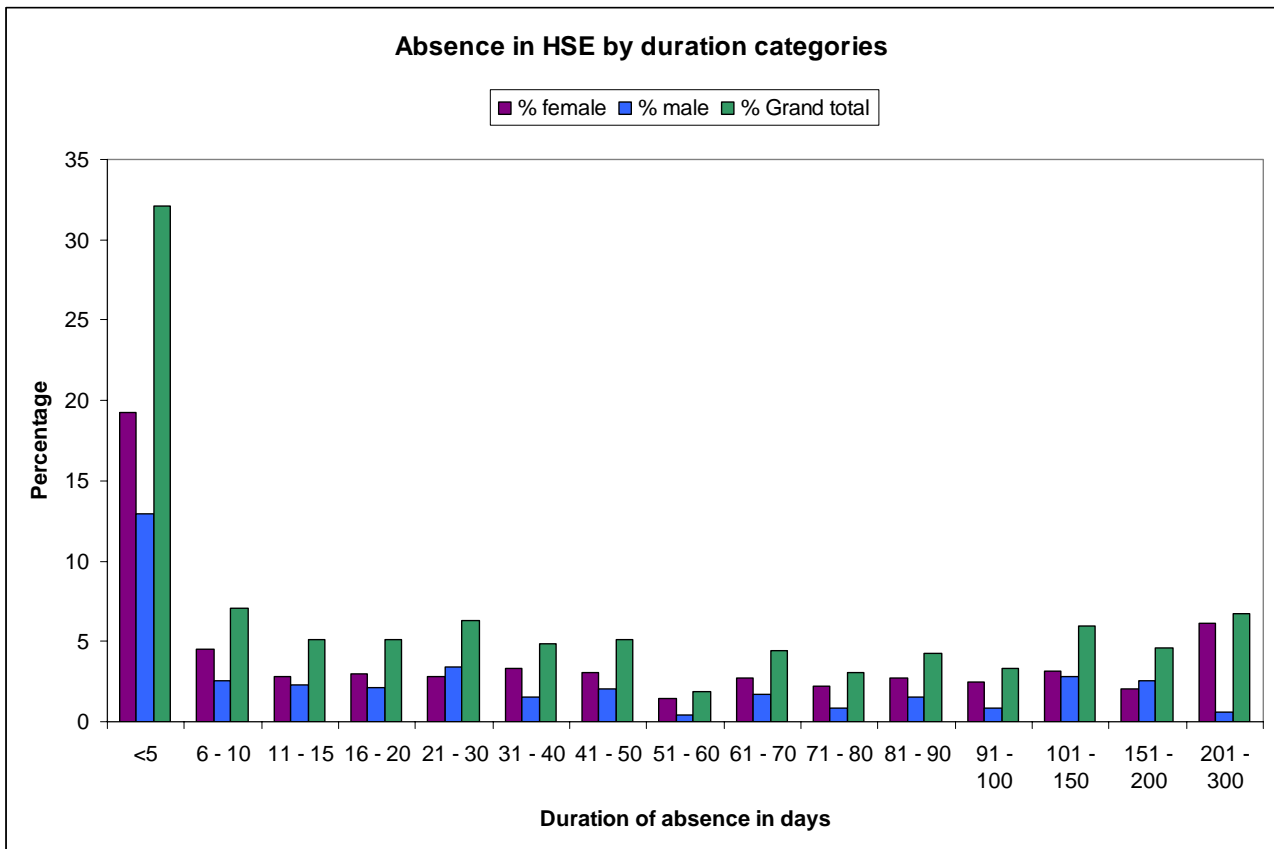
vii) Absence rate by geographical location



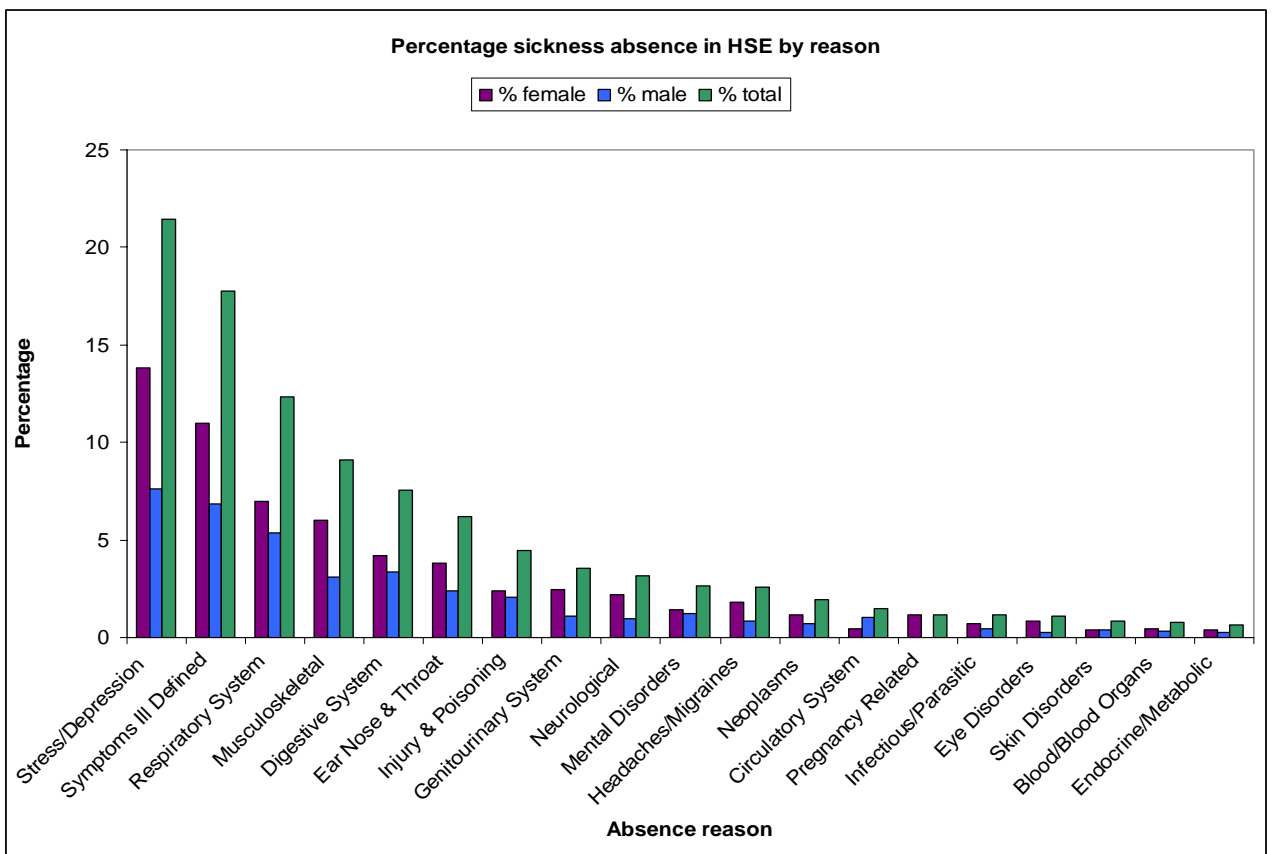
viii) Absence rate by discipline



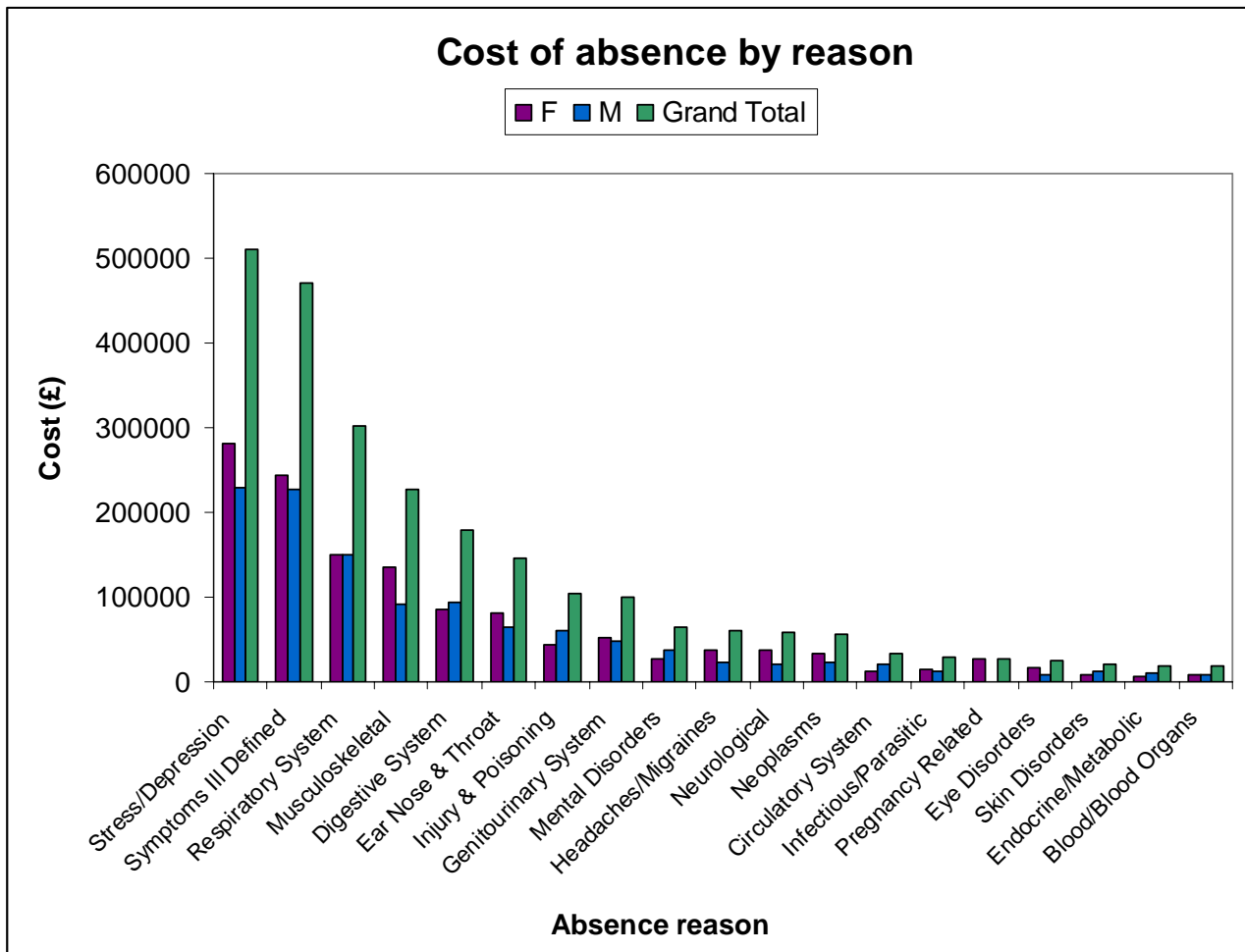
ix) Percentage absence by duration



x) Percentage absence by reason



xi) Cost of absence by reason



5. The above information gives rise to the following observations:

- Although men outnumber women in HSE the amount of absence attributed to women is more than the amount attributed to men.
- Looking at the age break down, the general picture is that female absences are well above the average and the HSE target. Male absences are well below the average and in some cases below the HSE target. The category with the highest absence rate is 55 – 60 age range.
- Looking at job bands, most absence is found in Bands 5 & 6 for both men and women. This indicates that job band is more of a factor than gender. Absence performance in Band 3 to SCS is already below the HSE target of 6.2.
- When cost of absence is factored in the situation becomes more complex. Band 3 absence costs HSE more than any other category. The bulk of the cost at Bands 2 & 3 comes from male absence, particularly relating to men 46 and over.
- Looking at Directorates, of the 12 directorates listed 5 are already below the 6.2 target level. RPD has the highest overall absence rate. OPSD is unique in having more male absence than female. The most marked gender divergence is in NSD. Of the Directorates with more than 250 staff members, only HID is below the HSE average and is in actual fact close to the 6.2 target. Looking at the costs of absence, RPD, PG & NSD all account for a higher proportion of absence costs than would be expected.
- When looking at location, the poorest performing region is the North West followed by Bootle, Scotland and London. There are some striking individual results. For example,

female absence rate in the Glasgow office is very high, whereas the male absence rate in Carlisle is also considerable. This data is useful for finding problem areas but does not give clarity over the roots of some of the national trends.

- The data for job discipline is derived from pay categories. Again the main function of this data is to highlight hotspots rather than illustrate overall trends. The results are consistent with the chart focusing on job band as the categories which are mainly Band 5 & 6 (e.g. administration) show higher rates. Some of the smaller disciplines have very high rates. In some cases this is due to the low numbers of staff present.
- The absence by duration shows that 32% of absence is less than 5 days and 34% is found in spells of 51 days or more in duration.
- The highest reason given for absence in HSE remains as stress and depression at over 20% of reported absences. The only category where male absence is greater than female is circulatory disorders. 'Symptoms ill defined' is the second most popular category. There has been reduction in the number of absences categorised as this as a result of the training provided by HRD

6. Having looked at some of the headline trends, it is now possible to probe deeper into what the causes are. This is where the absence data can be genuinely used to help direct action. Some of the hotspots identified relate to individual offices or Directorates. The amount of analysis required to understand why, e.g. female absence in NSD is so high, would not be appropriate for this higher level paper. Such details are best supplied to the relevant organisational section. **One recommendation of this paper is that each Directorate and Division receives a complete breakdown of absence for 2006/07.** This statistical data needs to be combined with focused directorate level action to address the trends and hotspots identified.

7. However there are some areas where more information can be provided for the Board. The following table are designed to give more insight into some of the more significant absence trends. The figures in all the following tables are the actual days absent.

- (reason) x (duration) x (Bands 5 & 6)

Reason	Absence <5 days in duration			Absence >50 days in duration		
	Band 5	Band 6	Grand Total	Band 5	Band 6	Grand Total
Blood/Blood Organs Total	14	17	31	61		61
Circulatory System Total	12	26	38	72	181	253
Digestive System Total	430	690	1120			
Ear Nose & Throat Total	373	610	983			
Endocrine/Metabolic Total	3	14	17		51	51
Eye Disorders Total	23	38	61		72	72
Genitourinary System Total	74	65	139		87	87
Headaches/Migraines Total	169	301	470			
Infectious/Parasitic Total	59	104	163			
Injury & Poisoning Total	60	93	153	84	459	543
Mental Disorders Total	13	15	28		277	277
Musculoskeletal Total	165	262	427	294	252	546
Neoplasms Total		2	2	94	252	346
Neurological Total	12	48	60		577	577
Pregnancy Related Total	24	53	77			
Respiratory System Total	550	813	1363	86	264	350

Skin Disorders Total	10	34	44			
Stress/Depression Total	42	123	165	750	1736	2486
Symptoms Ill Defined Total	164	369	533	504	836	1340
Grand Total	2197	3677	5874	1945	5044	6989

- (reason) x (duration) x (over 50s)

Reason	Absence <5 days in duration				Absence >50 days in duration		
	Age 51 - 55	Age 55 - 60	Age 61 +	Grand Total	Age 51 - 55	Age 55 - 60	Grand Total
Blood/Blood Organs Total	16	6		22		61	61
Circulatory System Total	16	13		29	164		164
Digestive System Total	161	132	18	311			
Ear Nose & Throat Total	172	124	23	319			
Endocrine/Metabolic Total	4	14		18		51	51
Eye Disorders Total	8	12	2	22		72	72
Genitourinary System Total	26	18	10	54	147	189	336
Headaches/Migraines Total	79	49	5	133			
Infectious/Parasitic Total	36	28	1	65			
Injury & Poisoning Total	21	41		62	121	84	205
Mental Disorders Total		5	1	6			
Musculoskeletal Total	100	132	13	245	375	347	722
Neoplasms Total	10	5		15	190	51	241
Neurological Total	10	13		23		66	66
Pregnancy Related Total		2		2			
Respiratory System Total	361	295	32	688	75		75
Skin Disorders Total	4	6		10			
Stress/Depression Total	32	19		51	683	1141	1824
Symptoms Ill Defined Total	126	90	18	234	559	596	1155
Grand Total	1182	1004	123	2309	2314	2658	4972

- (reason) x (duration) x (gender)

Reason	Absence <5 days in duration			Absence >50 days in duration		
	Female	Male	Grand Total	Female	Male	Grand Total
Blood/Blood Organs Total	38	22	60	61		61
Circulatory System Total	22	41	63	92	253	345
Digestive System Total	1182	817	1999			
Ear Nose & Throat Total	1047	717	1764			
Endocrine/Metabolic Total	26	23	49	51		51
Eye Disorders Total	60	55	115	72		72
Genitourinary System Total	199	42	241	285	189	474
Headaches/Migraines Total	530	219	749			
Infectious/Parasitic Total	193	143	336			
Injury & Poisoning Total	146	167	313	382	282	664
Mental Disorders Total	30	33	63	141	136	277
Musculoskeletal Total	434	273	707	821	350	1171
Neoplasms Total	8	10	18	348	145	493
Neurological Total	70	32	102	396	181	577

Pregnancy Related Total	190		190			
Respiratory System Total	1568	1273	2841	243	182	425
Skin Disorders Total	50	24	74			
Stress/Depression Total	130	159	289	3085	1313	4398
Symptoms Ill Defined Total	631	345	976	1824	839	2663
Total	6554	4397	10951	7801	3870	11671

8. The tables show the clear distinction between the main causes of short term and long term ill health. Short term coughs, colds and tummy upsets cause the majority of less than 5 day absence. This reinforces the need for return to work discussions after every absence period, in line with HSE policy.
9. There is a shift to stress and depression as the main cause of more than 50 day absences. This effect is particularly pronounced in women, Band 6's and the over 55s. It is vital that the work on stress in HSE reflects this. Any internal stress campaigns need to ensure that these sectors of the workforce are engaged.

Annex 4 - Input from Directorates on absence strategy

Initial Feedback from Directorates/Divisions on the Management of Attendance following the introduction of HSE's revised Strategy in April 2006

Directorates have been asked for feedback on changes and improvements made in Managing Attendance on the ground following the introduction of the revised Strategy and the rollout of the training workshops. D/ds were asked to report on areas of good practice, emerging absence issues/hot spots, and their ongoing monitoring/compliance assurance measures in place. Whilst there is evidence of areas of good practice in HSE, progress still needs to be made to ensure that HSE is an organisation that manages absences well..

Feedback received was as follows:

How has the new Managing Attendance policy been applied in the last year, and particularly following the Managing Attendance workshops?

HSL: Managers taking more responsibility with an increase in OHSA referrals and in seeking of OHSA advice. They have also seen an increase in recorded sickness absence which may be due to raised awareness of reporting/recording procedures.

HID: Increased focus on sickness absence particularly since the workshops. Managers more ready to take action (as evidenced in Staff Survey), and queries raised to sources of support have increased.

ND/OPSD: Workshops well received raising awareness of need to proactively manage cases, and provided reassurance of support that will be available as managers handle cases. Increase seen in queries raised to sources of support.

In ND, there have been some recommendations for dismissal due to poor attendance (long and short term cases). Managers have found the HR support very helpful but feel the dismissal procedure remains time consuming and stressful (though no practical suggestions for improvement were offered).

The Business Partner fears that the formal sick leave review meetings following the 21 day/5 spells of absence trigger points are not being held consistently.

FOD: Managers in FOD found the Managing Attendance workshops extremely helpful and believe that they have made managers much clearer and more confident.

In February the BP was commissioned by the Director of FOD to produce a paper analysing long term sick absence trends and to review all stress related absences in the last year. The report provided extremely useful information, particularly in light of the feedback from the staff survey regarding bullying in the workplace, as it identified that there were no particular hot spots of stress related absence, it also identified that there had been no increase in Band 6 absence in the months since agency staff were lost. However in some cases it identified a lack of management action at an appropriate time. Since then, considerably more focus has been placed on this item at Divisional Management meetings and members of the DMT's are carrying out their role of appraisal manager by questioning and providing support to line managers over handling of cases of long term absence. The response tends to indicate that

appropriate action is being taken at the right time. FOD MB will be provided with an updated report on a 6 monthly basis.

PG: Feedback on the MA workshops has been very supportive and they were well attended by senior managers.

PG has recognised a toughening of attitude in addressing absence issues. There has also been an improvement in recent OHS reports.

However, evidence of senior management auditing of attendance activity is limited though most feel that this is being managed well.

RPD: Workshops have greatly improved awareness of policy and procedures. There has been particular success in reducing long term absence cases in HRD.

Are senior management teams ensuring that correct standards are being applied consistently?

HSL: SMT lead from top down. Improved consistency is expected as new team leaders are put in place.

HID: Sickness absence and key cases reviewed monthly at various levels of management meetings. Possible dismissals due to absence discussed.

NSD/OPSD: Senior managers discuss staff reaching trigger points at Divisional Management meetings (and the ND Management Board). MA is now being seen as culturally important and managers know they will be challenged on progress made with cases though perhaps this still needs to be more rigorous.

FOD: The introduction of the Monthly Management report has increased awareness and raised the profile of sick absence management in FOD. Each month FOD Management Board share and review the monthly Management report with their respective management team.

PG: Strong senior management support of the workshops. However, evidence of senior management auditing of attendance activity is limited, though most feel that this is being managed well.

How do D/ds use absence statistics to ensure progress is being made – what monitoring arrangements have been put in place?

HSL: Business Partner checks with line managers that appropriate actions are being taken when various trigger points reached. Areas of concern flagged for Board and more detailed absence statistics provided on a quarterly basis for Board discussion.

HID: Monthly statistics reviewed at Board meetings. April figures are within target.

ND/OPSD: Senior managers receive monthly absence stats including names of staff reaching trigger points. Line managers have welcomed the automatic e-HR trigger notifications.

RPD: Use of absence statistics and reports being cascaded down to middle managers in HRD who are asked to report on progress.

COSAS: Some concern that a more formal arrangement is needed to ensure HoD that procedures are being followed consistently.

What further support is still required?

HID: Bespoke management reports are generated from e-HR as required and this approach is working well.

ND/OPSD: Managers are happy with the general policy and their greater level of responsibility. However they feel that there is still room for improvement in the quality of advice from the HR Service Centre e.g. on options and reasonable courses of action.

Additional support required in the usage and awareness of management information report options on e-HR.

More support and guidance required on the management of long term cases.

FOD: A suggestion for follow up workshops to reinforce the MA message and good practice.

Issues have been raised regarding the service of the previous OH provider ATOS, the HR BP will be seeking regular feedback on the new provider. Concerns have been raised by FOD MB about how their teams will capture information regarding referrals as in the past this would have been held centrally by the H&S Coordinator.

There is a need to generate specific local sick absence statistics and reviews.

More guidance on how to record sick absence information such as reviews on e-HR, perhaps to be covered in any follow up Managing Attendance workshops.

Some members of FOD MB have requested a more readily available and robust specialist support from HR in handling the increasing number of really difficult cases.

COSAS: Would find the automatic trigger notifications being sent to appraisal managers as well as line managers useful.

Any areas of best practice that others can learn from?

HSL: Improved awareness of reporting/recording may have led to an increase in absence figures.

HID: Cross-Directorate support on difficult cases has been well received and promoted consistency.

ND: Best practice is being shared around ND particularly through the admin managers group (CAMG). This is promoting consistency.

Has identified a number of Government initiatives/benefits to help support staff back to work.

Has also had experience of handling stress cases successfully.

PG: Initiated a follow up activity on managing trigger points in April 2006. On reaching a trigger point the line manager receives a note asking for confirmation that appropriate action has taken place. Many of the initial responses showed that line managers were not taking the correct action; this included failure to notify OHS in cases of stress but, more commonly discounting inappropriately. BP's challenged the line managers and coached them through the correct responses. This has led to a gradual improvement in correct management of absence. (It is appreciated that many D/ds lack the resources for this activity).

However anecdotal feedback suggests some line managers have used these trigger point letters as an excuse to instigate sick leave reviews with their staff i.e. where they are uncomfortable due to lack of confidence, over familiarity or fear of confrontation.

Examine their "Top 10" individuals on long term absence and would suggest a corporate approach along these lines.

RPD: Accountability of managers in HRD seen as a strong motivator for consistency.

**Any hot spots emerged over the last year e.g. in terms of reason for absence/location?
Any new or emerging pressures contributed to any lack of success?**

HID: No new ones but the handling of stress related illnesses continue to be the most difficult for managers to deal with.

OPSD: Anecdotal feedback that COIN issues have caused additional absence indirectly and directly e.g. through DSE.

ND/OPSD: Report the possibility of higher levels of short term stress through the impact of affordability plans issues, alterations to workloads and lack of (re)training.

The relatively older workforce in ND may be contributing to additional musculo-skeletal issues.

PG: Stress and MSDs remain by far the biggest causes and many feel that HSE's management of stress is inadequate (evidence from IH1 investigations and the Rose Court H+S Committee's need to develop extra assistance for staff).

Wary of the possibility that the HWWW project could increase stress levels and add to absence levels.

RPD: Change brought about by HRST led to an increase in stress-related absence in HRD though the position is now improving through careful management.

COSAS: Reported a particularly virulent chesty bug in early 2007 which has affected absence rates.

Annex 5 – Wellbeing services provided by HSE’s OHS – Capita

The following text has been taken from the contract negotiated between Capita Health Solutions and DWP/HSE/DFeS. They give a flavour of the services that Capita have signed up to provide.

Services available

Attendance management

A speedy and efficient service is required to support and assist line managers in managing and reaching decisions on sickness absence cases (both irregular attendance and long-term sickness, which is defined as continuous absence lasting more than 28 days). The primary aims of this service are: to support employees and managers in the workplace to prevent attendance problems developing; to get people back to work as quickly as possible; to support managers in deciding to terminate employment where a return to regular/good attendance within a reasonable period of time is not possible. The right levels of specialist advice to support decisions about warnings, future employment, rehabilitation and return to work are expected. Engagement with employees absent from work due to health reasons is required, in accordance with an agreed contact programme with the manager, to support them in resolving their health problems satisfactorily and as early as possible.

Case Conferencing will be available to the HSE’s managers, subject to local approval and via face-to-face or tele-consultation arrangements. A suitable clinician, usually one who has been involved in the case, will attend these. Managers will be able to gain generic interpretation and guidance from the OH advice line on issues relating to ongoing cases.

Long-Term Absences

Both Parties agree that within the first year of Commencement of Full Operations, the Lead Clinician in partnership with HR Policy Managers, agree an appropriate model and cost where outside the scope of the tender response and undertake a review of identified long-term absence cases under the terms of Core Service provision. The objective of the review will be to provide the necessary medical advice to allow managers to bring the absence to a conclusion through return to work, medical retirement or administrative action, reducing the long-term absence list by 75% from the date of Commencement of Full Operations.

Both Parties agree that within six (6) months of Commencement of Full Operations agreement shall be reached on the inclusion within the Contract of an incentivised Risk and Reward model with the prime objective of reducing the number of long-term absence days lost to the Authority. Both Parties are in agreement that the following shall form the underlying principles of the model:

- Any Approved Risk and Reward payment should be easily calculated against a pre determined set of criteria;
- It should be capable of being administered and paid for at a local level;
- There must be clear and unambiguous evidence that any improvements are attributable to the Contractor’s actions and not as a consequence of ongoing HR policies;
- Any improvement must be measured over an agreed period to further evidence that the model has had a long-term and sustained effect; and

- The agreed risk and reward payment should be capable of being funded from the savings realised.

Steps to address long-term absences will also include exploring the scope for developing a referral process from the OH service into the EAP service, phased in from the last quarter of 2007.

Culture, Training and Well-Being

The promotion of health and well-being has strong links with the culture of the Authority and there is a need for focus on improving management capability and employee capacity for an earlier return to work. The service will offer a range of education and awareness, best practice solutions and training that supports business strategies and as determined by the Occupational Health Strategy Board.

Services include occupational health consultancy, health promotion and advice and information services. Health screening is also available as a bespoke request beyond the over 50s scheme currently in operation.

Document1