

<b>Health and Safety Executive</b>		<b>Sector Information Minute</b>	
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Target Audience:  
All FOD Inspectors

## **PSP/STRESS PROGRAMME 2006-07 - HEALTH CARE MANAGING SICKNESS ABSENCE / RETURN TO WORK**

This SIM provides guidance and advice for undertaking management systems interventions on managing sickness absence and return to work arrangements as part of the PSP/Stress Programme 2006-07 within the health sector.

### CONTENTS

Topic Inspection Guide
Case studies

### INTRODUCTION

1 The Public Services Programme Business Group Delivery Plan sets out the rationale and objectives for policy and field led activities for 2006-07. More specifically, SIM 7/2006/02 describes the policy and field led activities being planned to promote management of sickness absence and return to work arrangements (MSA/R2W). A critical element of this work includes delivering 18 regional workshops and undertaking 34 targeted management systems inspections to persuade duty holders to adopt best practice on MSA/R2W.

2 The key prompt for undertaking these interventions is to determine the current arrangements in place for MSA/R2W and to examine the main causes of sickness absence - MSDs, stress, slips & trips and violence & aggression. Specific topic related guidance has been issued for each of these areas.

3 FOD Scotland and Wales are designing separate approaches to the targeting of NHS bodies within their Divisions and full details can be obtained from the respective versions of the PSP Business Group Delivery Plan. While this SIM provides additional information which mainly captures complementary MSA/R2W government initiatives within England (Annex 1), there is relevant information and advice for all FOD Divisions in the Topic Inspection Guide (see para 5 below).

### BACKGROUND

4 Within the NHS, over 700 employing organisations employ 1.3 million people. Musculoskeletal disorders (40%), stress (50%), and violence to staff (14%) are the principal causes of sickness absence<sup>[1]</sup>. Whilst overall sickness absence has reduced from 4.71% (2003-04) to 4.56% (2004-05), the rates vary between regions and trusts, with some levels as low as 2% in the acute sector and as high as 9% in the Ambulance and Mental Health Sectors. According to a recent NHS Partners report<sup>[2]</sup>, sickness absence costs for hospital wards are estimated at £275 million per year. So £82.5 million would be saved if a 30% reduction by 2010 in line with PSA targets was achieved. Also, conservative estimates indicate that stress alone costs the NHS in England approximately £300-400 million annually'.

## TOPIC INSPECTION GUIDE

5 A Topic Inspection Guide for the major public sector employers has been developed to help inspectors familiarise themselves with MSA/R2W good practice and so assist in preparing for interventions. It outlines the key messages to be promoted and identifies the main elements of an effective MSA/R2W policy, which reflect HSG 249 - Managing Sickness Absence and Return to Work - an employers' and managers' guide. The Guide also includes a questionnaire toolkit which inspectors may wish to use in discussions with Chief Executives, Human Resource Directors, Parishioners and Employees to ensure a consistent approach.

6 HSE will also be publishing further guidance on MSA/R2W in the very near future. Once available, FOD will be alerted and a link will be created here for ease.

## ENFORCEMENT

7 While there is a sound business case for managing sickness absence, and this needs to be emphasised during interventions, little of the good practice on MSA/R2W, outside of revisiting risk assessments for those with continuing ill health, can be enforced under existing H&S law.

8 Employers will be aware that they have certain duties under Disability Discrimination Act and Employment Rights legislation - both of which are enforced through tribunal hearings. Inspectors should make this clear to duty holders while stressing the benefits in terms of improved public sector efficiency and close Ministerial interest in public sector performance in MSA/R2W.

9 Employers should also be reminded that scrutiny for high sickness absence rates might also come from other public sector regulators such as the National Audit Office, Healthcare Commission and equivalents in Scotland and Wales.

## RECORDING

10. A standardised approach has been agreed for reporting Fit3 interventions. The key word "PSP6" should be used in the comment field for each contact

under the PSP 2006-07. Further instructions are provided at paragraph 34 and 35 of the main Public Services Business Group Delivery Plan.

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## ANNEX 1

### LINKS TO EXISTING INITIATIVES AND AGENDAS

#### **NHS Employers Organisation (NHSE) - ENGLAND**

The NHSE is the main body responsible for promoting health and safety within the NHS. One of their main drivers, in common with HSE, is the reduction of sickness absence within the NHS in England, and the NHSE has recently launched its own project aimed at effective **reactive** management of stress. This is predicated on management of stress on an individual basis. NHSE co-ordinates all stakeholder interests from across the NHS on health and safety issues and HSE is represented on their forum to secure improvements and monitor progress.

#### **NHS Employers Organisation Guidance (Chapter 5)**

The NHS Employers organisation<sup>[3]</sup> has published guidance to advise the NHS how best to manage sickness absence. The guidance sets out the importance of:

- Management (senior and line management) involvement and their training
- Accountabilities - clear roles and responsibilities of line managers and their training
- Occupational Health and Human Resources involvement
- Pre-employment screening and induction training
- Reporting arrangements
- Gaining commitment from staff
- Monitoring arrangements, including the use of 'total cost of absence'
- The use of information systems to record and assess (IT)
- Devising return to work strategies
- The guidance advocates the use of Bradford Scores

#### **'Improving Working Lives'**

The NHS was tasked with establishing occupational health provisions as required by the standards set out in the Improving Working Lives (IWL) initiative launched in 2000. The standards aimed to put in place robust human resource practices to promote effective employment practices and improving the working lives of people who work in the NHS. In practice, this requires the NHS to demonstrate year-on-year improvements to reducing violence against staff, accidents to staff and levels of sickness absence (see page 12 of IWL Standard). Achieving this standard (aka Practice Plus Accreditation) was set

for April 2006. Performance is reported to the Department of Health and Healthcare Commission as part of the delivery of the Core Standards.

### **Electronic staff records**

Linked to the UK Health Departments' Agenda for Change and NHS Pay Modernisation System has been the introduction of electronic staff record (ESR), which will replace all HR and payroll systems currently in use within the NHS. It will help to improve / standardise sickness absence recording and encourage a more transparent mechanism for monitoring performance. The system is currently being piloted and roll-out will be staggered across England and Wales with an anticipated completion date of April 2008. Inspectors should be aware however, that some NHS organisations are resisting adoption as they believe that current Human Resource arrangements provide an equivalent, if not better, service.

### **Occupational Health Smart Cards**

OHSC programme started in October 2001 in England, and aims to streamline and standardise the recording of personal, contractual and health clearance information when hospital doctors take up new training posts or otherwise move around the NHS on locum placements or for career development purposes. It is intended that the scheme will address undergraduate medical students in England and later other Health Departments. The card contains occupational health and health clearance data. ESR (see above) and OHSC have published a 'joint statement' in relation to the sharing of data to avoid unwarranted duplication. In practice, there is limited information on how successful this scheme is. However there is likely to be an indirect benefit to the organisational arrangements for MSA/R2W which Inspectors may wish to be aware of.

### **Bradford Scores**

'Bradford Scores' is a mechanism for assessing the irregularity of attendance of staff on sick leave and involves an assessment of frequency and duration of absence. The score shows whether an individual's absence record is made up of a few or many spells of short or long duration. It can be used to monitor trends in sickness absence, to provide trigger points for further action, and to provide comparisons with absence rates for an organisation as a whole. This system is used by a large number of NHS organisations. Further information on the application of this system can be obtained from the HCSCU.

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[1] Ministerial Taskforce on Health Safety and Productivity - One Year on Report November 2005

[2] NHS Partners 'Sickness Absence and Staff Turnover' August 2005

[3] The Management of Health, Safety and Welfare Issues for NHS Staff.  
Chapter 5 addresses Managing Sickness Absence

## TOPIC INSPECTION GUIDANCE

### MANAGING SICKNESS ABSENCE AND RETURN TO WORK HEALTHCARE SECTOR

#### Management System Inspection

1. Whilst inspections will necessarily focus on the key health and safety risk areas the opportunity can be taken to review sickness absence procedures.
2. To facilitate this the following have been provided:
  - **Key lines of enquiry** - MSA questions for interviews with staff and others
  - further background information - provided in the annex.
3. The intention is to provide health organisations with an overview of findings to encourage them to analyse their managing sickness absence and return to work (MSA/R2W) procedures further. This could be linked with the general feedback presentation at the end of the inspection process.
4. In addition to the above during the inspection, health organisations should be reminded of the following:
  - Sickness absence levels are a visible marker of an organisation's 'health' with levels in excess of sector averages suggesting significant organisational problems may be present.
  - By changing the way it works to address some of the causes of sickness, and improving the support for those returning back into work, an organisation can realise significant benefits. These include improving productivity, efficiency and staff morale, and fostering a culture of high attendance.
  - Managing sickness absence is good management practice. Action plans should reflect the need to show strong leadership, set clear goals and recognise the importance of valuing and involving staff.
  - Sickness absence management should be planned ahead, and involve appropriate members of the management team and TU and employee representatives.
  - Data systems need to be put in place to support better attendance management – real time recording and audit of absence enables managers to monitor more effectively, and take action at agreed trigger points.
  - The action plans should reflect that early intervention is key if an organisation is to manage sickness absence effectively. They should cover both short term and long term sickness absence, including access to occupational health and rehabilitation services.
  - Whilst short term absence accounts for most absence events in the Public Sector, more days are lost due to long term absence but involve only a small number of employees.
  - The 6 key elements to effectively manage sickness absence and return to work are:
    - Recording sickness absence
    - Keeping in contact

- Planning and undertaking workplace adjustments
- Using professional advice
- Return to work plan
- Co-ordinating the return to work process

For further information on these steps, visit the managing sickness absence website <http://www.hse.gov.uk/sicknessabsence/approach.htm>

Expert advice to support the inspection can be obtained from the following HSE colleagues:

- Julian Smith, CMU, tel 0161 952 8363;
- Penny Barker, CMU, tel 0151 951 4071;
- Yvonne Williams, FOD Wales, tel 01978 31 6021;
- Lucy Holmes, FOD Northern, tel 0161 952 8452;
- Julie Wood, FOD East and South East, tel 01256 404134;
- Gret Higgins, HSL, tel 01298 218370;
- Keith Wiley, PG, tel 0207 7176289.

### **Enforcement**

While there is a sound business case for managing sickness absence, little of the good practice on MSA or RTW, outside of revisiting risk assessments for those with continuing ill health, can be enforced under H&S law.

Employers will be aware that they have certain duties under Disability Discrimination Act and Employment Rights legislation both of which are enforced through tribunal hearings. Inspectors should make this clear to duty holders while stressing the benefits in terms of improved public sector efficiency and close Ministerial interest in PS performance in managing sickness absence.

Employers should also be reminded that scrutiny for high sickness absence rates might also come from other public sector regulators such as the Audit Commission.

# **KEY LINES OF ENQUIRY**

## **QUESTIONS FOR NHS STAFF ON MANAGING ATTENDANCE**

Page 2: Background

Page 3: Questions for the Board and Senior Management

Page 4: Questions for Human Resource Management

Page 5: Questions for Line Managers

Page 7: Questions for Employees

Page 8: Question framework

## Background

Absence levels are a good indicator of the health of an organisation reflecting overall levels of employee well-being. It reflects H&S management, the work environment and culture, job content and control, management style and workplace conflict and the management of sickness absence and return to work.

A well managed organisation will ensure good attendance through four strands<sup>1</sup>:

- Monitoring, measuring and understanding information about absence;
- Managing sickness absence when it happens;
- Promoting a healthy environment: tackling the underlying causes of absence including H&S management;
- Promoting a culture that encourages attendance.

Business in the Community (BITC)<sup>2</sup> in their survey of top organisation identified that their CEs and Finance Directors believe that in improving productivity it is more important to improve employees' energy and alertness through better management of health at work than to offer more performance pay.

Recent qualitative research undertaken on behalf of the PSP by external contractors has sought to understand the views of PS CEs and HRDs on attendance management in the PS<sup>3</sup>. Whilst we have only interim findings these suggest the following:

- CEs and senior staff largely have knowledge of their organisation's sickness absence and are aware of trends.
- Most CEs see improving attendance as an on-going issue but not of pressing importance and there are usually issues that require more immediate attention
- CEs view their sickness absence levels as an internal issue and largely do not sense any direct external pressure to improve
- Sickness absence is recognised as a contributor to improving productivity, managing costs and good customer service

Action on reducing sickness absence is largely driven by the CEs perceptions and appreciation of the above two issues:

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<sup>1</sup> See *The Well Managed Organisation*

<sup>2</sup> Business in the Community is a unique independent business led charity whose purpose is to inspire, engage, and support and challenge companies, to continually improve the impact they have on society. With a current membership of over 750 companies, including 71 of the FTSE 100 and 82 per cent of the FTSE's UK leading companies in their sector, together Business in the Community members employ 12.4 million people in over 200 countries worldwide, including 1 in 5 of the UK private sector workforce.

<sup>3</sup> Improving awareness of sickness absence management among CEOs and HR Directors in the public sector. Emerging findings prepared by COI for HSE on 10 March 2006. Due to be published May 2006.

- HRDs see sickness absence as a more important issue for them and their motivation to take action is driven by pressure from the board and professional pride in being seen to manage a core HR duty
- There is a view that the benefits from improving attendance can be achieved equally or to a greater extent by new working practices and technical innovations
- There is some evidence to suggest that CEs and HRDs may respond more positively if poor attendance levels are seen as a marker of a problem organisation and their pride in their reputation and the organisations is played on.
- CEs are interested in inspirational case studies and advice from HSE needs to be carefully referred to especially where the well known steps to improved attendance have been addressed.

## Senior Management and Directors

1. What issues in your organisation are barriers to achieving service delivery?

Or if sickness absence not identified as a barrier either directly or by inference then ask:

Sickness absence in your organisation is X - this ranks you amongst the worst performing NHS organisation in the country. This equates to Z numbers of staff being absent on everyday. How does this affect you delivering services?

2. How are you as a board (senior managers) demonstrating leadership in this area?
3. Which senior manager has responsibility for delivering better attendance?
4. How often do you discuss attendance as a board (senior managers)?
5. What information do you have available to support board (senior managers) discussions?
6. In this financial year what are you doing to improve attendance and what do you want to achieve this financial year?
7. What resources are you making available in this financial year to improve attendance?
8. What communications do you have with your staff on your commitment to managing attendance?

## Human resource management staff

1. How is your Board (or senior managers) committed to improving attendance and why?
2. What improvements in attendance do you understand your Board want to achieve in this financial year?
3. What is your role in improving attendance?
4. What resources are available to deliver these expectations?
5. What central support is provided to line managers to help them improve attendance?
6. What do you think line managers in your organisations have difficulty with dealing with improving attendance?
7. How are you monitoring progress and auditing your policies implementation?
8. What does your monitoring tell you about sickness absence and how are your actions responding to this information.  
  
(Probe; long and short term sickness, major causes of both, organisational changes, OH provision referral and response targets)
9. What advice have you received from your OH specialists on improving attendance (not advice on individual cases)?
10. How is your H&S management integrated into your management of attendance?
11. How and how often do you review attendance data and policies with staff and their representatives?

## Line managers

1. Do you believe your Board (senior managers) are committed to improving attendance and why?

(Probe do line managers see improvements in attendance as helping deliver services)

2. With regard to improving attendance what do you understand your Board (or senior managers) want to achieve in this financial year?

3. What is your role in improving attendance?

4. What skill sets do you have to deliver these expectations?

(Probe: confidence and ability to conduct return to work interviews, maintain regular contact with off sick staff, develop and agree return to work plans with a member of staff, knowing when and how to get professional advice including that from OH professionals, dealing with staff with mental health problems and disabled staff; investigating work-related absence)

5. What assistance is provided by your organisation to enable you to deliver your responsibilities in improving attendance in your team?

*(Probe: training; OH provision - does it provide practical advice in a readily accessible way to enable you to manage a period of sickness absence; assistance provided by HR staff, assistance from H&S adviser in dealing with potential workplace attributed absence)*

6. What aspects of attendance management do you find difficult?

- Dealing with GP vs. OH medical advice
- Talking to off sick staff
- DDA and how to make reasonable adjustments
- Planning and implementing modified R2W

7. How do you record sickness absence for your staff?

8. What information on sickness absence are you able to access?

(Probe: is this live data, for individuals, for your team and the larger organisational units, causes of absence, patterns of absence)

9. How do you use this information?

10. Do you discuss attendance data with senior staff?

11. Have you been invited to provide views on the improvement of attendance policies?

## Employees

1. What do you believe are your organisation's attitudes to sickness absence and attendance?
2. Do you believe the organisation is aiming to promote the well being of staff as well as manage individual cases of sickness absence?
3. What are the procedures you have to follow if you are off sick?  
(Probe: about longer term sickness absence)
4. How did you learn about the sickness absence and attendance procedures?  
(Probe: written guidance, specific training course, orally from managers)
5. What do you believe OH role is in improving attendance and managing sickness absence?
6. Do you think your manager has the necessary skills and confidence to manage sickness absence?
7. When concerns are raised about sickness absence being work-related do you believe they are addressed competently?
8. Have staff and staff representatives being involved in developing attendance policies and procedures and are you kept informed of changes?

Question framework

	<b>Board and Senior Managers</b>	<b>HR staff</b>	<b>Line Managers</b>	<b>Employees</b>
<b>Commitment and drivers</b>	Q1, Q4	Q1, Q2	Q1, Q2	Q1, Q2
<b>Roles and responsibilities</b>	Q2, Q3,	Q3	Q3	Q3
<b>Strategy and plans</b>	Q6	Q5, Q8		
<b>Resources</b>	Q7	Q4	Q5	
<b>Skills</b>		Q6	Q4, Q6	Q5
<b>Expert advice</b>		Q9	Q5	Q4
<b>Recording and analysis of sickness information</b>	Q5	Q7,	Q7, Q8, Q9	
<b>Communication</b>	Q8	Q11	Q10, Q11	Q7
<b>H&amp;S</b>		Q10	Q4, Q5	Q6

# RehabWorks and NHS Trusts - controlling time lost due to musculoskeletal ill health

## Introduction

Bury Physio / RehabWorks has been working in partnership with West Suffolk Hospitals NHS Trust and with East Anglian Ambulance NHS Trust to reduce the number of days lost due to musculoskeletal injuries and to improve staff health and wellbeing.

These projects support the government strategies that set PSA and Revitalising targets of reducing working days lost by 30% by 2010.

The methodology follows the Faculty of Occupational Medicine guidelines on management of back pain at work (FOM 2000) [www.facocmed.ac.uk](http://www.facocmed.ac.uk), which recommend a 3-stage strategy to manage back pain:

- **primary intervention**
  - safety culture
  - risk assessment and ergonomics programme
- **secondary intervention**
  - early advice and treatment in line with Royal College of General Practitioners (RCGP) guidelines [www.rcgp.org.uk](http://www.rcgp.org.uk)
  - fast track physiotherapy
- **tertiary intervention** (for workers having difficulty returning to normal occupational duties at 4-12 weeks)
  - active rehabilitation programme with a multidisciplinary 'package' of interventions

## West Suffolk Hospital Project

In 2000 to 2001 musculoskeletal absence cost the West Suffolk Hospitals NHS Trust £531,230 with 50% of this due to low back pain.

The Trust had in place a risk management and ergonomics programme (FOM primary intervention). Long NHS waiting lists prevented staff being able to access early physiotherapy.

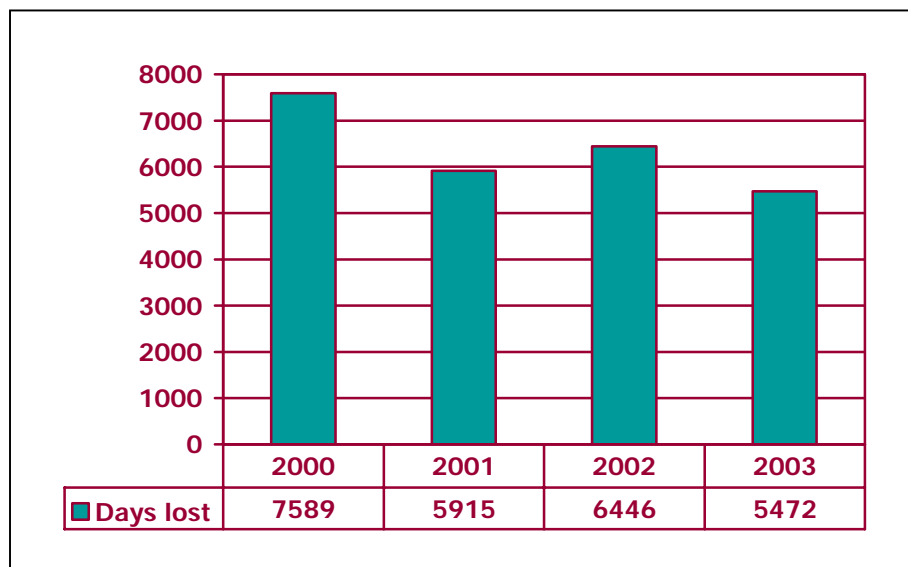
A fast track physiotherapy service with appointments within 48 hours of referral was set up in partnership with Bury Physio/ RehabWorks. The service was available to all staff with a problem that was causing time loss from work. The line manager must refer employees with musculoskeletal problems or following workplace injuries to Occupational Health. OH triages and where appropriate refers to Bury Physio / RehabWorks.

The average course of treatment was 6 individual sessions (FOM secondary intervention), with a few cases progressing to functional restoration (FOM tertiary intervention). Following treatment 96% of patients had returned to work; 88% were on normal duties; 8% with ongoing restrictions; and 2% remained off work.

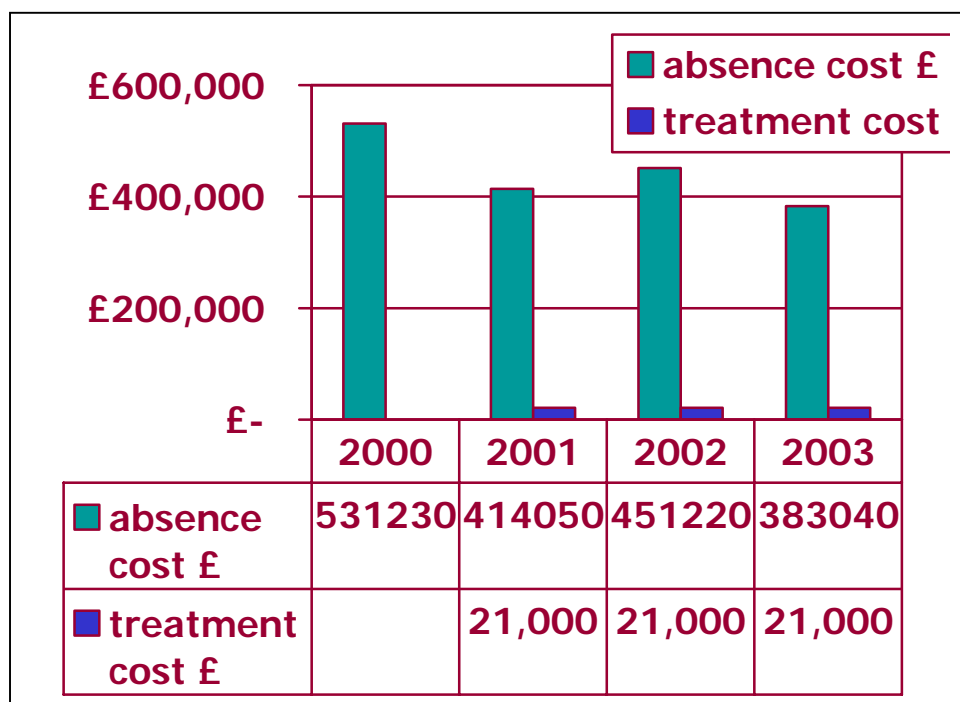
The physiotherapy intervention reduced the annual days lost from 7,589 to 5,915 in the first year and in 2002 and 2003 this reduction was maintained. The average annual costs for treatment was £21k. The cost of absence was calculated by salaries and wages and is based on an average pay rate of £70 a day. On this basis, the Trust achieved a 300% return on investment by providing fast track physiotherapy.

Graph 1 shows Days lost due to musculoskeletal ill health

## RehabWorks and NHS Trusts - controlling time lost due to musculoskeletal ill health



Graph 2 shows the cost based on an average salary of £70/day



For further details contact:  
 Jenny Saunders OH Manager  
 West Suffolk Hospital, Hardwick Lane  
 Bury St Edmunds, Suffolk  
 01284 713000  
[jenny.saunders@wsh-tr.anglox.nhs.uk](mailto:jenny.saunders@wsh-tr.anglox.nhs.uk)

### East Anglian Ambulance Trust – Pilot study

East Anglian Ambulance Trust (EAAT) also had a problem with musculoskeletal sickness absence. The Trust introduced fast track physiotherapy in 1999 and undertook a functional restoration pilot with RehabWorks in 2000.

The job of a paramedic is of very heavy physical demand level. EAAT identified 8 paramedics who had been off work between 9 and 15 months due to low back pain. All were requesting ill health

## RehabWorks and NHS Trusts - controlling time lost due to musculoskeletal ill health

retirement and were potential claims against the Trust. The group had lost 1,540 days at £75 day giving a total absence cost of £107,800 at the point of intervention.

The group participated in a functional restoration programme (FRP) alongside a graduated return to work, commencing work as 3<sup>rd</sup> man. The FRP was between 4 and 12 weeks and the cost for all eight was £14,294. All returned to work on normal duties, with only one relapse of 60 days by 1 employee.

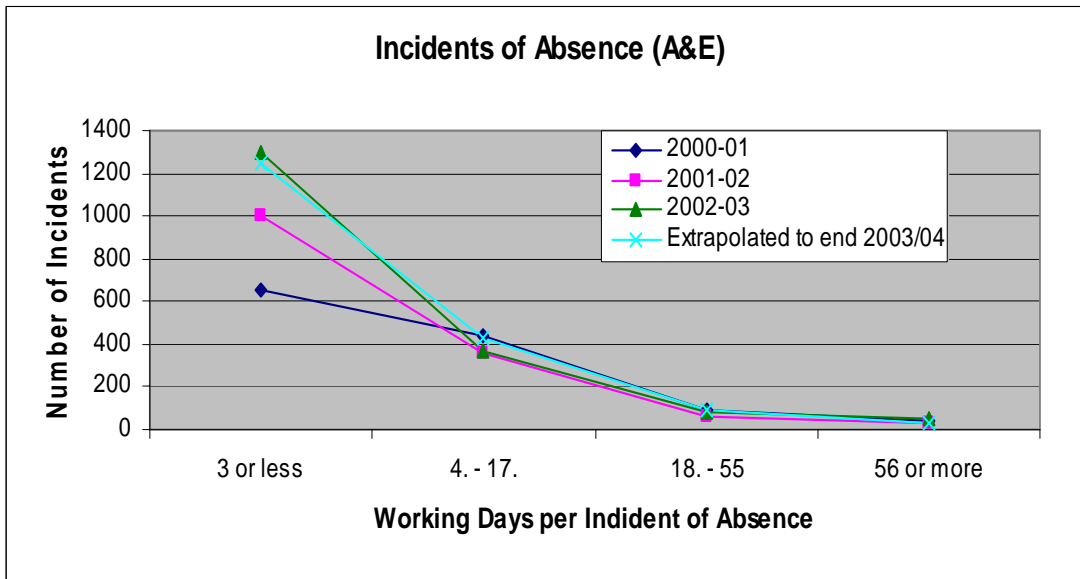
Case number	% deficit start	% deficit end	% improvement	Time off pre rehab in months	Time off Post-rehab months	Work status
1	27%	11%	16%	9	0	Left EAAT
2	39%	13%	26%	5	0	Full duties
3	27%	12%	15%	8	0	Full duties
4	43%	12%	31%	12	0	Full duties
5	52%	10%	42%	10	0	Full duties
6	21%	15%	6%	5	0	Full duties
7	36%	14%	22%	3	3	Left EAAT
8	56%	11%	45%	10	0	Full duties

### EAAT Absence Monitoring

Absence data over 4 years shows an increase in staff numbers, an increase in the incidents of sickness absence but a decline in the overall days lost per incidence of sickness.



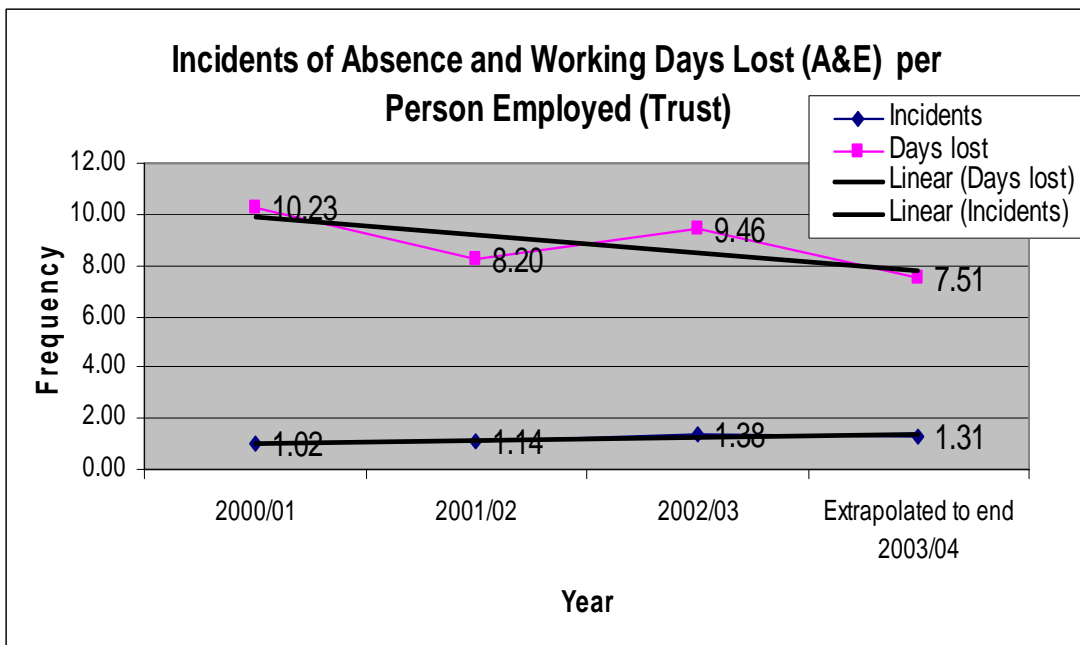
# RehabWorks and NHS Trusts - controlling time lost due to musculoskeletal ill health



## Average Number of Days Lost per Incident (A&E)

Average Number of Days Lost per Incident (A&E)	
2000/01	10
2001/02	7.2
2002/03	6.9
Extrapolated to end 2003/04	5.7

## Trendlines Incidents of Absence and Working Days Lost (A&E)



## Discussion

In 2004, the trend for increasing the number of short term absences in A&E appears to have halted. There is a reduction in the number of days lost though this has fluctuated over the last four years. There continues to be a reduction in the number of days lost per incident of absence.

## **RehabWorks and NHS Trusts - controlling time lost due to musculoskeletal ill health**

If the Trust lost the same number of days per incident this year as it lost in 2000/01 the total for days lost in A&E would have been 18442. This is almost 8000 days more than it actually lost. How many of these days were due to staff working on rehabilitation programmes or 'alternative duties' is not known.

For further details contact  
Tania Nicholls Risk Manager  
East Anglian Ambulance NHS Trust HQ  
Hospital Road  
Hellesdon  
Norwich  
Norfolk  
01603 242255  
[tania.nicholls@eaamb.nhs.uk](mailto:tania.nicholls@eaamb.nhs.uk)

Nicola Hunter  
Bury Physio and RehabWorks  
MayneWater Lane  
Bury St Edmunds  
Suffolk  
IP33 1QD  
01284 748200  
[Nicola@buryphysio.co.uk](mailto:Nicola@buryphysio.co.uk)