Attendance management in the Fire and Rescue Service

Managing sickness absence and managing and supporting attendance

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This study was commissioned by the Health and Safety Executive and the Department for Communities and Local Government (DCLG), and carried out by the National Centre for Social Research. It examined policy and practice in managing sickness absence within the Fire and Rescue Service. The aim of the study was to understand:

- the nature of current policies and practices;
- views and experiences of policies and practices among different types of staff;
- the degree to which policies and practices reflect recent recommendations;
- barriers and facilitators to adopting recommended practices; and
- practices that are considered useful and how policy and practice in attendance management might be improved.

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National Centre for Social Research
SUMMARY

Introduction (Chapter 1)

Study aims and objectives
This study was commissioned by the Health and Safety Executive and Communities and Local Government, and carried out by the National Centre for Social Research. It examined policy and practice in managing sickness absence within the Fire & Rescue Service. The aim of the study was to understand:

- the nature of current policies and practices;
- views and experiences of policies and practices among different types of staff;
- the degree to which policies and practices reflect recent recommendations;
- barriers and facilitators to adopting recommended practices; and,
- practices that are considered useful and how policy and practice in attendance management might be improved.

Study design and conduct
The study used qualitative research methods to allow detailed exploration of policies and practices from a range of different perspectives. Five case study services were selected to be broadly representative of all fire and rescue services. The selection comprised one service from each of the five different Fire & Rescue Service ‘family groups’. The services selected also had different levels of short and long term sickness absence, including two with improved sickness absence performance between 2000 and 2005, and different governance arrangements.

Across the case study services, 35 interviews were carried out with: strategic managers (chief fire officers, assistant chief fire officers, and directors of human resources); members of the occupational health team or service; and, line managers of operational staff (including retained staff), fire control and support staff. In addition, 30 interviews were conducted with employees with experience of sickness absence. An initial sample of employees was selected and invited to take part in the research. A short telephone screening exercise was conducted with those who agreed to take part, and participants were selected to ensure diversity in employee group, sex, age, pattern of absence, health condition and whether or not they had returned to work. Interviews were carried out between March and June 2007, on fire and rescue service premises in the case of managers and occupational health staff, and at employees’ homes in the case of employees.

Analysis and reporting of findings
Interviews were digitally recorded, transcribed verbatim and analysed using Framework which involved summarising data under key themes. The report presents key findings from across the case study services, without the use of numbers or any indication of prevalence (since the qualitative sample is non-representative). The report does not discuss the case study services separately, rather it highlights key
issues and differences, where these were evident in the data, in attendance management practices. The focus is to draw out lessons for practice across the five services, which might be relevant to the Fire & Rescue Service as a whole. Alongside this main report, each case study service received a short paper highlighting key issues that emerged for them individually when compared with the others.

Report structure

Chapter 2 provides an overview of, and context for, sickness absence performance and attendance management in the case study services. It also presents three overarching factors for successful attendance management. The following chapters examine specific elements of the case study services’ attendance management strategies in more detail. These elements of attendance management combine to form an holistic approach to attendance management which involved three distinct activities: managing sickness absence (Chapter 3); managing attendance (Chapter 4); and, supporting attendance (Chapter 5). Finally, Chapter 6 presents a discussion of the key findings from the research.

Attendance management in context (Chapter 2)

Governance arrangements for fire and rescue services

Fire and rescue services in England are run by 46 locally accountable Fire and Rescue Authorities (FRAs). The Fire and Resilience Directorate (FRD) of Communities and Local Government (CLG) provides advice and guidance and sets the overall policy direction for FRAs to follow. This is set out in the Fire and Rescue National Framework, which was given statutory effect through the Fire and Rescue Services Act 2004. FRAs are expected to make progress in all areas set out in the Framework, including key priorities relating to attendance management.

The Fire and Rescue National Framework is supported by the Audit Committee’s Comprehensive Performance Assessment (CPA) which examines how well FRAs are being run to meet the needs of local people, and sets a baseline for measuring improvement. FRAs received their first CPA reports and performance categorisation in July 2005. Alongside the National Framework, the CPA has been the catalyst for substantial or further improvements in attendance management and sickness absence performance across the five case study services.

Case study services’ sickness absence performance

There was an overall improvement in sickness absence performance across the case study services from 2005/06 to 2006/07. In 2005/06, the five case study services were performing in the bottom half of all fire and rescue services. By 2006/07, the two services which had performed least well among the five in 2005/06, had improved by around a third, and the performance of the remaining three services improved by between a fifth and a tenth. There was also a reduction in the range of performance among the five case studies. In 2005/06 there was a difference of three days/shifts lost due to sickness absence per wholetime uniformed employee between the highest and lowest performers (9.5 to 12.5 days/shifts lost); by 2006/07 this difference was one and a half days/shifts lost (7.5 to 9 days/shifts lost).
Overarching factors for successful attendance management

Interviewees in the five case study services described three key overarching factors for successful attendance management, which had contributed towards improving sickness absence performance. These factors were:

- effective use of performance management information;
- strategic prioritisation of attendance management; and,
- devolved responsibility for attendance management.

The case study services were at different stages in the production and manipulation of performance management information relating to sickness absence levels. It had been difficult to get accurate measures in systems set up for recording eight hour days and five day weeks, and major and lengthy redesigns of existing systems had been required. However, regular publication of comprehensive aggregate data, clearly displaying performance and trends, combined with clear messages from senior management and the devolution of responsibility for attendance management to supervisory managers, were cited as key drivers of improvement in sickness absence performance.

Managing sickness absence (Chapter 3)

Going off sick

For employees with experience of sickness absence, the decision to go off sick arose in three different ways:

- a sudden injury, or the sudden return of a longstanding problem, which made them immediately unable to work;
- illness or psychological problem that became increasingly severe: they continued to come to work until it was clear, or their GP insisted, that they could not; and,
- a planned operation or treatment, which meant that they and their line manager knew of the sickness absence in advance.

There appeared to be more scope for proactive engagement with foreseen health problems, such as through modifications to duties or referrals to occupational health, to try to avert or minimise sickness absence.

Contact during sickness absence

Although both managers and staff saw frequent contact by line managers once someone had gone on sick leave as beneficial, in practice it was clear that it did not always take place. Managers expressed reservations about appearing to intrude or pressurise staff and being too busy, and not all case study services prescribed or monitored the frequency of contact. Staff who felt there had been too little contact described strong feelings of disenchantment and estrangement.

Where people had experienced regular contact they described it making them feel valued and supported, and they were confident and pleased that their line manager was aware of the issues they were facing.
Role of occupational health during sickness absence

The five services had either in-house or contracted-out occupational health services. In-house services were seen as advantageous in terms of knowledge of the local fire and rescue service, staff awareness of occupational health, direct lines of communication, and integration into policy-making. Contracted-out services were seen as advantageous because of their affordability, independence and ability to draw on a broad range of expertise.

Services with external occupational health providers acknowledged that the relationship and respective roles and responsibilities of the human resources department and the external occupational health provider required greater clarification. This ensured that the occupational health contract was working efficiently, not only in terms of timely assessment and effective two-way communication regarding long term sickness cases, but also the provision of proactive healthcare input. Where roles and responsibilities had been clarified, the occupational health service provision was perceived to be improving.

There were some tensions between the supportive role of occupational health and its role in investigating whether ill health is a factor in persistent short-term sickness absence cases. This led to a reluctance by managers and staff to refer. There was also doubt among managers of the value of referring some cases, and a lack of clarity about the purpose of some referrals.

Staff who described positive experiences of occupational health felt the service had played an important role in their return to work. There were different arrangements across the service for funding private treatment but there were examples of cases where it was felt to have had a very beneficial impact in reducing absence. The Fire Services National Benevolent Fund rehabilitation services were also warmly praised, although there appeared to be scope for both more proactive information-giving and for more flexible residential arrangements.

Financial provision

Sick pay arrangements were viewed as too generous by some managers: a clear pattern of requests to return on modified duties before being reduced to half pay was seen as implying that people delayed returns until that point. Among staff on longer term absence there was sometimes a lack of clarity about what would happen after six months’ absence. The financial impact of sickness absence was mediated by private insurance and by primary or secondary employment, but sometimes financial pressures led people to return to work before they felt ready.

Managing the return to work

The key influences on the timing of returns to work were people’s own assessments of their health and the advice of GPs, but occupational health appointments were also an important trigger. There were different levels of planning for returns to work and different arrangements for being certified fit by occupational health, but there were cases where people returned after serious ill-health conditions or long absences without sufficient planning.

There was strong support for phased returns and modified duties among managers to aid returns to work but barriers to their effective use. Some staff members had been told that they were not available, or assumed this from the fact that a managed
return was not offered. Identifying appropriate roles for operational firefighters appeared to demand creativity and flexibility: it was said that modified duties were traditionally associated with very unpopular ‘office dogsbody’ roles. There was a resistance among staff to moving to a daytime hours structure. Arrangements for joint decision-making between occupational health and line managers did not always work well, and there was not always a managed progression back to usual duties. Finally, for retained staff there was said to be a reluctance by primary employers to release people for office work or day shifts, and difficulty in identifying appropriate roles given limited contact time.

Managing attendance (Chapter 4)

Return to work interviews

There was variation between the case study services in how systematically return to work interviews were used, and line managers expressed some reluctance about carrying them out where the absence was seen as unavoidable or the health condition perceived as straightforward. Done well, they could be a very positive and helpful interaction for staff, although for retained and fire control staff, finding time and a private space could be difficult. Services which were implementing return to work interviews more robustly had supported this with extensive training: in one service there had been a meeting with every watch to support the introduction of the procedures. Ensuring that at all levels the procedure was seen as a supportive one was viewed as important.

Trigger point reviews

All the services had introduced trigger point reviews relatively recently. Use of trigger points has required a considerable shift in attitude from both managers and employees towards the importance of monitoring sickness absence and intervening where individual attendance fails to reach required standards. Identification of trigger points was centralised in some services, but in others managers had developed their own monitoring arrangements. Training had played an important role in implementation, but some line managers remained uncomfortable conducting them. There appears to be scope to reinforce the supportive role of trigger point reviews and the value of their systematic use.

Redeployment, retirement, capability proceedings and dismissal

The change in the availability of early retirement and more active use of redeployment were seen as challenging but necessary by managers. There were some accounts of successful redeployments but also difficulties posed by equal pay legislation, pension scheme eligibility, likely staff responses and finding suitable roles for operational staff. Managers described greater willingness to use capability procedures and dismissal and it was felt that a few cases would have a big impact on staff awareness of their contract to attend work.
Supporting attendance (Chapter 5)

Welfare, counselling and trauma support
All the services described a perceived increase in sickness absence associated with what were seen as ‘welfare’ issues, both work-related and personal. These included work-related issues such as stress, workloads, poor work relationships and bullying, and issues related to people’s private lives such as relationship breakdown, bereavement or family ill-health. Two services had recently employed a dedicated welfare officer and staff counsellor, and these roles were felt to be very beneficial in reducing or preventing sickness absence. Two services had well-established trauma support networks, involving peer volunteers, providing immediate contact during or after a traumatic incident, group debriefing, and scope for individuals to access the service for support at any stage. Again, these were very highly valued by staff who had used them.

Fitness, health screening and health promotion
There was variation in the emphasis placed on fitness, and concerns among staff that standards had fallen. Two services carried out six-monthly fitness testing and this was felt to be valuable. All five services had introduced three-yearly screening for operational staff. Health promotion in the form of stress awareness training, newsletters and healthy workforce initiatives including, in one service, a focus on back care, was also being carried out.

Use of incentives
Finally, some services had introduced incentive schemes to encourage reductions in sickness absence, linking attendance with either the new national Continuous Professional Development payment or with eligibility for voluntary overtime. These were felt to have been successful.

Discussion of findings (Chapter 6)

Overarching factors for successful attendance management
Case study services furthest along the developmental trajectory in terms of sickness absence performance emphasised overarching factors for successful attendance management, alongside an holistic approach to attendance management. Overarching factors for successful attendance management were cited as: effective use of performance management information; strategic prioritisation of attendance management; and, devolution of responsibility for attendance management to supervisory management levels.

An holistic approach to attendance management
An holistic approach to attendance management included consistent management of individual sickness absence cases, the robust implementation of key elements of attendance management policy, and the introduction or revitalisation of additional initiatives to support attendance.
Case study services had introduced comprehensive absence management processes and procedures and were making effective use of occupational health arrangements, although there were differences in the consistency and robustness with which the different elements of attendance management were being implemented in practice.

Stronger sickness absence performance appeared to be associated with effective management of sickness absence involving: systematic, frequent and recorded contact by line managers with employees on sickness absence; early referral to, and input by, occupational health staff in sickness absence cases; a role for occupational health in preventing sickness absence cases before they begin; joint working between occupational health staff and line managers in planning returns to work that maximise opportunities for meaningful modified duties; creativity and flexibility in structuring phased returns to work which are supportive from both the line manager and employee perspective; and, flexible healthcare budgets which fund treatment as well as diagnosis.

It was also important that strategies to manage attendance were implemented robustly to ensure they were systematically utilised in all sickness absence cases. Strategies to manage attendance were most effective when they included: active monitoring of return to work interviews to ensure they are consistently and supportively carried out; clear mechanisms for identifying and following up employees requiring trigger point reviews; and, training for line managers in fulfilling their responsibilities for managing attendance.

Other initiatives which appeared to be beneficial in influencing sickness absence performance include: appointing a dedicated welfare officer and staff counsellor, and developing a trauma support network to help prevent sickness absence and augment existing occupational health provision; re-establishing physical training instructor networks, making time available for physical training, and introducing six-monthly fitness testing with monitoring of results to allow health and fitness interventions to be targeted both individually and globally; proactive health screening for non-operational as well as operational staff and greater resourcing of health promotion initiatives; and, use of incentives to encourage attendance.

Conclusions

A need for further development was highlighted by differences between the case study services in their ability to produce and use comprehensive aggregate sickness absence data in order to fully integrate absence management within an overall performance management framework. Although human resources staff brought valuable expertise with them from other organisations, there was still scope for sharing good practice across the Fire & Rescue Service.

Managers were benefiting from skills learnt through leadership and management development programmes (LMDP), but findings from across the case study services indicate that there is further scope for training for managers in attendance management, particularly in relation to resolving the tension between sensitive treatment and support for employees on sickness absence, and more disciplinary aspects of attendance management.

Finally, the research has identified a need to evaluate the effectiveness of current approaches to attendance management in fire and rescue services, and consider piloting new ones in order to sustain improvements in performance.
1 INTRODUCTION

This report presents the findings of an in-depth study of policies and practices in the management of sickness absence in the Fire & Rescue Service in England. The research was commissioned by the Health and Safety Executive (HSE) and Communities and Local Government (CLG), and conducted by a team of researchers at the National Centre for Social Research (NatCen). The findings from this research are intended to build on a range of initiatives for improving attendance management in public sector services generally, and in the Fire & Rescue Service in particular.

This chapter explains the research and policy background to the study, its aims and objectives, and the research design and methodology employed. Finally, the structure of the report is outlined.

1.1 Study aims and objectives

This study examined policy and practice for managing sickness absence in a small number of local fire and rescue services, focusing on the extent to which practice has developed in line with the Ministerial Task Force on Health, Safety and Productivity (MTF) recommendations. It aimed to provide an overall insight into effective practice and into the barriers and facilitators to adoption of such practice, as well as facilitating feedback to the individual fire and rescue services that participated in the study to inform action planning to be carried out locally following the research.

The research examined a range of issues. These were:

- the nature of current policies and practices in the case study authorities;
- views and experiences of existing policies and practices from a range of staff perspectives;
- the degree to which policies and practices in the case study authorities reflect MTF, HSE and CLG recommendations; and,
- barriers and facilitators to the adoption of recommended policy and practice.

It also sought to:

- identify practices that are considered useful and elicit further ideas and perspectives for how policy and practice in attendance management might be improved.

1.2 Study design and conduct

The study was conducted using qualitative social research methods. Adopting a qualitative approach enabled detailed exploration and examination of the processes, practices and dynamic interactions involved in attendance management. It also provided the scope to explore fully participants’ views, attitudes and experiences.

The research collated findings from five case studies of local fire and rescue services, involving between ten and 15 in-depth interviews conducted with staff in each. There were two main groups of respondents who were interviewed:
• strategic managers, occupational health staff and line managers (n=35); and,
• employees with experience of both short and long term sickness absence (n=30).

Our approach to selecting the five case study services, and the individual respondents from within them, is discussed below.

1.2.1 Sample selection and recruitment

A case study design was adopted for this study since it was felt this would enable an appropriate depth of analysis so that issues could be fully and comprehensively unpacked. It was also anticipated that such a design would facilitate sufficient breadth and diversity within the sample meaning that the overall findings from the research would be relevant to a wide range of fire and rescue services.

Case study service selection

Following extended discussions with HSE, CLG and CFOA (Chief Fire Officers’ Association), selection criteria were drawn up in order to ensure the selected case study services were broadly representative of fire and rescue services across England. These selection criteria were:

• to include one service from each of the five Fire & Rescue Service ‘family groups’ (these are groups of ‘like’ authorities, grouped according to a mixture of size, extent of rural/urban populations, and a measure of deprivation for the population);
• to select one service with each of five different patterns of sickness in 2004/05 in comparison with others in their ‘family group’ (high, medium, low, high long-term / low short-term, low long-term / high short-term);
• to select two services with improved performance from 2000 to 2005;
• to select services with different governance arrangements including two county and two combined fire authorities; and,
• to achieve a geographical spread of services in England.

A selection matrix was produced which included all fire and rescue services in England and a selection of five services which met the criteria listed above was made by NatCen. The chief fire officer at each of these services was written to by a researcher from NatCen, supplied with an information sheet about the research study, and invited to participate (the letter and information sheet are appended at Appendix A). At this stage, assurances were given regarding the anonymity of participating case study authorities and the independent nature of the research.

Of the original five selected services, two declined to participate. Both services explained that the reason for not taking part was concern about ‘overload’ because of research already taking place involving either the human resources department or employees. These services were replaced with two other services that shared the same key characteristics so that the selection criteria listed above were met fully.

Management and occupational health staff sample

NatCen asked a senior manager in each case study service to identify strategic managers, occupational health staff and line managers for involvement in the research. Each service was sent written guidance for doing this, accompanied by a
letter and information sheet for staff, inviting them to participate (these documents are appended at Appendix B).

The aim within each fire and rescue service was to gain a rounded view of attendance management practices. To achieve this, managers with strategic responsibility for attendance management and staff with direct experience of implementing policy and practice were included as follows:

- strategic manager(s) (chief fire officer, assistant chief fire officer and/or director of human resources);
- a member or members of the occupational health team or service;
- two line managers of operational staff (including retained staff);
- two line managers of non-operational staff (one line manager of fire control staff; and one line manager of support staff)

A total of 35 interviews with managers and occupational health staff were conducted across the five case study authorities. There were differences between case study services in the level of seniority of line managers that took part in the research, from crew manager level to more senior levels. Whilst this assisted the sample in terms of its diversity, it also meant that it was sometimes difficult to compare experiences across line managers. A breakdown of the sample of manager and occupational health staff interviews is given in Table 1.1.

Table 1.1 Management and occupational health staff sample profile

<table>
<thead>
<tr>
<th>Staff roles</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic managers</td>
<td>8</td>
</tr>
<tr>
<td>Occupational health staff members</td>
<td>7</td>
</tr>
<tr>
<td>Line managers (operational)</td>
<td>10</td>
</tr>
<tr>
<td>Line managers (non-operational)</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35</strong></td>
</tr>
</tbody>
</table>

**Sample of employees with experience of sickness absence**

The sample design for employees with experience of sickness absence included staff from across the different fire and rescue service employee groups (wholetime and retained firefighters, fire control staff and support staff) who had been absent for seven or more calendar days during the 12 months preceding their last day of sickness absence. The design also aimed to include employees who had not yet returned to work and a mixture of ill-health conditions.

The interviews with employees aimed to explore their experience of sickness absence policies and procedures including: how their sickness absence arose; their contact with line managers and other staff; their experiences of practices in managing sickness absence both away from work and when they returned; the experience of returning to work; and, suggestions for good practice in managing sickness absence.

The sampling of employees therefore required careful consideration since it presented additional issues of confidentiality and anonymity given the focus of the interviews on personal health and experience of sickness absence. The fact that
employee contact details and sickness absence records were held by the individual fire and rescue services also meant that it was critical that the approach adopted complied with the Data Protection Act.

Opt-in exercise
To achieve an approach to sampling that would meet all these requirements, an opt-in exercise was conducted. Staff who were involved in selecting and recruiting managers and occupational health staff for interviews were also asked for their help in generating a sample frame of employees from which NatCen eventually selected people to participate.

To ensure diversity in the characteristics of the sample frame generated and on the basis that only some of those invited to participate would opt in, each service was asked to identify 105 employees to ensure a large enough sample frame was generated. NatCen provided the case study services with a detailed specification for the criteria for selecting employees to be contacted, and a letter, information sheet and contact form to be sent out to all selected employees on NatCen's behalf (see Appendix B). These documents introduced NatCen and provided information about the research study, including the purpose of the study, what participation would entail and arrangements for confidentiality. Letters were sent to employees’ home addresses, both for confidentiality and to enable staff currently on sickness absence to participate.

Employees who were contacted were asked to respond in one of two ways. Those who were interested in taking part were invited to complete the relevant part of the contact form with their contact details and return this directly to NatCen. In this way, their employers were unaware of whether or not they had elected to take part in the study. Employees who opted in were added to the sample frame from which NatCen selected respondents for interview. Employees who did not wish to participate were asked to complete a different part of the form and send this directly to NatCen. The role of the opt-out option was to ensure that if not enough employees came forward, a follow up letter would not be sent to employees who did not want to participate. In practice, no follow-up was required as large enough sample frame from which to select 30 employees (6 per case study service) was generated.

A total of 489 letters were sent out to employees across the five case study services. The invitation to participate letters generated an overall opt-in rate of 23 per cent (n=112), ranging from 16 to 26 opt-ins per case study service.

Screening exercise and recruitment
The size of the sample frame generated enabled NatCen to carry out a screening exercise with employees by telephone to gather further information from them about the length and number of their sickness absences, the nature of their condition/s, and their age. A copy of the screening questionnaire can be found in Appendix B. At this stage, researchers made decisions about who to invite to participate in an in-depth interview to achieve diversity within the sample across the key characteristics of employee group, gender, age, days absent, condition and whether or not they had returned to work. Potential respondents were then telephoned and, where they agreed to participate, an interview appointment was arranged.

A total of 30 in-depth interviews (6 per case study service) were conducted with firefighters, control and support staff with experience of sickness absence. A breakdown of the achieved sample of employee interviews is given in Table 1.2.
Table 1.2  Employee sample profile

<table>
<thead>
<tr>
<th>Sampling variable</th>
<th>Number achieved</th>
<th>Quota set</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wholetime</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Retained</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Control</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Support</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>19</td>
<td>10+</td>
</tr>
<tr>
<td>Female</td>
<td>11</td>
<td>10+</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-39</td>
<td>11</td>
<td>10+</td>
</tr>
<tr>
<td>40 and over</td>
<td>19</td>
<td>10+</td>
</tr>
<tr>
<td><strong>Days absent</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7-14</td>
<td>10</td>
<td>10+</td>
</tr>
<tr>
<td>15 and over</td>
<td>20</td>
<td>10+</td>
</tr>
<tr>
<td><strong>Condition</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>17</td>
<td>5+</td>
</tr>
<tr>
<td>Mental health</td>
<td>3</td>
<td>5+</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>5+</td>
</tr>
<tr>
<td><strong>Returned to work</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Returned</td>
<td>27</td>
<td>10+</td>
</tr>
<tr>
<td>Not returned</td>
<td>3</td>
<td>5+</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>30</td>
<td>30</td>
</tr>
</tbody>
</table>

The achieved sample represents diversity across the key sampling criteria identified for employees. Fewer employees whose sickness absence was related to a primary mental health condition and fewer employees who had not yet returned to work were included than originally intended. This may be because these people were less willing to identify themselves or because they felt less able to participate in an interview. Mental health issues were however raised by several employees whose condition was listed as musculoskeletal or other. The reported conditions that had led to employees’ sickness absence encompassed:

- musculoskeletal problems, particularly injuries to backs and knees. These were incurred either on or off duty, and were either one-off problems or longstanding problems which had recurred;
- cuts and lacerations, again incurred either on or off duty;
- illnesses such as pneumonia or severe infections;
- planned operations or planned treatment; and,
- psychological issues including mental health conditions and welfare issues: bereavement, the care needs and emotional consequences of an ill family member, depression, and stress arising from work or from poor work relationships.

1.2.2  Conduct of fieldwork

Interviews with managers and occupational health staff were conducted in private at their place of work. Interviews with employees with experience of sickness absence were conducted at their homes in order to preserve their anonymity. All interviews lasted between 60 and 90 minutes and employees with experience of sickness absence were given £20 as a thank you for participating.

Interviews were conducted by NatCen researchers between March and June 2007 and followed a topic guide. This identified the key issues and sub-topics to be explored, without specifying question wording or order. Researchers could therefore be responsive to the circumstances of and relevant issues for each individual participant. Three different topic guides were developed for the interviews with: strategic managers, human resources and occupational health staff; line managers;
and, employees with experience of sickness absence (see Appendix C). All interviews were digitally recorded with the permission of the respondent and transcribed verbatim for full analysis.

1.3 Analysis and reporting of findings

The interviews were analysed using Framework, a thematic and in-depth approach to qualitative research analysis developed by NatCen and used widely in social research. First, the key themes and sub-topics were identified by reading transcripts and considering the research questions. Then, a series of matrices were developed in Excel: columns represented sub-topics, and rows represented individual respondents. Each transcript was then read carefully, and the data were summarised in the relevant cells. This approach meant that the very varied interviews could be analysed in a common thematic structure. The range of views or circumstances relevant to each sub-topic could be reviewed (by looking down columns), but the full circumstances of each individual case was retained for in-depth 'within case' analysis. The linkages between themes in individual cases were apparent, and comparisons could be drawn between individual cases and between groups of cases.

The report presents key findings from across the case study services, without the use of numbers or any indication of prevalence (since the qualitative sample is non-representative). The report does not discuss the case study services separately, rather it highlights key issues and differences, where these were evident in the data, in attendance management practices. The focus is to draw out lessons for practice across the five services, which might be relevant to the Fire & Rescue Service as a whole. Alongside this main report, each case study service received a short paper highlighting key issues that emerged for them individually when compared with the others.

1.4 Report structure

Chapter 2 provides an overview of, and context for, sickness absence performance and attendance management in the case study services. It also presents overarching factors in successful attendance management. The following chapters discuss specific elements of the case study services’ attendance management strategies in more detail. Chapter 3 looks at managing sickness absence in individual cases looking in particular at contact during sickness absence, the role of occupational health during sickness absence, financial provision, and managing the return to work. Chapter 4 examines key strategies for managing attendance, including return to work interviews, trigger point reviews and redeployment, retirement, capability proceedings and dismissal. Chapter 5 discusses initiatives to support attendance, including welfare, counselling and trauma support, fitness, health screening and health promotion, and the use of incentives. Finally, Chapter 6 presents a discussion of the key findings from the research.

2 ATTENDANCE MANAGEMENT IN CONTEXT

Chapter 2 provides an overview of key aspects of the context for attendance management in the case study services. It examines performance, policy and
arrangements relating to attendance management against a backdrop of rapid change and modernisation across the Fire & Rescue Service as a whole. The chapter begins by outlining the governance arrangements for fire and rescue services in England (Section 2.1). It continues by examining sickness absence performance among the case study services (Section 2.2). Finally, the chapter discusses overarching factors for successful attendance management in the case study services (Section 2.3).

2.1 Governance arrangements for fire and rescue services

Fire and rescue services in England are run by 46 locally accountable Fire and Rescue Authorities (FRAs). Each FRA has responsibility for a local fire and rescue service, with operational management provided by a chief fire officer. FRAs have the responsibility to control and administer the business of their fire and rescue service so as to ensure that the core functions of FRAs as set out in the Fire and Rescue Services Act 2004 are discharged.

There are currently five different types of FRA in England:

- Combined Fire Authorities (formed as a result of Local Government reorganisation during the period 1996 to 1998; members are appointed representatives of the constituent local authorities)
- Non-metropolitan County Fire Authorities (exist in areas where no unitary authorities were established in the late 1990s; the fire authority functions in these areas are generally exercised through the council’s Public Protection Committee)
- Metropolitan Fire and Civil Defence Authorities (set up under the Local Government Act 1985 in the former metropolitan authorities; these authorities provide both fire and emergency planning services, but the majority of their resources are concentrated on fire and rescue; these authorities are local authorities in their own right, but members are not elected to them directly, instead they are mandated by the constituent borough councils)
- London Fire and Emergency Planning Authority (formerly the London Fire and Civil Defence Authority established under the Greater London Authority Act 1999 and reconstituted as the fire authority for London in 2000)
- Council of the Isles of Scilly

The Fire and Resilience Directorate (FRD) of Communities and Local Government (CLG) provides advice and guidance and sets the overall policy direction for FRAs to follow. This is set out in the Fire and Rescue National Framework, which was given statutory effect through the Fire and Rescue Services Act 2004. FRAs are expected to make progress in all areas set out in the Framework, including key priorities relating to attendance management. Priorities in the 2006-08 National Framework are as follows:

- to introduce and administer effective absence management processes and procedures to facilitate the achievement of government targets for the reduction of sickness absence;
- to ensure that occupational health arrangements (including the provision of occupational health advice) are efficient and effective; and,
- to give full consideration to the health and fitness of all staff.

The Fire and Rescue National Framework is supported by the Audit Committee’s Comprehensive Performance Assessment (CPA) which examines how well FRAs are
being run to meet the needs of local people, and sets a baseline for measuring improvement. The audit process assesses the performance of FRAs on an annual basis against the Fire and Rescue performance framework which includes the following categories:

- value for money and improved financial management;
- good governance, greater accountability, improved decision-making and proper conduct of public business; and,
- better use of performance information and improved data quality and analysis.

FRAs received their first CPA reports and performance categorisation in July 2005. Alongside the National Framework, the CPA has been the catalyst for substantial or further improvements in attendance management and sickness absence performance across the five case study services.

2.2 Case study services’ sickness absence performance

Figure 2.1 provides a graphical representation of sickness absence performance by each case study service from 2005/06 to 2006/07. Figure 2.1 shows their performance, as measured by Fire and Rescue Best Value Performance Indicator (BVPI) 12(i) (average number of working days/shifts lost due to sickness absence per wholetime uniformed employee), in 2005/06 and in 2006/07, in relation to the average performance of all fire and rescue services in 2005/06.

Figure 2.1 demonstrates an overall improvement in performance across the case study services. In 2005/06, the five case study services were performing in the bottom half of all fire and rescue services. By 2006/07, the two services which had performed least well among the five in 2005/06, had improved by around a third, and the performance of the remaining three services improved by between a fifth and a tenth. Figure 2.1 also shows a reduction in the range of performance among the five case studies. In 2005/06 there was a difference of three days/shifts lost between the highest and lowest performers (9.5 to 12.5 days/shifts lost); by 2006/07 this difference was one and a half days/shifts lost (7.5 to 9 days/shifts lost).

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1 In 2009 Comprehensive Area Assessment (CAA) will supersede the Comprehensive Performance Assessment (CPA) of local government.
2 Includes wholetime firefighters and fire control staff.
3 During 2005/06 there were 9.5 shifts/days lost per person by wholetime uniformed employees. The target for 2005 was an average of 6.5 days/shifts lost per person.
4 Range calculated to the nearest half day/shift lost due to sickness absence.
2.3 Overarching factors for successful attendance management

Many key elements of the case study services’ attendance management policies and occupational health arrangements had been introduced within the last five years, and had been reviewed and revised following the introduction of the Fire and Rescue National Framework and the results of the CPA. These elements of attendance management are discussed fully in Chapters 3, 4 and 5 and combine to form an holistic approach to attendance management which involved three distinct activities: managing sickness absence (Chapter 3); managing attendance (Chapter 4); and, supporting attendance (Chapter 5). However, the research found that in addition to this holistic approach to attendance management, interviewees in the five case study services described three key overarching factors for successful attendance management, which are discussed in turn below.

2.3.1 Effective use of performance management information

Each case study service was at a different stage in the production and manipulation of performance management information relating to sickness absence. The biggest issue for all services had been the accurate calculation of shifts lost to sickness absence using management information recording systems set up for an eight hour working day and five day week. For county fire authorities relying on county council management information systems, inaccuracies in sickness absence recording resulting from the miscalculation of days/shifts lost had been identified that were still being ‘bottomed out’. Without accurate management information, some case study services were unable to produce statistical information for the purpose of effective performance management and review.

One case study service had overcome this barrier by cutting and pasting information from the operating system for duty management on a month-by-month basis into a spreadsheet. This strategy allowed for the interrogation of sickness absence figures and the provision of aggregate data to managers, split by service support group, operational and support staff, and by short and long term sickness absence. It also
enabled the provision of predictive information on how performance might look at the end of the year. Regular publication of these data, using charts and graphs to display performance and trends, combined with clear messages from senior management (see Section 2.3.2) and the devolution of responsibility for attendance management to supervisory managers (see Section 2.3.3), was cited as a key driver of improvement in sickness absence performance.

“[Publishing] the data [is important because although managers have] always had names [and] knew who was off sick…they weren’t actually seeing the picture of what it meant for their…service support group, or…the brigade as a whole.”
- Strategic manager

In other case study services, major and lengthy redesigns of in-house management information systems had improved the robustness and availability of management information. There was still, however, a need for improved understanding of how to best utilise the data for performance management purposes.

“We still need to get better at data analysis, at looking at the trends…trying to second guess [what’s] going to happen.”
- Strategic manager

2.3.2 Strategic prioritisation of attendance management

Alongside the effective use of performance management information, the strategic prioritisation of attendance management was viewed by strategic managers (chief fire officers, assistant chief fire officers, and directors of human resources) as another key driver for sustaining improvements in sickness absence performance. The two top performing (in 2006/07) case study services particularly emphasised the progress they had made towards improving political and managerial leadership relating to attendance management. For example, in one service, the strategic prioritisation of attendance management had been enhanced through the engagement of elected members\(^5\) in providing leadership, scrutiny and political accountability for sickness absence performance. The service had implemented a sickness improvement plan which included making sickness absence performance a key responsibility of the FRA audit committee. Attendance was placed at the top of the agenda for the audit committee’s quarterly meeting and members were provided with performance data and reports on progress of proactive interventions.

In addition, the other service had given further impetus to its attendance management procedures and systems through establishing an absence management steering group. The group was chaired by the deputy manager of human resources, and attended by a number of middle managers, the occupational health manager and welfare officer. The purpose of the group was to engage heads of departments in maintaining the improving sickness absence rate through providing an active forum for exploring attendance management practices from the joint perspective of senior and middle managers. The group was contributing towards planning new approaches to attendance management training for line managers, and reviewing attendance management policy.

\(^5\) Elected members are appointed representatives of the constituent local authorities.
2.3.3 Devolved responsibility for attendance management

A third overarching factor for successful attendance management was described by the case study services as the devolution of responsibility for attendance management to supervisory management levels. A review of sickness absence in the Fire & Rescue Service (Fit for Duty, 2000) found that “it was not unusual for principal officers to express the view that their brigade has an occupational health scheme, and to imply that this is the solution to any sickness absence problem without recognising the management role for officers of the brigade” (2000: 30). Case study service interviewees acknowledged that traditionally there had been a reluctance, especially among operational staff, to engage in ‘people’ as opposed to ‘technical’ or ‘operational’ management. Indeed, some staff were still sceptical about the quality of managers.

“[From the] leading firefighters, all the way to chief, [they] all [started as] firefighters. There’s no management skills. It’s only what they’ve picked up on the way…So I don’t think there is very good [people] management in the fire service to be honest.”
- Employee (operational)

However, both leadership and management development programmes (LMDP) and the Fire & Rescue Service Integrated Personal Development System (IPDS) were said to be helping to clarify the roles, requirements and expectations of managers and improve their leadership and management capability. Strategic managers talked about an important cultural shift or step change associated with LMDP, IPDS and performance management, and explained that successful attendance management should not be viewed in isolation from this deeper culture change.

“It goes much wider than sickness… for middle and senior managers last year, there was a huge cultural shift assisted by [a] leadership [and management development] programme. We’re now…putting all our supervisory managers…through a […] programme aimed at improving performance…It isn’t just about structure, it’s about our vision…, our leadership, our business processes, our values and behaviours, pay and recognition, and all those things need to come together.”
- Strategic manager

“[LMDP] show[s] […] people [that] actually they are being paid this money because this is…their responsibility. Nobody ever doubts their firefighting prowess…but…they’re all managers… watch managers, crew managers and station managers; they’re not officers anymore…So, now, they have to accept the role that they’ve actually got to manage their particular section and some are doing it very well…[others may] never take to it because it’s [not] how they’ve been brought up. But as it gradually filters down through, I think it will make the organisation far better.”
- Line manager (non-operational)

“Everyone is aware of it […] the strategic plan – five years ago, it would [only] be a handful of people who knew what the strategic plan [was], …what the aims [of the organisation] were and what our mission statement was. [That’s] all changed.”
- Employee (operational)
Fit for Duty (2000) also highlighted the importance of line managers having clear responsibility for day-to-day management of attendance, and receiving appropriate guidance and training to support this. All case study services had implemented, or planned to implement, revised attendance management policies with a package of policy-specific training for managers and awareness raising for employees.

“From introducing the policy we did [a] two year [cycle] of training for all of our managers… part of that was primarily to refocus their line managerial responsibilities in terms of the absence of their people…And then get the message down to their people that the line managers did actually have a role to play in all this.”
- Strategic manager

In addition to policy-specific training, line managers were also positive about the skills learned through LMDP which could be applied to attendance management. LMDP was felt to be particularly important in the context of managing a close-knit watch, where making management decisions relating to other team members’ attendance, performance and pay could make managers feel uncomfortable.

“It’s something we’ve never done before, not in my time in the fire service…[LMDP] was teaching me…new ways of actually dealing with people [be]cause I was very much a militaristic person and I’ve sort of pushed that back out the way now…[LMDP is] all about how to deal with people, communicating with people and understanding people better. Yeah we needed it.”
- Line manager (operational)

The devolution of attendance management to supervisory management levels was seen to have raised challenges. It meant managers had to develop new skills, make time for new tasks, and make a mental shift from being ‘peer’ to being ‘boss’ which was difficult especially in smaller and more informal teams. It was clear that training played an important role in supporting these changes. Chapters 3 and 4 discuss these challenges, the variation in how consistently line managers were implementing new arrangements for attendance management, and identify areas where there are further training needs. Overall, however, senior managers were confident that staff throughout their service were beginning to contribute in positive ways towards organisational change required by the modernisation agenda.

“I feel as though the organisation’s been like a big boulder that’s been stuck in the mud and the moss and we’re now trying to get it rolling and we’ve given it a push and it’s starting to move, but very soon it’ll be going downhill and it’ll really start to accelerate…I can feel that movement start to happen now and it’s getting a bit easier to energise it and you can start feeling others contributing towards it; it’s not just having to be top-led. People are starting to make things happen [through] their own initiative and their own innovation.”
- Strategic manager
2.4 Chapter summary

Significant improvements in sickness absence performance had been made across the case study services. The top performing case study services in 2006/07 had adopted an holistic approach to attendance management (elements of which are discussed in chapters 3, 4 and 5), but were also further along a trajectory for attendance management which emphasised the effective use of performance management information, the strategic prioritisation of attendance management, and the devolution of responsibility for attendance management to supervisory management levels.
3 MANAGING SICKNESS ABSENCE

Chapter 3 examines how sickness absence is managed in individual cases. The chapter begins by looking at the decision to go off sick and the scope for preventative intervention before this (Section 3.1). Section 3.2 discusses the issue of contact with line managers, senior management and peers during sick leave. Section 3.3 looks at the role of occupational health staff, arrangements for medical help and treatment and the role of the Fire Services National Benevolent Fund. Then sick pay arrangements and the financial impact of sickness absence for individuals are described (Section 3.4). Finally, Section 3.5 looks at the management of the return to the work process, describing first the timing and planning of returns to work and the role of phased returns (i.e. returning on reduced hours) and modified duties (also called light duties or altered duties).

3.1 Going off sick

For employees with experience of sickness absence, the decision to go off sick arose in three different ways. One group experienced a sudden injury, or the sudden return of a longstanding problem, which made them immediately unable to work. Another group experienced an illness or psychological problem that became increasingly severe: they continued to come to work until it was clear, or their GP insisted, that they could not. The third group had a planned operation or treatment, which meant that they and their line manager knew of the sickness absence in advance.

There were thus only limited opportunities to try to avert the sickness absence, and in practice few in the sample had made any such attempts although some had received support from occupational health when they had experienced previous episodes. There were instances where it appeared that there may have been scope to try to avert the sickness absence, for example through changes to duties or referral to occupational health, and cases where line managers were aware of developing issues but occupational health had not been involved.

3.2 Contact during sickness absence

3.2.1 Contact with line managers

Management perspectives

Managers generally saw maintaining contact with staff as important, and this was strongly echoed in the staff interviews. Managers saw it as important to ensure the service understood the reason for sickness absence and how it was affecting the staff member, to be able to offer help and support, to identify scope for referrals to occupational health, to maintain the relationship with the service, to ensure returns to work could be discussed at the appropriate point, and so that the staff member was aware their absence was being noted and monitored. The expectation was that the main initiator of contact would be the line manager, and this role had been emphasised where attendance management had been devolved to watch managers.
Procedures for contact varied. One case study service had no formal procedures but strategic managers believed that there was nevertheless active contact. Three services had prescribed the regularity of contact but did not have formal procedures for monitoring contact. In one service there was much more emphasis on line manager contact, with a requirement for regular completion of contact sheets which were monitored by more senior managers. This was one of the two top performing services out of the five case study services in 2006/07.

Contact happened through home visits, telephone and email contact, informal visits by staff to stations and, for retained staff, via their attendance on drill nights. However, it was clear from both line managers and staff that contact was not always regular or frequent and that line managers were not always proactive, sometimes relying on the staff member to make contact. How aware strategic managers were of this varied: some acknowledged that there was not always regular contact, others believed that regular contact was being implemented more consistently than the interviews with staff and line managers suggested. It was only in the service with a system for recording and monitoring contact that the line managers and staff interviewed consistently reported regular contact. In other case study services, line managers described for example keeping in touch only if it was obvious that the medical problem was severe and the absence likely to be long term, or only if they felt the staff member would welcome it.

Managers who did not do regular contacts explained a number of reasons for their reluctance. First, they did not want to appear to pressurise the staff member about returning to work and felt that contacting people could have this effect even if it was not in any way the motivation.

“It’s a difficult one because I’m never quite sure whether it’s right to ring them up at home or not because I don’t want them to feel that you’re actually pressurising them if they are genuinely ill, you know, to get back to work. ‘Cos we’ve got quite a good team relationship and it’s difficult to sort of have a foot in both camps if you’re management and you want to be a team, you know look after your team as well.”
- Line manager (non-operational)

There was also concern that their contact might be unwelcome or intrusive, either perceived as threatening or just an intrusion at a difficult and personal time. It was felt that it needs personal skills that not all managers have. People were particularly concerned about intruding if the colleague was off with psychological problems such as depression, bereavement or family or relationship breakdown. There was also concern that contact would be unwelcome if the person was off for a work-related reason, for example stress related to workload or workplace changes, or if there was a disciplinary issue or a difficult relationship with the line manager.

“I was the one that reported [the colleague]. Now would she want me ringing up as a line manager when she is off through stress-related illness because of the harassment claim, for me to ring her up and say ‘oh how are you?’ ….. So somebody that’s off with stress it’s very difficult. Do you contact them or don’t you and how often do you contact them?”
- Line manager (non-operational)
“In fact that’s a bit of a bug-bear with people that have been off for a period of time that they’re sort of out of sight, out of mind. … And it is a difficult thing isn’t it, you know, visiting people …. [I]t’s not something everybody’s comfortable in doing. It’s easy if somebody’s been off for a period of time just to think, ‘oh …the doctor’s certificates are coming in and X, Y, Z’s been done and all the forms are right’ and…let them get on with it …. I know the time when I was off for an extended time … you get your officer boss visiting you …. Unless you’ve got a certain relationship with them it can be like, ‘oh you’re checking up on me’.”

- Line manager (operational)

Line managers also talked about being too busy, particularly to make home visits and especially where staff were geographically dispersed. Male line managers sometimes doubted whether a female colleague would want them to visit them at home.

Where line managers of retained staff were themselves retained it was particularly difficult to make time for contact except on drill nights, which meant that retained staff who were not well enough to attend drill nights had very little contact.

“[The] guidelines say that you should keep in contact with someone who is long term sick, but that can be very difficult because you have a full time job and you have a part time job and they also say you have to ring so and so up once a month or whatever to make sure he is ok and if there is anything we can do for him, and that can be difficult. So you know some support with that might be better.”

- Line manager (operational)

This led to a preference for occupational health or welfare officers to make contact and particularly to carry out home visits, on the grounds that they were more likely to be seen as independent, to have the time, and to have the skills and manner necessary to make the visit successful. In some case study services there were occasionally contradictory perceptions between occupational health and line managers as to who should lead on contacting staff.

**Staff perspectives**

The need for more regular and frequent contact with line managers arose very clearly in the interviews with staff members. Regular contact initiated by line managers was seen to play an important role. This was especially the case as people were away from work for longer, becoming more isolated, depressed, frustrated and estranged from work, and more worried about whether, when and how they would be able to return. But people whose absence lasted for less than four weeks also expressed strong disappointment and surprise that their line manager had not been in touch.

Where they had not had any or enough contact, they said this had contributed to a real sense of estrangement from and disenchantment with the service. It led to concerns about the value placed on them and their return – the phrase ‘out of sight, out of mind’ used by the line manager quoted above was echoed by several staff members – and could in turn undermine their commitment to returning as quickly as possible. They described line managers being unaware of what they were
experiencing and not helping them access support from occupational health, and said that this in turn made them reluctant to be open with their line manager.

At the most minimal end of the spectrum, there were accounts of no contact at all during a three month absence, responses only to the staff member’s emails, three telephone calls in eight months, and, in the case of a retained member (who lived close to the fire station), one home visit in 18 months. Others described contact that was more frequent but still unsatisfactory to them, for example texts or telephone calls but not a home visit, or very cursory telephone calls revolving around requests for sickness certificates rather than suggesting a genuine concern for their well-being.

“\textit{I’ve had one phone call from my line manager …. That’s it …. Years ago, because it was all more personal, the whole service was far more personal, somebody would phone you up, somebody would pop round for coffee, you know. Okay, they’re checking on…but at least you feel like somebody… cares. Whereas now you just feel like a number…I think it’s disgusting, I do…[Later in interview] Somebody seeming to show some kind of sympathy would’ve been ideal. …[otherwise] it just turns you against it straightaway so, you know, they’re not bothering contacting me or, or showing any concern or, or anything.}”
- Employee (operational)

There were people for whom minimal contact was sufficient, particularly if they had a lot of contact with occupational health staff. And there was a more general view that if you were off with work-related stress then frequent contact from a line manager could be problematic. For example, one person in this situation said:

“\textit{If I’d had contact with my line manager I would’ve felt quite pressured and that wasn’t anything that I wanted really.}”
- Employee (non-operational)

At the other end of the spectrum were people who gave very positive accounts of the contact they had experienced from line managers. Especially if the health issue was sudden and severe, it was important to people that contact was made very quickly, and home visits were well received. People valued regular contact – weekly, every ten days or fortnightly. The nature of the contact was also important. People want a contact that was not just chasing sick notes or asking when the person would be back, but:

- showing genuine concern about how they were;
- asking about treatment and plans;
- asking about any support the person needed, helping people to access occupational health and welfare officers, giving information about the Benevolent Fund;
- being proactive in giving information about pay arrangements but not using the drop to half pay to exert pressure for a return to work; and,
- giving the right level of information about what was happening at work – so that the person felt involved but not under pressure

“He came to see me, asked how I was, didn’t particularly mention work, didn’t particularly mention ‘when do you think you’ll be back at
work?’ – the typical sort of managerial question put to somebody who’s on the sick, and I suppose I didn’t get that. He asked if I needed anything. It was very good.”
- Employee (operational)

Where people had experienced regular contact they described it making them feel valued and supported, and they were confident and pleased that their line manager was aware of the issues they were facing.

“I think it’s important that you value your people. As opposed to just going through a procedure because it is written down, go a bit further and deliver it with a bit of feeling and warmth and sincerity as opposed to – ‘I am down the page here tick, tick, tick and right speak to you next week’. And set aside a bit of time for them.”
- Employee (operational)

3.2.2 Contact with peers and senior managers

Contact with peers was highly valued by people, particularly if there was little or no contact from the line manager or a problematic relationship. Generally though people described very little such contact, particularly retained staff. It was said that in the past contact from colleagues was much more forthcoming reflecting more of a ‘family’ culture with very close mutually supportive relationships within watches, whereas the culture was seen as more of a ‘business’ one now. The change was also seen to reflect the fact that colleagues were less likely to come from the same small geographical area nowadays. Where people had had contact with peers such as home visits and telephone calls they had found this very important in sustaining relationships and contact with work. Some people had called into stations as they started to get better and had felt this had helped to sustain relationships, build their confidence in returning to work and ensure that colleagues were aware they were genuinely ill and trying to get back to work as quickly as possible.

Contact by senior managers was also important. This was not mentioned in the strategic management interviews except in the service with the most developed contact policy, where two line managers described a practice of monthly contact by group managers as well as their own regular contact. Contact from senior staff was viewed as important by people with experience of sickness absence, particularly if their injury was long term and severe or had been sustained on duty, and there was disappointment where senior staff had not been in touch. In one service there was a requirement for staff to make a monthly written report on their progress to the Chief Fire Officer. Only one staff member commented on this, finding it unhelpful at a time when they were in extreme pain.

3.3 Role of occupational health during sickness absence

3.3.1 Occupational health arrangements

Three of the case study services had in-house occupational health units, managed within the human resources department in two, and the health and safety department in one. Two case study services had a contracted-out occupational health service. Managers and employees saw advantages in both models as listed below.
Perceived advantages of an in-house occupational health unit

- Awareness among occupational health staff of the culture of the organisation, the nature of different jobs within the organisation, and scope for modified duties, phased returns, reasonable adjustments and redeployment
- Awareness within the organisation of what the occupational health unit can do (e.g. referral to external services) to facilitate rehabilitation and return to work of employees
- Direct lines of communication between occupational health, human resources, management and employees
- Occupational health staff are well-known and approachable for both employees and line managers
- Occupational health staff are fully integrated in relevant policy-making committees (e.g. health and safety) and steering groups

Perceived advantages of a contracted-out occupational health service

- Considered more affordable for smaller and more rural services
- Fully independent from the fire and rescue service, confidential
- Ability to draw on a broad range of expertise from across the Fire & Rescue Service, and other branches of the emergency services

Services with external occupational health providers acknowledged that the relationship and respective roles and responsibilities of the human resources department and the external occupational health provider required greater clarification. This ensured that the occupational health contract was working efficiently, not only in terms of timely assessment and effective two-way communication regarding long term sickness cases, but also the provision of proactive healthcare input. Where roles and responsibilities had been clarified, the occupational health service provision was perceived to be improving.

For example, one case study service had retendered the contract for an occupational health service, having developed a clearer specification for the role and responsibilities of the provider. Coupled with the appointment of a welfare officer with a remit for case management of long term sickness absence cases, this retendering process had stimulated more efficient and effective management of sickness absence. Regular and practical dialogue between the organisation and the occupational health service had been enhanced through the introduction of monthly meetings attended by the welfare officer, staff counsellor, physical education officer and occupational health doctor.

3.3.2 Contact with occupational health

Management perspectives

All five services had arrangements for automatic referral to occupational health at 28 days absence (14 days in one case study service). There were also arrangements for earlier referral by line managers or staff themselves. In some services occupational health staff scrutinised sickness absence reports and themselves initiated earlier contact where appropriate. The emphasis placed by management on earlier referrals seemed to vary between the services. Occupational health involvement was seen to play an important role in attendance management, providing an opportunity for investigation of the condition, referral for medical support
(see Section 3.3.2), exploration of the scope for modified duties (see Section 3.5.3) and encouraging a return to work. Welfare officers were felt to play an important part particularly where there were psychological issues or work relationship problems. Managers described individual cases where they felt that this early referral had been effective in supporting a quicker return to work by identifying issues that needed to be addressed, accessing medical help or initiating a return to work.

A number of barriers to involving occupational health were evident. First, there was sometimes a sense among managers interviewed of occupational health involvement as challenging rather than providing positive support. This emerged because they saw at least part of the role of occupational health as being scrutinising and identifying absence that was not health related, or because they thought occupational health might be too quick to say someone was too ill to return to work. In most case study services it was said that this had been a more prevalent culture in the past and it was being addressed with varying degrees of success.

“I think the culture’s changed. At first they were frightened of it thinking ‘it’s going to get me out of a job’. Now they actually self-refer a lot of the time, saying, ‘Can you help us here cos I’m not sure what I’m supposed to do with this knee.’ And occ health of course have the facility to do that. And the idea is not to get them out of the job, the idea is to keep them in employment.”
- Occupational health staff member

There was some doubt among line managers about the value or purpose of involving occupational health for example if someone was getting adequate support from their own GP. Some line managers described referring people only after they had returned to work, apparently not realising that occupational health could add to what GPs are providing in helping someone return to work. There were also complaints about the quality of occupational health support, particularly in one service where occupational health provision was contracted out and it was felt that advice was not sufficiently well attuned to the needs of the service (see Chapter 2).

There were differences between the case study services in whether contact with occupational health was seen as compulsory or voluntary, and whether attendance management policies described occupational health appointments as compulsory. Where the procedures did not describe contact as compulsory, it was felt it would be useful if they did. There was also sometimes a lack of clarity about exactly what should fall to the manager and what to occupational health staff. Some occupational health staff felt that line managers were too quick to refer, and did so before they had themselves gathered information and decided exactly where they needed occupational health input.

**Staff perspectives**

Almost all the people interviewed with experience of sickness absence had been in contact with occupational health. Those who had not had mostly been off for periods of two or three weeks, but there were also people who had been off for several months without contact, both retained and wholetime staff.

There were very positive descriptions of contact. The occupational health nurse in one service was particularly described as providing very supportive regular contact. People valued being given advice about managing their condition, access to medical help, and support in returning on modified duties.
“She would probably more than likely phone me once a week…At the very beginning it was…every couple of days…[saying] …not to worry about what was going on at work, just to focus on what’s needed now, because she knows…I am conscientious...And...the counselling, she did suggest that, she said ‘I think you do need it, you do need it quite quickly’. So she was really good because she set it all up …[w]hich I was immensely grateful to her for.”
- Employee (non-operational)

"I don’t know what your experience of GPs is but mine has always been that … they are always late and they never have enough time so you don’t really get a thorough job done do you and they don’t necessarily get to a root of a problem …. Whereas I actually got to know from going to occupational health that yeah I have a kink in the bottom of my spine and it was to do with how [I] stand.”
- Employee (operational)

However, others were more critical. This emerged where people had not had contact, where contact had been very infrequent or by telephone only where they would have preferred a home visit. People were not impressed by what they described as formulaic approaches, working through a checklist of questions rather than an in-depth investigation of their condition and how they were feeling. There were reports of occupational health staff making insensitive comments, for example that it was unlikely that someone would be able to return to work, or implying their condition was not severe or they were reluctant to return to work. There was frustration with being required to attend an appointment which led to no obvious benefit or help. This was especially the case where people were too ill or in too much pain to travel comfortably, if they were getting satisfactory help from their GP or awaiting the outcome of NHS investigations which would determine the treatment plan, or if they were seeing a welfare officer regularly. These cases highlighted the importance of occupational health doing more than just gathering information about the health issue that had already been given.

3.3.3 Other support

Funding for private treatment
There were different arrangements in the five case study services for funding private diagnosis or treatment. In four of the services, budgets were very limited and the emphasis was on investigative treatment, with little or no money available for actual treatment beyond physiotherapy and sometimes also counselling. In one larger service there was more extensive funding with a bigger emphasis on paying for treatment as well as budgets for investigative consultations and scans, counselling, physiotherapy and condition management advice⁶.

Strategic managers were generally very positive about the value of such interventions. They saw them as having a direct effect on people’s ability to return to work and giving an important message about the value placed on the individual, making people more inclined to return as quickly as possible, and meaning that a request to attend a meeting at 28 days is viewed more positively. Staff also gave

⁶ It was not clear whether, in this larger service, funding was greater on a per staff capita basis.
very positive accounts of being referred for physiotherapy, counselling or appointments with specialists for scans or other investigative work.

“I had some quick therapy down at the hospital and some physio and I jumped all the queues and got in and back to work in 3 days and carried on with the therapy once a week and it resulted in no time off which was very good.”
- Employee (operational)

However there was criticism where such interventions were felt to have come late, where the quality of physiotherapy was felt to compare poorly with NHS provision, and where treatment or a diagnostic operation was not funded.

The Fire Services National Benevolent Fund

The Fire Services National Benevolent Fund provides rehabilitation services, financial support and a helpline for people off sick. Staff who had attended rehabilitation centres were very positive about the experience, praising the quality of provision and commenting on the value of specialist provision based on a real understanding of the demands of operational firefighting.

“Absolutely brilliant...I felt myself very, very lucky that I had that facility ...Definitely got me back to work quicker. I got myself fit enough to pass the medical...[though] still [hadn’t] got hundred percent movement. I was going to the gym here and there but then when I went back to the follow-up they looked at it and says ‘let’s start pushing this now, let’s get it really better’. And he got it back to hundred percent movement really. So it was absolutely brilliant.”
- Employee (operational)

Some people had not been able to get a place as quickly as they would have liked. It was also suggested that there would be value in more flexibility, for example being able to attend at the weekend only where people had returned to their primary employment or had caring responsibilities. In some services there were procedures for line managers or occupational health staff to provide information proactively about the Benevolent Fund: this was welcomed but seemed not to operate elsewhere.

3.4 Financial provision

For whole time staff, the usual sick pay arrangement is six months full pay and then dropping to half pay, although where an injury was sustained on duty pay remains at the full time level and there is discretion for this in other cases too. For retained staff, the retainer fee plus up to four drill payments in a year are paid, with more generous provision if the injury was sustained on duty.

Among strategic management and line managers, there was a view that it was important that the fire service had good financial provision but that the existing provision for full time staff was too generous and encourages people to stay off for longer than they need. The clear pattern of requests to return on modified duties at the six-month point was seen as implying that people delayed returns until that point. It was suggested that the period for full time pay should be shorter and that there
should be more scope for discretion in its duration. Among staff, the pay arrangements were generally well understood although people were unclear about what the decision at the six-months point was based on. Where people were off for longer this was a source of real worry and they needed more information. One person for example had not had any information about pay and assumed that since their pay had not changed when they recently reached the six months point they would remain on full pay, but had received no contact about this.

The actual financial impact of being off sick varied. Some people experienced little or no impact, because they were still on the full pay period, had private insurance, had been able to return to primary or secondary employment or, in the case of retained staff, because they did not rely on their fire service salary. For other people though the financial impacts were more considerable, especially combined with the loss of the primary or secondary employment wage, and some people said they had returned sooner than they should have because of financial pressures, or that they would be more likely to consider modified duties at the point when their pay fell irrespective of their health.

3.5 Managing the return to work

3.5.1 Influences on the timing of returns to work

As the previous section outlined, financial pressures played a part in influencing the timing of returns to work. A much clearer influence though was people’s own assessment of their health, or the advice of their GP. People generally described being committed to returning to work as soon as they felt able to do so and being clear that they could not yet return, or could not have returned earlier. There were also recurrent references to feeling guilty about being off because of the impact on other staff, and for some a sense of work building up to be dealt with on their return. There were a small number of cases though where people said that the inadequacy of contact while they were off made them disinclined to return to work as soon as they could.

Occupational health appointments were also an important trigger. There were a number of cases where the scope for a return to work, particularly on modified duties or reduced hours, was identified at an occupational health appointment. There were also cases where people delayed their return to work until an occupational health appointment, either on their own initiative or on the advice of their line manager or occupational health staff. Contact with line managers did not play such an evident direct role in triggering returns to work (although as noted in Section 3.2 it was highly important in other ways).

3.5.2 Planning returns to work

Some returns to work involved no planning – the staff member simply notified their line manager that they would be returning on a given date. These were generally returns after shorter absences and less significant health issues. However, one person returned in this way after a major operation, and another after a four month absence, with no discussion with line managers and no occupational health involvement. Both were cases where there had been little or no contact with line managers or occupational health during the absence, and neither staff member felt the arrangements were adequate. There was more active planning in cases of
longer absence, where there had been occupational health involvement, and with phased returns or modified duties. This had involved a series of discussion in advance of the return to work about the timeframe, the need for any modifications to the person’s work or their working hours, arrangements for briefing and re-training as required, and arrangements for seeing occupational health before and after the return to work.

There were different arrangements among the five case study services for being certified back to work by occupational health. Some services had compulsory occupational health appointments for operational staff returning after a fixed duration, whereas others had just a general encouragement to line managers to refer people for such an appointment. There was surprise where people had not been required to attend after a serious condition or long absence, or that the appointment did not involve a more detailed examination. Managers acknowledged that there were cases which were not identified and referred to occupational health. Staff with experience of sickness absence sometimes felt it would have been useful, on reflection, if occupational health had been involved in assessing their fitness to return, discussing the need for modified duties or hours, and following up after their return to monitor their health.

“Occupational health never invited me down to assess me to see if I was okay. I was back at work after a major operation and not been assessed.”
- Employee (operational)

More robust approaches to return to work interviews and trigger point reviews (see Chapter 4) were viewed as helpful here as they were an opportunity to pick up on a need for continuing occupational health involvement.

### 3.5.3 Phased returns and modified duties

Among strategic management and line managers, there was general support for the idea of phased returns and modified duties as ways of getting someone back to work sooner as well as maintaining contact, preventing isolation and distance, helping people to keep up to date with procedures and changes, allowing people to re-integrate at work, and giving an opportunity for the manager to assess their capability. One strategic manager for example said they would support a policy under which occupational health are involved early on in all cases to discuss whether the person can return to a modified role. Staff with experience of sickness absence also valued them as a more supportive way of returning to work earlier and reducing the need for retraining.

“It’s about saying to people, ‘Well actually, you know, you’re not fit to come to work as a firefighter, but we can use you in community safety,’ and we’re doing much more about phased return to work and alternative duties …. And that actually gets them back into the work ethos as well, cos I think there’s a thing … where being off work becomes the norm, and you’re got to break that sort of routine. And the quicker you get people back to work in whatever form the better.”
- Strategic manager

However, it was widely said by management that phased returns and modified duties required a change of culture and attitude among managers and staff. It was also
said to be necessary to change the attitudes of GPs who are not sufficiently flexible, viewing a patient as either too ill to work or fit to return to normal duties. As with other issues, there were some differences between the five services in how far they had progressed. It was one of the two top performing services in 2006/07 out of the five case study services where the change seemed to be most advanced, with more proactive exploration of the scope for modified returns, more flexibility about their structure, and more systematic joint decision-making and management. Training and support for line managers was seen to be important in embedding cultural change and ensuring consistency in practice.

“Not everybody likes the idea of altered duties. I think sometimes people get the wrong idea about altered duties …. It’s always up to us to sell it at the minute, and I think if heads of department and line managers are selling it as well then we’ll get less people having the wrong thoughts about it. You know, it is a productive job we put you into, it is a job that you can do. It allows you the time off for your physio appointments, it allows the time off during the day to do the exercises you’ve got to do for your knee. If the injury, the problem you’ve got, stops you from doing any significant manual handling, that won’t be in the job.”
- Occupational health staff member

A number of issues emerged from interviews with managers and with staff.

Availability of phased returns and modified duties

Although none of the strategic managers or line managers interviewed said they would refuse to allow phased returns or modified duties, some staff said that their request was either refused or strongly discouraged by their line manager. One person for example said that they were told that such returns were ‘not allowed’, and another that ‘you’re either sick or you’re well’. In other cases a phased return or modified duties was not offered by the line manager – including after periods of several months off – and the staff member therefore assumed it was not available.

Identifying suitable roles for operational firefighters

Strategic managers and line managers acknowledged that, in the past, modified duties had not always involved meaningful work. The increased emphasis on community safety, for example home fire safety checks, was said to offer a wider range of roles. One manager described working through the job description to identify what an operational firefighter could and could not do and creating an appropriate package of responsibilities. Others talked about exploring with the person what they were able to do and designing a role around it. The value of a meaningful role was clearly recognised here.

“We’ve even had some people who have … discovered skills that they didn’t know they had and then some people have then gone on to permanently transfer into other roles which they probably would never have considered. …. People sometimes talk to me about how it was fifteen or twenty years ago where alternative duties was you came in and you wandered around the station painting a sign which was not really conducive to getting somebody back into the working environment because people want to feel useful, they want to feel they are doing something, they do not want to feel as if they are in
the way or superfluous.”
– Occupational health staff member

However, some managers said that it could be difficult to find an effective role, and seemed not to approach developing appropriate roles with as much creativity and flexibility.

Among staff there was very strong antipathy to modified duties among those who associated them with office work and the sort of work that no-one else would do, and it was clear this could be a major barrier to such returns to work.

“Everybody knows that option’s there, to do light duties. But I think the majority of the people...if they’re operational staff, they’d rather stay off work until they’re fit to come back ‘cause the light duties part is so sort of soul destroying really .... ‘Cause there’s nothing structured and you’re just a general dogsbody. Can you fetch this, can you fetch that, can you file these? That sort of thing really.”
- Employee (operational)

This had led one person to refuse an offer of modified duties involving routine clerical work, and others to discourage GPs, consultants or occupational health staff from recommending them. There were mixed reports about the availability of community safety roles, and in some services they were constrained by the requirement to do visits in pairs and the need for transport. These views underpinned a preference among some for ‘unofficial’ modified duties, where colleagues ensured that someone who was not yet at full strength was able to avoid the most demanding tasks. In one service with a larger community safety department, there was more scope for finding suitable roles and some staff commented very positively on having done valued work and developed new skills.

Scope to remain with the watch and shift

Linked with this was a preference among operational and control staff to remain with their watch and on their usual shift pattern. Both management and staff felt this could be beneficial for reintegration and could provide a more supportive working environment because it meant returning to established roles, supportive relationships and established working patterns.

“That lady…took comfort [from] being as much part of the watch as she could and that gave her great comfort, great support and that worked for that particular lady. If we had said to that lady ‘no, you’re in area headquarters and you’re doing Community Fire Safety or you’re driving a van or you’re [doing routine office work], she wouldn’t have come back. That just wouldn’t have helped her.”
- Strategic manager

In the management interviews there were different descriptions of the working hours available on phased returns. Staying with the watch and working a part time version of the usual shifts (for example fewer days on) was not always available. The different approaches were: structuring posts flexibly around individual requirements; a preference for a nine-day fortnight but with some flexibility; or a more fixed use of the nine-day fortnight for a set duration of four weeks. It was acknowledged that staff have a strong preference for the shift structure, and can find moving to daytime hours difficult to adjust to and disruptive to domestic routines. If both adults in the household worked and they had children, it could be very disruptive to child care routines to have a substantial change in hours. It also had an impact on the scope
for secondary employment. However managers also felt that it could be impossible
to accommodate someone in a meaningful role with their watch, of limited value if
they were left alone whenever there was a call out, and difficult to provide modified
duties during a night shift.

There seemed to be variation between managers across, and also within, the five
case study services in how flexible they were willing to be in structuring posts. Some
were willing to be as flexible as possible around the health and also domestic needs
of staff provided that the agreed hours met business needs, so that for example very
short shifts, or a day a week only, or not having a fixed pattern might not be possible.
Others seemed more reluctant to accommodate domestic demands or insisted that
certain parts of the day were covered. In Fire Control in particular it was said that
day-only shifts were hard to manage and caused resentment among other staff.
There was also a view that the very unpopularity of the nine-day fortnight was useful,
since people's dislike of it encouraged them to return to full time work more quickly.

Among staff there was strong antipathy to daytime shifts because of the disruption to
domestic routines and the scope for secondary employment, as noted above. For
some, it was a reason to avoid returning earlier on a phased return and instead to
wait until they were well enough to work full time and thus return immediately to their
usual working pattern. Where there had been flexibility to accommodate for example
medical appointments or domestic responsibilities, this had been strongly valued.

Involvement of occupational health

Occupational health were generally involved in discussions about phased returns and
modified duties, but there seemed to be differences in, and different perceptions
about, whether it was line managers or occupational health who led decision-making
and the management of returns to work. The general view was that occupational
health should be involved in advising on what functions were appropriate and what to
avoid, but that line managers should determine what meaningful role could be carried
out and how it could be implemented in their department – particularly given the
emphasis on targets for departmental performance. In one service, several line
managers criticised the fact that the contracted out occupational health determined
the structure of the modified return to work, making decisions which line managers
viewed as sometimes unworkable or ineffective.

“It’s always been a mindset that what occupational health
recommend is what you get, not that occupational health make a
recommendation it comes back to me as a manager and we say
what we can manage within those recommendations. I have
recently actually overridden an occupational health recommendation
because they had no knowledge of how we work.”
– line manager (non-operational)

This contrasted with a service where there was a systematic approach to shared
decision-making:

“We would work that through with the occupational health. So, you
know, we’d say, ‘Right, we want them [back on modified duties].
They would go and see them and they would, you know, discuss
with them, you know, the treatment they’ve had and, you know, what
they’re like, and then they’ll generally come to us and say, ‘Right,
[they can] do X, Y and Z, can you fit that in?’ We would look at it and
generally say, ‘Yeah, that’s okay, we can sort that out .... [I]t’s worked out well.’”
– line manager (non-operational)

Line managers in some services said they needed more advice from occupational health staff, in the form of discussion rather than written information, and more involvement in decisions. Some service had meetings between line managers, more senior managers, occupational health and the individual to discuss how to manage their return, and this was viewed much more positively than arrangements which were limited to written advice by occupational health to line managers. Line managers wanted advice from occupational health about where someone could be deployed, what they could and could not do, the likely speed of their return to full health and what to look out for, and the support that they should or that occupational health could provide.

Managing progression to usual duties

Part of the antipathy to modified duties appeared to lie in the fact that there was not always a structured and managed progression back to usual duties. Where there had been a step-wise approach with a gradual increase in the range of duties building up to the normal work, with regular reviews with line managers and occupational health, this was valued. But there were also cases where staff did not feel they were being encouraged to progress to full duties in a structured way, and would have languished for longer on modified duties if they had not themselves pressed for a full return. Managers acknowledged that this managed approach was not always taken, reflecting the absence of clear procedures for contact between occupational health and line managers or simply the pressure of workloads.

Among staff there had generally been little continuing contact with occupational health after the return to work and people would have valued more input particularly if their condition continued to affect them.

Issues for retained staff

Flexible returns to work were seen as particularly important for retained staff who it was said can end up ‘drifting away’ from the fire service and never returning if they lose contact for too long. However, they were also seen as particularly difficult to provide because the more limited time commitment meant less flexibility in what could be arranged, and because primary employers were said to be reluctant to release staff for either day shifts or non-operational work. In one service it was said that there are no opportunities for anything other than operational work. In other case study services the opportunities were limited to attending drill nights, doing theory training or work on procedures, and doing paperwork or filing. Only one of the retained staff interviewed had returned on modified duties, doing drills and training for the first week back. Others would have liked to attend drill nights but were told they could not be paid, or were not offered any alternative to returning on their usual working basis.

“Is there anything different I could have done? Yes, probably, some [fire safety] checks and things, but because I have not been trained to do the checks I couldn’t do them … I could definitely do [administrative work but] it wasn’t offered… I am … quite happy to do admin and paperwork, Command Support where you have to

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7 It is not clear why they could not be paid, since there is scope for payment for attendance at drill nights on modified duties.
organise and be quite detailed in what you are doing … admin is
something I am fairly good at so I am sure I could have done
something.”
- Employee (operational)

### 3.6 Chapter summary

There was variation between the services in how robustly they were implementing
different elements of attendance management. Stronger performance in sickness
rates was associated, within the study sample, with systematic frequent contact by
line managers, early referral to and effective input by occupational health, and more
creative and positive approaches to phased returns and modified duties.

A clear finding from the research is that there is a need for more proactive, frequent
and effective contact by line managers when people are off sick, and for this to be
documented and reviewed by senior management. There appears to be a need for
training for line managers here, particularly in how to balance a ‘welfare’ role with
procedural requirements such as for sickness certificates and a scrutinising function
where this is necessary.

There is also scope for more regularised contact by occupational health, senior
management and peers. The evidence suggests that these should generally be seen
as additional too, rather than in place of, line management contact. However, it may
be effective for this to be the primary contact where the relationship with the line
manager is part of the reason for the absence, and there is perhaps scope to support
retained line managers through for example the retained liaison officer role that one
service was developing. There is scope for more involvement of occupational health
both earlier in sickness absence and also in a preventative role before it begins.
Funding for private medical treatment was fairly limited but viewed very positively by
staff and management, although there may be political difficulties in extending its use
by a public sector organisation and there is a need to audit its cost effectiveness.

In terms of returns to work, there is scope for more use of phased returns and
modified duties. The key issue here is developing roles creatively and flexibly which
are within people’s capability, are meaningful jobs, make good use of existing skills
and support their reintegration. There is scope for more joint working between
occupational health and line managers to design roles and monitor progress. There
is resistance to moving from shifts to daytime work, but this could perhaps be
reduced with more flexibility on the part of management and staff, and proactive
management from daytime back to shifts.
4 MANAGING ATTENDANCE

Chapter 4 explores strategies used across the five case study services to manage attendance. Each strategy is discussed in detail, beginning with return to work interviews, used following any period of sickness absence to welcome an employee back to work, discuss any on-going problems and identify any support needs (Section 4.1). The chapter then looks at trigger points for reviewing an employee’s attendance record. Such reviews take place where cumulative sickness absence has reached a level where intervention may be required in order to address reasons behind non-attendance (Section 4.2). Finally, approaches to managing situations where a return to the job is not possible are examined, namely redeployment, retirement, capability proceedings and dismissal (Section 4.3).

4.1 Return to work interviews

Management perspectives

All five case study services had a policy of return to work interviews following sickness absence. They were seen as an important opportunity to ensure the line manager knew what had led to the absence and any issues it raised, to identify any continuing support needs and if appropriate make a referral to occupational health, to ensure that the person was fully fit for role, to check their competency and need for updates or training, and to aid reintegration ensuring the staff member was briefed on any changes at work. They were thus seen as having an important role to play in supporting successful returns to work (discussed in Chapter 3). Some managers also saw them as valuable to show they were monitoring the member of staff, to indicate where they did not entirely believe their account of their absence, and to discuss any patterns in sickness absence.

“The reasons for [the manager] doing [return to work interviews] are…several…One is to let [employees] know what happened when [they] were off. The second is to make sure [they’re] fully fit. And the third is to make sure [they] know [the manager has] got [his or her] eye on [them] if [the manager does] not entirely believ[e] what [they are] saying. [The manager] can’t actually do the third or say it [directly] but…that’s what it’s around.”

- Occupational health staff member

Return to work interviews were seen as playing a two-fold role in managing attendance. They were an opportunity to flag and address underlying health or welfare issues which might threaten future attendance, and they were intended to discourage avoidable future absence. Return to work interviews were therefore viewed as having two functions, one supportive and the other scrutinising. The balance in emphasis between these two aspects varied between the five case study services. This dual role or function appeared to underpin concerns or reluctance around carrying out return to work interviews among managers, and influenced the reaction of staff members to them.

In practice, it was in the case study services that placed more emphasis on the supportive function of return to work interviews that they were more consistently carried out. Strategic managers here described having successfully changed
attitudes and experiences so that return to work interviews were seen as primarily serving a supportive purpose. There had also been a push to devolve return to work interviews to watch manager level and in both services, completed return to work interview forms were routinely reviewed by senior management. This was seen as useful both to pick up on issues that needed action or investigation, and to raise the priority of return to work interviews.

In the other three services, return to work interviews did not have the same priority and were not consistently conducted, with varying degrees of awareness of this among senior staff. In one service this was the result of a deliberate decision to focus initially on trigger point reviews and then to move on to focus on return to work interviews. Across the three services where return to work interviews had less priority, there was no procedure for completed forms to be reviewed by senior management (although one service was introducing this). There was, however, a recognition that to be effective, the policy needed to be supported by more training for line managers with more active involvement of senior managers in reviewing forms.

Line managers themselves in these three case study services described not doing return to work interviews when it was clear that someone’s sickness absence had been unavoidable, if they felt the ill-health condition was straightforward, or if it was a more complex case but they knew that occupational health had been involved and had confirmed the staff member’s fitness to return to work. One line manager described checking which days of the week a person’s absence had fallen on, and doing a return to work interview if there was a pattern of absence around the weekend, since this raised a question about whether the sickness absence was avoidable, but not doing an interview if there was no such doubt. Managers said that the interviews were viewed by staff as insulting if the absence was health related, and that you could tell if someone was not fully fit without having to interview them. They described finding it embarrassing and awkward to carry out the interviews and felt they were prying, particularly if there had been emotional or psychological aspects to the absence. As a result, some line managers had never carried out a return to work interview despite having people who had been off sick.

“As much as I would say that we enforce these back-to-work interviews, I’ve never conducted one. If I think that it’s a genuine sickness…depending on the individual [an interview] could be quite counterproductive because it’s almost as though if you’re very proud you’ve got a good sickness record, then all of a sudden just because you’ve [been off] one day you’re sitting down with your line manager going through questions...It’s down to, I would say, applying a little bit of common sense and discretion.”
- Line manager (operational)

People also described using more informal processes where, for these reasons, they did not feel a face-to-face meeting was necessary or appropriate. This involved, for example, conducting return to work interviews by telephone to check informally that someone was fit for work; completing the form without having a meeting, logging the reason for sickness and the fact that there were no outstanding issues; or, having an informal chat with the person but not completing a form.

Having effective training and guidance on the purposes of return to work interviews, the ways in which they could support staff and the appropriate style and content, was seen as important by managers at all levels. Both the services which were
implementing return to work interviews more robustly had supported this with extensive training: in one service there had been a meeting with every watch to support the introduction of the procedures. Ensuring that at all levels the procedure was seen as a supportive one, was seen as important.

“When this was first introduced it surprised me that various heads of department at the time, corporate and operational, either found them to be very threatening things or felt that they had to be threatening in a return to work interview ... So the sickness absence return to work interview part of it I think probably got off to a bit of a strange start, but I think it’s well understood now, I think people do understand what it’s about.”
- Occupational health staff member

Finally, on a practical note, actually conducting return to work interviews was sometimes problematic, especially for retained and control staff, across the five case study services. Crewing levels in fire control meant that there were often only three members of staff on duty, with the only option being for the crew or watch manager to send the third member of staff not involved in the interview out for a break. This meant the interview was subject to interruption by calls to the control room. There were also constraints on conducting interviews for retained staff, as the weekly two-hour drill night was the only guaranteed time that line managers and employees had available for conducting interviews, and it was often difficult to schedule potentially complex and sensitive discussions alongside training and other drill-night activities.

**Staff perspectives on return to work interviews**

From the interviews with staff members, it was clear that return to work interviews could play a very positive role particularly in supporting the return to work. People valued it where their line manager had expressed concern for them, checked out how they were feeling, provided reassurance, identified any difficulties with the return to work and updated them on what had happened while they had been away.

“We had an hour in her [line manager’s] office where she just sort of said you know, ‘lovely to see you back but don’t push it, if it’s too much then do say and we’ll think about the light duty thing again, or whatever.’ And it was all very positive I mean it was just like a – the return to work interview to all intents and purposes, she had to do this return to work interview. It wasn’t an interview though, as I said it’s how you pitch it .... [I]t was nice that she had the chat you know and took me to one side sort of thing.”
- Employee (non-operational)

One person whose recent period of absence had related to a difficult relationship with their line manager was very pleased to have the interview carried out by a member of human resources staff instead of their line manager. There was a preference for an interview that was structured, in-depth where necessary, but informal: some felt that the need to work through a form had made the interview less effective.

Others described very perfunctory interviews. For example one person whose line manager had not known they were off sick and had not contacted them said:
“I didn’t see my line manager for another four or five days, so the next time I saw him, I go in, say, ‘boss, you know, I’ve been off sick’. ‘Oh have you? What was wrong?’ ‘Been off with this, blah, blah, blah.’ ‘Oh right, okay, yes, are you okay now?’ ‘Yes, yes, I’m okay now, blah blah’. ‘Right, sign there’, and that’s it, job done …. I think it’s a total waste of time, I mean…that was it, that was the total sum of it.”  

- Employee (operational)

In some cases interviews were not carried out, or only some time after the return – a matter of several months in one case. A perfunctory interview or none at all was seen as unproblematic by some people, where there had been a lot of contact with the line manager or with occupational health or a short absence. But other people were surprised and disappointed not to have had more discussion - particularly after a longer absence or a more serious event, but also after absences of less than 28 days.

Overall, none of the staff members interviewed described their own return to work interview as being challenging or intrusive. However there were general comments that other line managers do conduct return to work interviews somewhat aggressively, that they are not necessary if the absence was health related, and that some people avoided going off sick despite being ill to avoid the interview. There was a view that return to work interviews had reduced persistent short-term absence but there were also concerns that they had led to ‘presenteeism’, i.e. to staff coming in to work when they were in fact not well enough to perform their duties, because they wanted to avoid a return to work interview that would be unsupportive or would put them under unnecessary pressure.

Equally, however, no-one described their own interview as identifying a need for support. In many cases the staff member felt there genuinely were no support needs, or the issues were already known through previous contact with line managers and occupational health. However, there were also cases where an interview was cursory or did not place but where it appeared that a more in-depth approach might have uncovered a support need – particularly where people returned form a long period off or where they had faced a major issue regarding their health or personal life. Here, there were instances where it appeared that there would have been value in a referral to occupational health, to confirm fitness to return, to monitor the recovery to full health or to give advice about managing a continuing condition. There were also instances where people felt that their line manager ought to have asked and known more about their experience, both to be able to support them better and to explore any need for different equipment or clothing or for modified duties.

Overall, then, return to work interviews are seen as having an important role of play in managing attendance levels but there were differences between the five case study services in how robustly they had been implemented.

### 4.2 Trigger point reviews

All five case study services used trigger points for reviewing an employee’s attendance record. Trigger point reviews took place when a single episode of sickness absence or cumulative episodes had reached a ‘trigger point’. Trigger

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8 This may reflect the fact that people whose sickness absence was not health- or welfare-related are probably less likely to have opted to take part in the study.
points are defined by reference to the number of episodes or days of sickness absence in a specified rolling time period, either six or 12 months. Once an employee ‘hits’ a trigger point, then an interview is required to take place between the employee and their line manager. The purpose of the interview is to highlight the amount of sickness absence, to explore the reasons for this, to discuss any support that may be required, and to agree appropriate or acceptable targets for improved attendance. If there is no acceptable or sustained improvement in attendance, then a formal procedure can be invoked with the potential to culminate in dismissal.

The introduction of trigger points in attendance management policy had happened relatively recently in the case study services, within the last five years. Use of trigger points has required a considerable shift in attitude from both managers and employees towards the importance of monitoring sickness absence and intervening where individual attendance fails to reach required standards. Strategic managers across the five case study services regarded trigger points for individual attendance review as a vital element of successful attendance management policy, particularly for tackling persistent short-term sickness absence. However, the services were at different stages in terms of the robust implementation of this aspect of policy. Key factors in the effective application of the trigger point mechanism are discussed in turn below.

4.2.1 Trigger point levels

There was some variation across the case study services in the number of days or episodes of absence which would trigger an attendance review (see Table 4.1). One case study service did not set trigger points over the shorter six-month rolling time period, whilst the others set trigger point levels over both six- and 12-month periods.

<table>
<thead>
<tr>
<th>Trigger point levels</th>
<th>Amount of sickness absence</th>
<th>6-month rolling period</th>
<th>12-month rolling period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>episodes (n)</td>
<td>days (n)</td>
<td>episodes (n)</td>
</tr>
<tr>
<td>Lowest</td>
<td>2</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Highest</td>
<td>3</td>
<td>9</td>
<td>5</td>
</tr>
</tbody>
</table>

Line managers and employees were, on the whole, satisfied that trigger point levels were simple and fair, although concern was expressed that a ‘one size fits all’ approach for uniformed and support staff did not reflect the higher fitness levels required for operational firefighters. This involved the greater physical demands that firefighting entailed, the need to be able to use equipment (for example it was said that even a minor cold could make it very difficult to use breathing apparatus), and the fact that night shifts can place a higher demand on health levels (this also applied to fire control staff).

“This attendance policy…sits well with people who predominantly work days …You can get through a day [when] you’re feeling a bit ropey, but you can’t get through a 15 hour night, and you’re almost penalised for being responsible enough to say I’m not coming in because I’m not up to it.”
- Line manager (non-operational)
4.2.2 Identification of employees requiring trigger point reviews

The identification of employees requiring trigger point reviews had been centralised in some case study services, but in others the responsibility for identification was that of the line manager. Either method appeared to work well, provided that identification was timely and there were robust processes for monitoring outcomes.

One service had prioritised the robust application of trigger points by making identification, notification and monitoring the responsibility of the absence management group, which expanded its remit of discussing individual long-term sickness absence cases to include the identification of all employees hitting trigger points. Letters were sent out on a monthly basis to employees and their line managers, highlighting the requirement for an interview to take place and written feedback to be provided to the group afterwards. Senior management here said that initially the response was low, with approximately three-quarters of cases requiring follow-up letters to the line manager, and sometimes a second follow-up letter to the departmental or group manager stating that a trigger point review was overdue. However they felt the strategy had improved the number of trigger point reviews taking place so that, by March 2007, approximately nine out of ten trigger point reviews were being conducted after receipt of the first letter.

In one case study service, notification that a trigger point review was required was sent to employees and their line managers on a quarterly, rather than monthly, basis. Some line managers felt that the delay in notification made trigger point reviews more difficult to conduct as an employee’s last episode of absence could have been up to three months previously.

In services where identification of employees requiring trigger point reviews was the responsibility of the line manager, line managers were concerned that employees requiring an attendance review might be overlooked. Because sickness absence notification had been centralised (for example employees were required to book sick by telephoning a central ‘sick line’), line managers felt they no longer had the same ‘close eye’ on employees’ attendance as they had done previously. Several line managers had compensated for this by creating their own monitoring strategies and keeping independent records of sickness absence which was giving them more confidence in identifying employees requiring trigger point reviews.

4.2.3 Trigger point policy and training

Case study services had improved the consistency and robustness with which the trigger point mechanism was applied by revising and re-launching their attendance management policies, accompanied by training for supervisory managers. In one service the policy was communicated to all staff in small group sessions by a member of the human resources team. Consequently, line managers were very clear about their role in reviewing employees’ attendance and valued having an auditable, clear and transparent procedure to follow, which encouraged the consistent application of attendance management policy across teams and departments.

“[Line managers] used to pay lip service to [trigger point reviews] and I don't mean that [in a] derogatory [sense] because... there were never any checks on it...it wasn’t very robust as a system. Whereas now, watch and crew managers, as well as station managers, understand that this is part of their role, it’s their job, it’s a function they’ve got to perform, therefore they’ve got to do it well. So they
can’t just write ‘yeah, no issues’ at the bottom of the form.”
- Line manager (operational)

Nevertheless, in spite of training received, attendance management policy documents which contained the trigger point procedures were sometimes viewed as long-winded and unwieldy by line managers, who felt that a managers’ ‘toolbox’ or ‘quick guide’ to the policy would be helpful.

“The policy itself can be hard work, it’s not a simple policy to read through and follow…I’d have to take advice on a lot of things…[It needs to be] put into [plain] English for a start…We could…take out all the ambiguities and revamp it, I’m sure it could be put in a far more user-friendly fashion than that.”
- Line manager (non-operational)

Occupational health staff also mentioned that better written guidance about the support that occupational health could provide, and the types of circumstances under which they should be involved, would assist managers in taking responsibility for conducting full trigger point reviews. They felt that some line managers simply referred cases immediately, and sometimes inappropriately or unnecessarily, to occupational health.

“A toolkit [for] sickness absence [policy] is one of the priorities as far as I am concerned…I would really like to see that moving on…developing a much better system for…managers to know what they are doing.”
- Occupational health staff member

4.2.4 Conduct of trigger point reviews

Line managers were positive about the trigger point procedure when faced with persistent short-term sickness absence cases.

“[Employees] will realise with the people actually who are supervising them or managing them, that they will take sanctions against them, rather than it be this thing that, you know, ‘Well they can do nothing and it will disappear off into the ether and up to headquarters before anything might or might not happen’.”
- Line manager (non-operational)

“I just served an informal ACAS disciplinary action on one individual, and it’s certainly improved her sickness absence…I think it will start to put a message out…‘You’re not automatically just coming in here…to take the time off when you want to, we’re actually going to be watching you’.”
- Line manager (non-operational)

However, as with return to work interviews, many line managers were uncomfortable conducting trigger point reviews. Some line managers and employees seemed to regard them as solely a disciplinary tool, rather than also being a mechanism for identifying employees in need of support. They talked about the need to be able to exercise discretion in whether or not to conduct a trigger point review as they felt the
procedure was unnecessary if an employee’s sickness absence had been health related. Finally, as noted in Section 4.1, there were also practical constraints to conducting timely trigger point reviews, notably the need for cover, privacy and contact time (the latter being particularly an issue for retained staff).

However, where line managers had been encouraged to conduct trigger point reviews, it was clear that the procedure could be beneficial. They were able to describe cases where conducting the review had helped to identify an underlying issue which, if not resolved, might have led to further absence, and cases where the interview had prompted a referral to occupational health.

“[A colleague] was struggling with the shifts and various...aspects of the job...He went through a phase of having quite a lot of sickness in a very short period of time... I just thought, well, he’s been off sick...[But] I got...told [by the group manager], ‘well this is the third time he’s been off in the last two months, surely you should be doing something else?’... So that pulled me back into place...[that] perhaps he should go and see the occupation[al] health [nurse], because [there] might be something that they could come up with ...that could probably accommodate him better...If I’d been left to my own devices it wouldn’t have gone any further...I’d have just signed the form and sent it off.”
- Line manager (non-operational)

There appears to be scope for reinforcing positive messages about the importance of a consistently applied trigger point policy, and to emphasise its supportive function, in order to ensure that interventions to support employees with health- or welfare-related difficulties are not delayed.

4.3 Redeployment, retirement, capability proceedings and dismissal

All five case study services described how changes in the eligibility requirements for early retirement on health grounds were leading to greater consideration of redeployment and more use of capability proceedings leading to dismissal. As with other strategies to manage attendance, this was seen to have been prompted by the modernisation agenda. It was clear that all five services were at a relatively early stage in the implementation of this new emphasis. Strategic managers referred to small numbers of cases being taken forward, and not all staff were aware of the new emphasis.

4.3.1 Redeployment and retirement

The change in the availability of early ill-health retirement was seen by management as a major change in the fire service and one that was likely to be ‘a culture shock’ as more staff became aware of it. Management acknowledged that operational staff were very reluctant to consider office-based jobs. Traditionally, as discussed in Chapter 5, the type of office-based jobs to which operational staff were moved either in a permanent redeployment or for a temporary period of modified duties were seen as mundane, routine, ‘dogsbody’ roles. There was also a general view among managers and operational staff that moving to office-based jobs meant losing the camaraderie and support that firefighters valued highly.
However it was felt that ill-health retirement had been too available and had sometimes been abused in the past, and that it was necessary to reduce reliance on it. For example, people talked about cases where prolonged sickness absence had in the past been resolved through ill-health retirement where redeployment (or capability procedures) would have been an option. It was also noted that the Disability Discrimination Act required more active consideration of redeployment instead of redundancy or dismissal.

There were some accounts of very successful redeployments, where the staff member was said to have been placed in a valuable role which made good use of their skills and to which they had responded very positively. However, it was said to be challenging to find the right role for operational firefighters because their skills and experiences may not lend themselves to office work, and because the opportunities for work which does make use of their skills – such as in community fire safety roles – are limited, particularly in smaller services. There were also particular difficulties associated with the redeployment of retained firefighters, where injuries sustained on duty meant they were unable to continue in an operational role, but were ineligible for ill-health retirement and yet unable to be redeployed alongside primary employment commitments. Such cases were proving sensitive and difficult to resolve.

Equal pay legislation and pension scheme eligibility were also seen to raise barriers to some redeployments, and it was generally acknowledged that redeployment is not being used as much as it could be. The general view of managers was that progress was being made and that successfully managing cases would support cultural change within the organisation, but that it was challenging.

“There’s been a significant impact upon our ill health retirements...I think it is challenging, but if the sort of will is there, there are ways forward with it...Part of the challenge I think is trying to get the individual and the organisation on the right wavelength so that both have a like mind about what they’re trying to achieve here, and there’s that sort of confidence, if you like, of the employee that you are trying to retain them...but also confidence on the employers side, the management side, that the employee is being fair towards the organisation, and I think that will get stronger as we get more cases, as time goes on.”
- Strategic manager

There were few actual experiences of redeployment among the staff interviewed. One person was shocked to be told on their first day back after a long absence that they were being redeployed. Others where there was some doubt about whether they would ever be able to return to operational duties said they would find it difficult or impossible to adjust to an office-based role, but there was acknowledgement that it was an option that had to be explored. One respondent described an early informal and supportive discussion about the possibility that he may need to be redeployed to office-based work and how he felt:

“Devastated, I am not happy at all. You know [firefighting] is something I enjoy doing. But I would get accustomed to it and I would deal with it and just get on with it, you know. One thing the fire brigade teaches you is you just get on with it, you know.”
- Employee (operational)
4.3.2 Capability and dismissal

Managers described a growing willingness to consider using capability proceedings and dismissal to manage sickness absence where the system was being abused or where there were genuine concerns about capability. This was rooted in a recognition that long term sickness absence or persistent periods of short term absence could not be allowed to run on unmanaged, because of its impact on overall performance and because of the pressure it placed on other members of staff.

It was said that informal warnings were often effective, but in most of the case study services, staff stated that a small number of cases were being pursued through formal procedures. It was felt that just a few cases would have a big impact on assumptions among staff that sickness absence could not ultimately be effectively challenged. Some services had improved their procedures, for example simplifying the process and clarifying or shortening the time periods between different stages of escalation.

As with strategies to reduce the use of early retirement, it was said that the willingness to use institutional proceedings represented a cultural change in the Fire & Rescue Service. This was highlighted also by the fact that some staff, at both management and employee level, said that the use of dismissal was simply unprecedented – that noone had ever lost their job because of incapacity due to ill health. The view among managers was that it would take time to build institutional willingness to use capability proceedings, and that providing effective and consistent support to line managers would be essential.

“The facilities for warnings up to final warning and ultimately dismissal on the grounds of capability … is something that just … was a real no no for the Fire & Rescue Service. So we’ve got that facility in place but obviously that is going to be quite a transition for our managers to be able to move to that.”

- Strategic manager

There were four cases among the staff interviewed where the possibility of capability proceedings or dismissal had been raised by either occupational staff or line managers. In all four cases, staff described an informal, casual and brief mention, in one case over the telephone. In none of the cases was there any follow-up and line managers seemed to be unaware of the issue where it had been mentioned by occupational health staff, and vice versa, suggesting that it was not the result of a formal organisational decision.

4.4 Chapter summary

The modernisation agenda has led to a new emphasis on strategies to manage attendance, both through identifying and dealing with cases where there is a need to provide support because of an underlying health or welfare issue, and through addressing less disciplined attitudes towards attendance.

Return to work interviews and trigger point reviews were seen as important here, although not all managers and staff were convinced of their value and effectiveness. They were seen to have both a supportive and scrutinising or challenging purpose, and the tensions and difficulties this raised meant that some services had yet to
achieve their robust implementation. The services which had implemented them robustly had emphasised the supportive function rather than the challenge function, and had supported the implementation with detailed training, alongside monitoring by senior management.

There was also a new emphasis on using redeployment in place of early ill-health retirement, and on using capability proceedings leading to dismissal as a last resort either where ill-health meant someone could not return to work or where poor attendance was a disciplinary issue. It was clear that the services were all at early stages here, dealing with small numbers of cases only, and that it represented a substantial cultural change which was challenging to the Fire & Rescue Service.
5 SUPPORTING ATTENDANCE

Chapter 5 examines key initiatives which were described by case study services as playing an important role in supporting or encouraging attendance. Each initiative is discussed in detail, beginning with welfare, counselling and trauma support (Section 5.1). Next, fitness, health screening and health promotion initiatives are discussed (Section 5.2), and finally the use of incentives to encourage attendance is described (Section 5.3).

5.1 Welfare, counselling and trauma support

5.1.1 Welfare and counselling

It was recognised across the case study services that there were a range of what were called ‘welfare’ issues that impacted on performance and sickness absence. These included work-related issues such as stress, workloads, poor work relationships and bullying, and issues related to people’s private lives such as relationship breakdown, bereavement or family ill-health. Two of the case study services had employed a dedicated welfare officer and staff counsellor to enhance their occupational health provision. These posts had been created within the last five years, and were felt to bring a number of benefits in terms of attendance management.

Welfare support provided from within the organisation meant that the welfare officer was in a good position to understand the culture and successfully mediate between the individual and the employer where necessary. In a rapidly changing organisational environment, welfare support for supervisory managers was considered to be especially important and a dedicated welfare officer meant managers had immediate access to advice and assistance.

The absence of a welfare officer post in one case study service was proving to be an issue for the occupational health advisor, demonstrating the value of such a post for comprehensive and effective occupational health provision.

"I do get involved in a lot of welfare issues but welfare isn’t strictly part of my role but we don’t have a welfare officer as some brigades do. Welfare is a line management responsibility but very often people come to me with that. Which encroaches on my time more than I would like it to."

- Occupational health staff member

All case study services had dedicated funding reserved for referral to external counselling services. After physiotherapy, referral for counselling services for work-related or personal stress constituted the next highest proportion of referrals to external services by occupational health staff.

5.1.2 Trauma support

Two of the five case study services had well-established trauma support networks. These peer support networks were coordinated by the occupational health
departments, and comprised between ten and 15 volunteers, selected and trained from across the range of staff, including males and females, uniformed and support staff. The networks had been recently revitalised through new recruitment rounds and training for volunteers, and information about the trauma support networks was included in firefighters’ and control operators’ induction and on-going training.

The trauma support process involves two stages. Firstly, a trained ‘defuser’ will telephone the crew while they are dealing with an incident, and then contact them again two to three hours afterwards. A group debriefing session run by a trained ‘debriefer’ is then set up if requested, to take place within the next two to three days. Debriefing is non-therapeutic, but designed to raise awareness about post traumatic stress disorder (PTSD), helping uniformed personnel to recognise, manage and understand the reactions they may have following exposure to traumatic incidents, and when and how to get further professional help.

Trauma support can be requested directly by any firefighter or control operator, but is automatically offered to fire and fire control crews on a voluntary basis following exposure to traumatic incidents. These were usually defined as less common events (fatalities or serious injuries in fires, as opposed to road traffic accidents), or events with the potential to be particularly disturbing (fatalities involving children, severe disfigurement or mutilation, and events involving aggression or violence towards fire service personnel).

Comments from employees interviewed for the research demonstrate that trauma support networks and debriefing are highly valued by uniformed personnel, although occupational health staff noted that there was still sometimes reluctance to engage where there was a more ‘macho’ station culture.

“I was unlucky enough to have [to attend an incident involving] children that burnt to death in a fire and it really affected us… Sometimes the [trauma] support isn’t needed…[but] we know that it’s offered…[and] in this instance they did everything 100% right…[the volunteer] just has a cup of tea with us and chats over a few things, well [they don’t] do much talking actually, [they] let[ ] everybody do the talking…[having the trauma support network is] imperative.”
- Employee (operational)

“What used to happen in the past…there used to be incidents that had happened, whether it be a, a loss of life with somebody like, you know at times, you’d just…bring your appliance in…put everything away…and you go home… [You’d] just think and dwell on it…But nowadays because we do this debriefing…I think it’s a lot better.”
- Employee (operational)

“[The trauma support team also] send out a letter to your homes a couple of weeks later…that says ‘I understand that you were involved in a traumatic incident on whatever date, this is just a follow up to check if you want a debriefing, this is completely anonymous and your colleagues won’t be any the wiser’, that kind of thing, …I’ve never accepted one but I’ve always had a letter through and I think that is fantastic.”
- Employee (operational)
Two of the case study services without trauma support networks were actively working towards establishing or developing existing arrangements to provide a more effective debriefing intervention. Strategic managers said that trauma support networks were also important terms of employees’ confidence in, and positive attitude towards, the service as a caring employer.

5.2 Fitness, health screening and health promotion

5.2.1 Fitness

While fitness was acknowledged by all case study services to play a potentially important role in preventing sickness absence, not all services had prioritised fitness to the same degree. Despite availability of gym facilities or fitness equipment across the case study services, strategic emphasis on maintaining good levels of fitness varied. In one case study service occupational health staff, line managers and employees interviewed were concerned about the level of emphasis on fitness.

“I don’t think [fitness is] promoted as well as it could be…We used to have…physical training instructors on the stations…[but] their qualifications have lapsed…Although there [are] good facilities and equipment on fire stations now…it’s fairly optional whether you use that equipment or not. So I think there is a bit of a gap there in terms of possibly what could be required to be the minimum level of fitness and what is actually the minimum level of fitness.”
- Line manager (non-operational)

In contrast, the top performing case study service in 2006/07 had appointed a dedicated physical education officer (PEO) with responsibility for re-establishing, supervising and training networks of physical training instructors (PTIs) whose role is to assist operational colleagues in developing individual fitness programmes. Dedicated time for physical training was incorporated into the working day, and line managers and employees were positive about the benefits of the emphasis on physical training.

“On watch…[we’re] carrying out PT every day as required…when [everyone] finally got their heads round it,[they] got on and did it…and it’s paying dividends most definitely. If you come to my station everyone’s fit…and [ ] the PTIs for the watches are doing their job in instruction of physical fitness training individually for the…crews.”
- Line manager (operational)

Six-monthly fitness testing was being carried out in the two top performing (in 2006/07) case study services using the Chester step test (an aerobic fitness test commonly used across the Fire & Rescue Service). PTIs or watch managers were responsible for conducting the tests, while monitoring of the results was carried out by the PEO or occupational health staff, with advice and support being offered to individuals as necessary. The results of fitness testing were also felt to provide an important overview of fitness and health issues across the organisation, assisting the targeting of proactive health initiatives (see also Section 5.4.3 below).
“The information that feeds back allows you globally to target things, and individually to keep an individual up to speed.”
- Occupational health staff member

5.2.2 Health screening
All five case study services had introduced three-yearly screening for operational staff, regardless of age. Three-yearly health screening was also offered on a voluntary basis to fire control and support staff. Non-operational staff valued access to health screening, especially where the occupational health unit was proactive in its provision.

[Occupational health staff came to the department] for the day and everybody that was in [ ] was free to go and see them and [have] all the usual things, [they] take your blood pressure, check your blood sugar levels, get you to do a step test and then... they actually give you advice on...eating, exercise...staying well and fit...They had a very big take up of that.... It also enables people...to go and speak to them and say, 'Look, this is what's happened, I've got this problem...what d'you think I should do?'
- Line manager (non-operational)

5.2.3 Health promotion
Examples of health promotion included stress awareness training, newsletters and healthy workforce initiatives, including health and well-being exhibitions. These were either run by the in-house occupational health unit, or involved joint working between the service and the contracted out occupational health service. Examples included:

• a quarterly programme of stress management training run by the welfare officer covering stress awareness, causes and symptoms, dealing with stress, and understanding traumatic stress; and,
• provision of back fitness training, advice on preventing back complaints and how to deal with back problems, run by the PEO, jointly working with a physiotherapist from the contracted out occupational health service.

5.3 Use of incentives
A final strategy for supporting attendance, that some case study services had introduced, was the use of incentives to encourage employees to minimise their sickness absence. Two types of incentives were in use, or being considered, by different services.

The most commonly considered type of incentive was the linking of attendance with the new national Continual Professional Development (CPD) payment. To qualify for the payment, employees are required to achieve a minimum score across a range of job performance indicators. One case study service had included attendance as one of the indicators although, in order to avoid unfairly penalising individuals for health related sickness absence, GP-certified sickness absence was ignored when calculating the attendance score. Strategic managers were unsure at time of interview about the effect of including attendance as part of the CPD scoring system.
“What I’m expecting [the CPD payment] to do would be two things. One, it’ll drive down the [amount] of casual sickness, and two, it’ll probably increase the [amount] of longer term sickness[ ] as people realise that if they get a sick note it takes them out of that. And [although] doctors don’t ordinarily give sick notes very quickly, [ ] we’ll keep an eye and see how that goes.”
- Strategic manager

Another incentive initiative piloted in one of the case study services linked attendance to eligibility for voluntary overtime. The initiative had a “dramatic effect” on sickness absence levels, although once again there were concerns about the unintended effects of an incentive scheme of this type.

“Overnight, the by-product of this overtime arrangement was that the sickness record for patchy sickness just disappeared…[However], I think it is a perverse motivator…[there have] definitely been instances where people have dragged themselves in and they are not fit for work…[It’s problematic for me as a line manager] in charge of the overall safety…because [if you tell them to book sick] you are [in effect] making a decision on how much money they [can] get”.
- Employee (operational)

5.4 Chapter summary

Strategic managers, occupational health staff, line managers and employees interviewed agreed that successfully tackling sickness absence involved managing sickness absence (discussed in Chapter 3), managing attendance (examined in Chapter 4), and supporting attendance (described in this chapter). These three activities were seen to form an holistic approach to attendance management.

The top performing case study services in 2006/07 tended to have established a combination of initiatives to support attendance, which were viewed as forming part of an holistic approach to attendance management. Interestingly, there appeared to be an association between the implementation of more of these types of initiatives, and sickness absence performance. This apparent association would merit exploration through further research, and the auditing and evaluation of strategies.
6 DISCUSSION OF FINDINGS

This study of attendance management in the Fire & Rescue Service has identified both areas where case study services have made positive and significant progress in attendance management and sickness absence performance, and areas where further work is needed to consolidate and sustain these improvements.

It is encouraging that practice has been developing in line with recommendations for attendance management outlined in the MTF (Ministerial Task Force for Health, Safety and Productivity) review of managing sickness absence in the public sector (2004), and also in HSE (Health and Safety Executive) and CLG (Communities and Local Government) guidance. Case study services furthest along the developmental trajectory in terms of sickness absence performance emphasised overarching factors for successful attendance management, alongside an holistic approach to attendance management, which included consistent management of individual sickness absence cases, the robust implementation of key elements of attendance management policy, and the introduction or revitalisation of additional initiatives to support attendance.

6.1 Overarching factors for successful attendance management

Chapter 2 explored how those case study services which were performing better in comparison to the others were further along a trajectory for attendance management which emphasised the following:

- effective use of performance management information;
- strategic prioritisation of attendance management; and,
- devolution of responsibility for attendance management to supervisory management levels.

These overarching factors for successful attendance management complemented an holistic approach to attendance management which involved managing sickness absence, managing attendance and supporting attendance.

6.2 An holistic approach to attendance management

Chapter 3 highlighted that stronger sickness absence performance among the case study services appeared to be associated with:

- systematic, frequent and recorded contact by line managers with employees on sickness absence;
- early referral to, and input by, occupational health staff in sickness absence cases;
- a role for occupational health in preventing sickness absence cases before they begin;
- joint working between occupational health staff and line managers in planning returns to work that maximise opportunities for meaningful modified duties;
- creativity and flexibility in structuring phased returns to work which are supportive from both the line manager and employee perspective; and,
- flexible healthcare budgets which fund treatment as well as diagnosis.
Chapter 4 emphasised that strategies to manage attendance required robust implementation to ensure they were systematically utilised in all sickness absence cases. Strategies to manage attendance were most effective when they included:

- active monitoring of return to work interviews to ensure they are consistently and supportively carried out;
- clear mechanisms for identifying and following up employees requiring trigger point reviews; and,
- training for line managers in fulfilling their responsibilities for managing attendance.

Chapter 5 indicated that initiatives to support attendance also appeared to be beneficial in influencing sickness absence performance. These initiatives were:

- appointing a dedicated welfare officer and staff counsellor and developing a trauma support network to help prevent sickness absence and augment existing occupational health provision;
- re-establishing physical training instructor networks, making time available for physical training, and introducing six-monthly fitness testing with monitoring of results to allow health and fitness interventions to be targeted both individually and globally;
- proactive health screening for non-operational as well as operational staff and greater resourcing of health promotion initiatives; and,
- use of incentives to encourage attendance.

### 6.3 Conclusions

There were differences between the case study services in their ability to produce and use comprehensive aggregate sickness absence data in order to fully integrate absence management within an overall performance management framework. Each service appeared to have developed its own in-house management information system, and there was an apparent lack of consistent practice in recording and manipulating sickness absence data across fire and rescue services generally. Even where sickness absence data was believed to be robust enough for systematic interrogation, strategic managers expressed concerns about the service’s ability to conduct effective and useful data analysis. Although human resources staff brought valuable expertise with them from other organisations, there was still scope for sharing good practice across the Fire & Rescue Service.

Also, although managers were benefitting from skills learnt through leadership and management development programmes (LMDP), findings from across the case study services indicate that there is further scope for training for managers in attendance management. It was important that line managers received training in proactive contact and consistent conduct of return to work interviews and trigger point reviews, particularly how to balance performing a ‘welfare’ role with fulfilling procedural or disciplinary requirements. The better performing case study services were stressing both the supportive aspect of managing sickness absence, and the need for a robust approach to attendance management in order to enhance performance management.

Finally, the research has identified a need to evaluate the effectiveness of current approaches to attendance management in fire and rescue services, and consider
piloting new ones in order to sustain improvements in performance. For example, it is unclear to what extent, and in what ways, accelerated medical support schemes, trauma support networks and six-monthly fitness testing may help to reduce or prevent sickness absence. A systematic audit of the deployment of resources and measurement of impact on sickness absence and returns to work would also assist in conducting cost-benefit analysis of various strategies and initiatives aimed at preventing or reducing sickness absence. This would enable better decision-making relating to maximising the use of resources in attendance management.
References


Department for Communities and Local Government, Fire and Rescue Service Operational Statistics Bulletin for England: 2005/06 (June 2007)


APPENDIX A    CASE STUDY SERVICE RECRUITMENT DOCUMENTS

Letter to Chief fire officers

Dear

Improving Sickness Absence Management in the Fire and Rescue Service in England

I am writing to ask for your help with an important piece of research that is being carried out to support the Fire and Rescue Service in its efforts to improve sickness absence management. The Health and Safety Executive (HSE) and the department for Communities and Local Government (CLG) have commissioned the National Centre for Social Research (NatCen), an independent research contractor, to undertake a study of sickness absence management in the Fire and Rescue Service for England.

The commitment to undertake this research is set out in the Fire and Rescue National Framework 2006-08 (paragraph 5.32), and the research project was announced in Fire and Rescue Service Circular 49-2006. The project has the full endorsement of CFOA, who have been involved in the development of the work through Chris Enness. If you have any queries about the project, he would be happy to discuss them with you.

The Fire and Rescue Services in the sample for this research have been selected to reflect different patterns of current and historical sickness absence rates, governance arrangements, family groups and geographical locations. Your Fire and Rescue Service has been selected as one of the five case study services and I would be most grateful if you could consider whether your service would be able to take part. The enclosed information sheet provides further information about the study and exactly what participation would involve. NatCen will not pass on the names of anyone who participates in this research. Information provided and findings from the interviews will be treated as strictly confidential and reported in a way that will ensure that individual staff members and the FRS cannot be identified.

I will contact you by telephone in the next week to discuss the research and find out whether you would be willing for your Fire and Rescue Service to participate. In the meantime, if you have any questions regarding this research please do not hesitate to contact NatCen, HSE, CLG, or CFOA using the contact details provided below.

Yours sincerely,

Clarissa Penfold (National Centre for Social Research)

CONTACT DETAILS

<table>
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<th>NatCen</th>
<th>Clarissa Penfold (Senior Researcher)</th>
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<td>Tel: 020 7549 9564</td>
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<tr>
<th>HSE</th>
<th>Laura Smethurst (Principal Research Officer)</th>
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<th>CLG</th>
<th>Mark Dunn (Senior Research Officer)</th>
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<th>CFOA</th>
<th>Chris Enness (Deputy Chief Fire Officer)</th>
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<td>Tel: 01745 535250</td>
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Information sheet for CFOs

Research into the management of sickness absence in the Fire and Rescue Service

INFORMATION FOR CHIEF FIRE OFFICERS

- The National Centre for Social Research (NatCen) is carrying out this research on behalf of the Health and Safety Executive (HSE) and the department for Communities and Local Government (CLG). NatCen is an independent research institute. Further information about us can be found on our website (www.natcen.ac.uk).

- The purpose of the research is to explore current policy and practice in the management of sickness absence within the Fire and Rescue Service in England, with the aim of identifying ways in which practice could be improved in the future. Five Fire and Rescue Services will be invited to form the sample for this research. The sample members are selected to reflect different patterns of current and historical sickness absence rates, governance arrangements, family groups and geographical locations.

- In each FRS we would like to conduct qualitative in-depth interviews with the following personnel:  
  - Chief Fire Officer (or a senior manager with strategic responsibilities nominated by the Chief Fire Officer)  
  - Director of Human Resources (or a nominated senior member of HR staff)  
  - A member of HR staff with expertise in sickness absence data collection and monitoring and any IT system that is used for recording and monitoring absence  
  - A member of the Occupational Health team or service  
  - Four line managers/supervisors (one from fire control, one from a non-uniformed department, and two line managers of firefighters)  
  - Six employees with experience of sickness absence (one from fire control, one from a non-uniformed department and four firefighters)

- Each participating FRS would need to identify a key contact person (e.g. the HR Director) to assist the NatCen research team as follows:  
  - Supply copies of written guidance, procedures and policies relating to sickness absence management to the NatCen research team (provided you agree to these being made available)  
  - Identify appropriate line managers, contact them about participating using letters and information sheets provided by NatCen, and arrange interviews  
  - Identify a sample of employees who have recently experienced sickness absence and forward a letter on our behalf, asking them to respond directly to NatCen indicating whether they are willing to participate  
  - NatCen will provide materials (letters and information sheets) for all potential participants and will liaise directly with the key contact about our exact requirements with a view to minimising any burden and disruption that participation in this study may cause

- A member of the research team would conduct interviews during May and June 2007. The timing will be discussed in more detail with the key contact person you appoint. Interviews with strategic and other managers will take place at work and last between an hour and an hour and a half. We will work with your key contact person to ensure that these take place at an appropriate and convenient time and location. Interviews with employees with experience of sickness absence will be of a similar duration and take place at their home or a suitable location of their choosing outside work.

- Information from the interviews will be treated as strictly confidential and reported in a way that will ensure that individual staff members and the FRS cannot be identified. NatCen will not pass on the names of anyone who participates in the research. No-one within the FRS will know which employees with experience of sickness absence have been interviewed.

- All interviews will be digitally recorded, with respondents’ permission, and transcribed verbatim. This ensures we have a full record of what is said for detailed and rigorous analysis, as well as enabling the interviewer to focus on asking appropriate exploratory and follow-up questions.
We will provide an individual case study report to each FRS that has participated in the research. This bespoke report will present the findings and conclusions of the main report, and also identify key aspects of their approach compared with other FRSs, highlighting the issues that emerge as particularly relevant to them in the development of policy and practice. Findings from the research across the five case study authorities will be collated and presented in a final report to HSE/CLG in September 2007 for publication. Individual staff members and the names of participating FRSs will not be identified in any of these reports.
APPENDIX B  RESPONSIDENT RECRUITMENT DOCUMENTS

Guidance for case study services for selecting respondents

Research - Sickness Absence Management

Guidance on arranging staff interviews and sending letters to employees

(______ Fire and Rescue Service)

STAFF INTERVIEWS

We would like to interview the following staff (7 in total):

- Chief Fire Officer (or a senior manager with strategic responsibilities nominated by the Chief Fire Officer)
- Director of Human Resources (or a nominated senior member of HR staff)
- A member of the Occupational Health team or service
- Two line managers of firefighters (one of wholetime and one of retained if applicable)
- One line manager of fire control staff
- One line manager of non-uniformed staff

The four line managers should be directly involved in managing individuals on sickness absence. For uniformed staff we are assuming these will be either watch managers or station managers (rather than crew or group managers), but we will be guided by HR as to which management level is most appropriate.

We would like HR to approach staff to ascertain whether they are willing to participate and arrange interviews on our behalf. A draft letter template and information sheet are attached for you to pass on to staff you approach. Please feel free to use and / or adapt the letter as you see fit. The information sheet explains the purpose of the study, what participation would entail, and confidentiality arrangements for the research. It would be helpful if staff could read this before agreeing to take part.

Ideally we would like to carry out these interviews during a single visit to the area, over two or three days. In order to keep travel between interviews to a minimum, it would be helpful if the seven staff are geographically co-located within the same area of the FRS. Interviews will last approximately an hour to an hour and a half. In setting up the interviews, we would need a two-hour interval between start-times for interviews being conducted at the same location, and a longer interval, to take account of travelling time, for interviews at different locations. It would also be very helpful if a private office / meeting room or other suitable venue could be arranged for each interview.
LETTERS TO EMPLOYEES

We would like to interview six employees with recent experience of sickness absence. We are adopting an opt-in recruitment strategy whereby employees will be approached by the FRS and asked to respond directly to NatCen, telling us whether or not they are interested in participating in the research. Although we only need to interview six employees, we need to aim for a higher number of opt-ins so we can get a good mix of ages, lengths of sickness absence and types of condition. We would be very grateful, therefore, if HR could send out 105 letters/information sheets (NatCen will supply these as soon as you are ready to send them) to a group of employees with experience of sickness absence compiled by following the instructions below:

Working backwards from 31\textsuperscript{st} January 2007 please:

- List the first 40 wholetime firefighters who were absent for any shift(s)
- List the first 40 retained firefighters who were absent for any shift(s)
- List the first 10 fire control staff who were absent for any shift(s)
- List the first 15 non-uniformed staff who were absent on any day(s)

Check each list and remove any employees who were absent for fewer than seven calendar days during the 12-month period preceding the last day of their sickness absence. Replace with employees who were absent for seven or more calendar days (by continuing to work backwards from 31\textsuperscript{st} January 2007). Finally, check that overall the list of 105 employees includes:

- At least 35 employees who were absent for \textit{between 7 and 14 calendar days} during the 12-month period preceding the last day of their sickness absence
- At least 35 employees who were absent for \textit{15 calendar days or more} during the 12-month preceding the last day of their sickness absence
- At least 25 employees who have \textit{not yet returned} to work
- At least 25 employees who were off work with \textit{musculoskeletal} conditions (e.g. upper limb, back, knee)
- At least 25 employees who were off work with \textit{mental health} conditions (e.g. post-traumatic stress reaction, anxiety/depression, phobia, psychosis)

Remove and substitute names as necessary (by continuing to work backwards from 31\textsuperscript{st} January 2007), to achieve the above.

Please do not hesitate to telephone Clarissa Penfold at NatCen on 020 7549 9564 if you need any further guidance or would like to discuss or clarify these instructions. Also, please let us know if the selection method outlined above is not feasible or consistent with the way you hold data, or you can identify a more straightforward way of selecting employees. We appreciate that arranging staff interviews and selecting and sending letters to employees is no small undertaking, and we are extremely grateful for your assistance, which is invaluable to the outcome and quality of the research.
Dear Colleague

RE Improving Sickness Absence Management in the Fire and Rescue Service for England

I am writing to ask for your help with an important piece of research that is being carried out to support the Fire and Rescue Service in its efforts to improve sickness absence management. We are one of five Fire and Rescue Services that have been selected to form the sample for the study. The purpose of this letter is to give you the opportunity to be interviewed as part of the research.

The Health and Safety Executive and the Department for Communities and Local Government have commissioned the National Centre for Social Research (NatCen), an independent research contractor, to undertake a study of sickness absence management in the Fire and Rescue Service for England. This research forms part of the Fire and Rescue National Framework 2006-08 (paragraph 5.32), and was announced in Fire and Rescue Service Circular 49-2006.

NatCen is conducting interviews in each FRS and would like to include staff views representing a range of roles and perspectives. If you do take part, NatCen will treat everything you say within the interview as strictly confidential. They will not pass on the names of anyone who participates in the research to anyone else. They will report the findings of the research in a way that will ensure that individual staff members and the FRS they work for cannot be identified. The enclosed note from NatCen provides you with further information about the study and exactly what your participation would involve.

NatCen plan to carry out the interviews in our area during March/April/May/June 2007. I will be in touch with you shortly to discuss the research, whether you would be willing to take part, and if so, arrange a date and time when it would be convenient for you to be interviewed.

If you have any queries about the research please contact me on XXXXXX XXXXXX, or Clarissa Penfold at NatCen on 020 7549 9564.

Thank you for your help.

Yours sincerely,

Director of Human Resources
Information sheet for managers strategic managers, occupational health staff and line managers

Research into the management of sickness absence in the Fire and Rescue Service

INFORMATION FOR STAFF

• The National Centre for Social Research (NatCen) is carrying out this research on behalf of the Health and Safety Executive (HSE) and the department for Communities and Local Government (CLG). We are an independent research institute. Further information about us can be found on our website (www.natcen.ac.uk).

• The purpose of the research is to explore current policy and practice in the management of sickness absence within the Fire and Rescue Service, with the aim of identifying ways in which practice could be improved in the future and examples of good practice.

• The research will involve interviews with senior managers, human resources and occupational health staff, line managers and employees within five Fire and Rescue Services.

• We are particularly interested in hearing the views and experiences of staff who are involved in the management of sickness absence in the FRS. If you agreed to be interviewed we would like to ask you about:
  - Working conditions, organisational culture and sickness absence performance in the FRS
  - How sickness absence is managed and monitored
  - Training, policies and procedures for managing sickness absence
  - How sickness absence management can be improved

• A member of the research team will be conducting interviews during May/June 2007. The interview would last for between an hour and an hour and a half. We can be flexible about when the interview takes place, to cause as little disruption to your working day as possible. We will conduct the interview at your workplace or anywhere else that is convenient to you.

• Information from the interviews will be treated as strictly confidential and reported in a way that will ensure that individual staff members and the FRS they work for cannot be identified. NatCen will not pass on the names of anyone who participates in the research to the FRS or anyone else.

• The interview will be digitally recorded, with your permission, and transcribed verbatim. This ensures we have a full account of what is said for detailed and rigorous analysis, as well as enabling the interviewer to focus on asking appropriate exploratory and follow-up questions. Only the Natcen research team will have access to the recording and the transcript, and following the completion of the research both will be destroyed.

• Findings from the research across the five case study authorities will be presented in a final report to HSE/CLG in September 2007, and then sent to each participating FRS. In addition, we will provide an individual case study report to each FRS. This will present the issues, findings and conclusions of the main report, but also identify key aspects of their approach compared with other FRSs, highlighting the issues that emerge as particularly relevant to them in the development of policy and practice.

• If you would like to speak to a member of the NatCen research team in confidence please do not hesitate to contact Clarissa Penfold on 020 7549 9564.
Letter to employees

Dear Colleague

Improving Sickness Absence Management in the Fire and Rescue Service for England

I am writing to ask for your help with an important piece of research that is being carried out to support the Fire and Rescue Service in its efforts to improve sickness absence management. We are one of five Fire and Rescue Services that have been selected to take part in the study. The purpose of this letter is to give you the opportunity to take part in this research.

The Health and Safety Executive and the department for Communities and Local Government have commissioned the National Centre for Social Research (NatCen), an independent research contractor, to undertake a study of sickness absence management in the Fire and Rescue Service for England.

NatCen is conducting interviews in each FRS and would like to include the views of employees representing a range of roles and perspectives. The NatCen research team has asked me to forward details about the research to employees who experienced any period of sickness absence during late 2006 / early 2007. However, we will not know whether you choose to take part or not. Whether or not you take part in the research is entirely up to you, and NatCen will not be informing me, the FRS, or anyone else, of the names of the people they interview.

If you do take part, NatCen will treat everything you say within the interview as strictly confidential. They will report the findings of the research in a way that will ensure that individual employees and the FRS they work for cannot be identified. Everyone who is interviewed will be given £20 as a token of thanks for giving up their time. The enclosed note from NatCen provides further information about the research and exactly what participation would involve.

So that NatCen know we have sent you this letter, please complete the form and return in the prepaid envelope to NatCen. Do not send the form back to us. On the form you should indicate whether or not they may contact you to explain the research and see if you are willing to take part. It would be very helpful if you are able to do this as soon as possible within the next seven days.

If you have any queries about the research please contact, in confidence, Rosalind Tennant at NatCen on 020 7549 9557.

Thank you for your help.

Yours sincerely,
Information sheet for employees

Research into the management of sickness absence in the Fire and Rescue Service

INFORMATION FOR EMPLOYEES

- The National Centre for Social Research (NatCen) is carrying out this research on behalf of the Health and Safety Executive (HSE) and the department for Communities and Local Government (CLG). We are an independent research institute. Further information about us can be found on our website (www.natcen.ac.uk).

- The purpose of the research is to explore current policy and practice in the management of sickness absence within the Fire and Rescue Service, with the aim of identifying ways in which practice could be improved in the future and examples of good practice.

- The research involves interviews with senior managers, human resources and occupational health staff, line managers and employees within five Fire and Rescue Services.

- To understand what works and what has not worked so well in supporting people on sickness absence and in work, we are particularly interested in hearing the views and experiences of employees who have recent experience of sickness absence. If you agreed to be interviewed we would like to ask you about:
  - Your background and personal circumstances
  - Reasons for, and experience of, sickness absence
  - Experience of sickness absence policies and procedures whilst working for the FRS
  - Contact with the NHS and other sources of support
  - Working conditions and sickness absence in the FRS
  - How policy and practice in sickness absence management can be improved

- We would be grateful if you could complete and return the enclosed form to indicate whether or not NatCen can contact you to tell you more about the research and see if you are willing to take part. If you are happy for us to contact you, we will need your personal contact details. Either way, we would be grateful if you could return the form to NatCen in the pre-paid envelope within the next seven days.

- A researcher from NatCen will then contact you to discuss your possible participation. We need to make sure that a cross-section of employees with different experiences of sickness absence is included in the study. For this reason we cannot guarantee that everyone who volunteers to take part will be interviewed, although we would hope to include most.

- Information from the interviews will be treated as strictly confidential and reported in a way that will ensure that individual staff members and the FRS cannot be identified. NatCen will not pass on the names of anyone who participates in the research. No-one within the FRS will know which employees with experience of sickness absence have been interviewed. Taking part in this research is entirely voluntary.

- We will be conducting interviews during June 2007. The interview would last approximately an hour and a half, and would be conducted at your home (or another location if you prefer), on a date that is convenient to you. Everyone who is interviewed will be given £20 as a token of thanks for giving up their time.

- The interview will be digitally recorded, with your permission, and transcribed verbatim. This ensures we have a full account of what is said for detailed and rigorous analysis, as well as enabling the interviewer to focus on asking appropriate exploratory and follow-up questions. Only the Natcen
research team will have access to the recording and the transcript, and following the completion of the research both will be destroyed.

- Findings from the research across the five case study authorities will be presented in a final report to HSE/CLG in September 2007, and then sent to each participating FRS. In addition, we will provide an individual case study report to each FRS. This will present the issues, findings and conclusions of the main report, and also identify key aspects of their approach compared with other FRSs.

- If you would like any further information, or to speak to a member of the NatCen research team in confidence, please do not hesitate to contact Rosalind Tennant at NatCen on 020 7549 9557.
Contact form for employees

RESEARCH INTO THE MANAGEMENT OF SICKNESS ABSENCE IN _______ FIRE AND RESCUE SERVICE

Are you happy for NatCen to contact you to discuss the research and see if you are willing to take part?

YES / NO  [delete as applicable]

If you answered YES, please print your name and contact details clearly, and indicate your job type, below. NatCen will contact you soon to discuss the research and see if you are willing to take part. Thank you.

Your full name: __________________________________________________________
Address: _________________________________________________________________
__________________________________________________________
__________________________________________________________
Postcode: _______________________________________________________________

Telephone number (s): __________________________
__________________________________________________________

Employee group [please tick the appropriate box]:
[ ] Wholetime firefighter
[ ] Retained firefighter
[ ] Control
[ ] Non-uniformed/support

If you answered NO, please print your name clearly and indicate your job type below. This will ensure you are not contacted again – your FRS will not be told who answered yes or no, only the names of employees who have returned this form. Thank you.

Your full name: __________________________________________________________

Employee group [please tick the appropriate box]:
[ ] Wholetime firefighter
[ ] Retained firefighter
[ ] Control
[ ] Non-uniformed/support

Thank you for taking the time to complete this form. Please return it to NatCen, 35 Northampton Square, London EC1V 0AX in the pre-paid envelope provided.
Employee screening questionnaire

Screening Questionnaire for Telephone Recruitment

ENTER UNIQUE ID (from opt-in form) __________________

My name is X X, and I’m a researcher at The National Centre for Social Research (NatCen). Thank you for expressing an interest in the participating in the study on sickness absence management in the FRS. NatCen is carrying out this research on behalf of the Health and Safety Executive and the Department for Communities and Local Government but we are an independent research institute. We are particularly interested in hearing the views and experiences of employees who have recent experience of sickness absence. We need to make sure that a cross-section of employees with different experiences of sickness absence is included in the study. For this reason we cannot guarantee that everyone who has volunteered to take part will be interviewed, although we would hope to include most. I have a few quick questions I’d like to ask you, if that’s OK, and your answers will help us in making a decision about who we should interview. I want to remind you that any information you give us will be treated as strictly confidential and no-one within the FRS will know which employees with experience of sickness absence have expressed an interest in participation. Is it ok to ask you these questions? Do you have any questions you’d like to ask me?

1. Can I just check first of all, how old are you?

ENTER:________________________

[Code age group (circle as appropriate):

16 – 25 01
26 – 40 02
41 – 65 03 ]

2. Can I check your working pattern? Are you (on the)....

[Code working pattern (circle code as appropriate):

Wholetime / Control

Rotating shift pattern 01
Day crew 02
Part-time 03

Retained

Retained duty system 100% 04
Retained duty system 75% 05

Non-uniformed / support / corporate / control

Full-time 06
Flexible duty system 07
Part-time 08 ]
3. Approximately, how many days were you off sick through illness or injury in the last 12 months?

ENTER:______________________________

[Code number of days off sick (circle code as appropriate):

Between 7 and 14 days 01
15 days or more 02]

4. Were you off sick more than once? YES / NO

IF YES, can you remember how many times you were off sick?

ENTER:______________________________

[Code number of episodes of sickness absence (circle code as appropriate):

One episode 01
Two to four episodes 02
Five or more episodes 03]

5. Can you tell me briefly, in your own words, what type(s) of condition were you mainly off sick with?

ENTER:______________________________

[Code type of condition (circle code as appropriate):

Musculoskeletal 01
Mental health 02
Other 03]

6. Is/was your condition (illness/injury) related to your work/duties in the FRS? YES / NO

[ Code as appropriate:

Work-related 01
Not work-related 02]
7. Did you have any contact with your employer during your sickness absence(s)?

YES / NO

IF YES, can you remember who that contact was with?

ENTER:________________________

[Code all types workplace contact that apply (circle as appropriate):

Line manager 01
Occupational health 02
Human resources 03
Other 04 ]

8. Were you in contact with any of the following?

[Code all types of support (circle as appropriate):

GP 01
Hospital consultant/specialist through OH 02
Hospital consultant/specialist through GP 03
Any other service 04 ]

9. Have you returned to work? YES / NO

IF YES, was that to the same job? YES / NO

IF YES, was your job modified in any way to help you return to work? YES / NO

[Code return to work (circle as appropriate):

Not yet returned to work 01
Returned to same job 02
Returned to same job with adjustments 03
Redeployed 04 ]

Thank you very much for answering those questions. We will be deciding in the next few days who we need to interview. We will contact you to confirm this, but if we are able to interview you when would be convenient?
APPENDIX C  TOPIC GUIDES

Strategic manager and occupational health staff topic guide

P6168 Sickness Absence Management in the Fire and Rescue Service

Objectives:

- To explore the nature and impact of current sickness absence policies and practices in the case study fire and rescue authority
- To examine barriers and facilitators to the adoption, development and review of robust and well managed sickness absence policies and practices
- To understand how the implementation of sickness absence policies and practices relates to strategic objectives and priorities
- To elicit views on ‘what works’, areas of concern, and how policy and practice in sickness absence management can be improved

Introduction:

- Introduce self and NatCen as independent research contractor
- HSE/CLG have commissioned the research to support FRS
- The interview will focus on successes and challenges in managing sickness absence in local FRS and how it relates to strategic priorities
- Confidentiality: in main report (quotations will be anonymised), but also make aware of written feedback to FRS
- Full report to HSE/CLG and individual case-study report to FRS in September 2007
- Explain about digital recording and seek permission to record
- Confirm length of discussion (no longer than 90 mins)
- Confirm whether need to conduct additional short telephone interview with HR sickness absence data specialist and obtain contact details
- Any questions

*Box/shaded sections (1 and 4) to be additionally asked of sickness absence data specialist

1. Background

- Respondent job title and responsibilities
  - How long in role
  - Previous roles in current FRS and any other FRS
  - Any other relevant previous experience outside FRS

- Structure of HR department / OH health unit
  - How HR / OH is organised and how it has developed historically
  - Details of OH arrangements (how service is delivered and whether appropriate, including staff training)
  - Number of staff, roles and relationships with others within FRS
  - Representation on internal and wider/external committees

2. Sickness absence policies and performance
Origin of policies, procedures and systems for sickness absence management
- Where policies originate from (County, another FRS, guidance from CLG, HSE, legislative requirements, other)
- Key historical developments, adaptations and changes – including impact of other policies, organisational change initiatives on sickness absence management
- Recent developments and modifications (including any pilots of new policies/procedures, health and well being initiatives, introduction of flexible working patterns, health and safety promotion)
- For County Fire Authorities, how sickness absence management is viewed more widely within local authority
- Whether any Union involvement in policy development

Current position of FRS in terms of sickness absence rates and BVPI 12
- How performing, current position, reasons for this (extent to which most recent published statistics reflect current situation, performance in relation to other Family Group members and reflections on reasons for this)
- Key patterns/causes of sickness absence (explore for short and long term; work and non work related causes; use of sick leave for other reasons)
- Key impacts of sickness absence – any problems it causes
- Historical absence rates and reasons for change/stability - identify a) areas of improvement and how this happened, and, b) areas where sickness absence management is proving more difficult or challenging and reasons why this is the case
- Identify current key strategic priorities in terms of managing sickness absence, key drivers for these [e.g. BVPIs 12 i and ii; CPA; Fire and Rescue National Framework], and how they will be met

Current organisational culture of FRS relating to sickness absence and its management
- For strategic managers – how is sickness absence management a focus of strategic management priorities, who is involved and at what forums (explore perspective on business case for managing sickness absence and attitudes of senior management within FRS)
- For line managers – attitudes and approaches to managing sickness absence, for different levels of line management, whether line managers are comfortable with role, whether proactive, what works and what could work better
- For employees (explore variations across different staff groups and by occupational status/grade) – how employees have been informed and how they are responding to sickness absence policy, attitudes to taking leave, and response to how sickness absence is managed
- Explore health promotion and health & safety within the FRS
- Explore working conditions (e.g. shift system, scope for flexible working)
- Explore attitudes of unions/other employee representatives
- Any cultural shift over recent years
- Explore impact of Disability Discrimination Act 2003 and changes to criteria for ill-health retirement
- Impact of changes to the Firefighters’ Pension Scheme (in dealing with injuries and other long term sickness issues)
- Explore any local issues which impact on the above
3. Managing sickness absence - practice

- Explore what typically happens when an employee is absent from work due to sickness or disability and whether differs according to type of staff (wholetime, retained, control, non-uniformed), length of time off sick, cause of absence, pattern of absence and how [establish chronology of what happens]
  - Process for employees to notify employer they are off sick and how this is documented
  - Self certification period, GP certification period
  - First contact by employer, who does this and when
  - Point at which OH and HR get involved in individual cases and what triggers this
  - Communication issues between employee, line managers, others involved in sickness absence management
  - Are interventions / contacts recorded, how, and how shared; whether or not it’s timely
  - Frequency of contact (telephone and face-to-face meetings)
  - Home visits
  - Provision of / referral to treatment, rehabilitation and support services including external support and rehabilitation through OH (e.g. FSNBF rehabilitation services, counselling, Jobcentre Plus Access to Work scheme, Disability Services)
  - Disciplinary/capability procedures

- Explore return to work process
  - Planning returns to work, how this happens, who attends meeting / return to work interview (e.g. line manager, HR, OH, employee)
  - Scope for adjustments, options available (e.g. modified duties, reduced hours, redeployment)
  - Timings and decision making process about when used, whether varies
  - Process of managing and monitoring returns to work (e.g. frequency of meetings, OH assessment/test)
  - How recorded; what is recorded; how reviewed
  - What works well/not so well in returns to work process
  - Explore any sickness absence management issues associated with early retirement, injury awards, financial arrangements, work-related absences
  - Perceived balance between disciplinary action and support and rehabilitation and extent to which different interventions are offered on a voluntary or compulsory basis (explore decision-making process)

- Explore any issues for retained duty system staff which are unique to that group
  - Explore issues around sickness absence resulting from sickness or injury arising out of authorised duty for retained duty system firefighters including compensation for loss of retained earnings / primary employment earnings and liaison with primary employer
  - Identify any differences in roles played by line managers, HR and OH in comparison with role played for wholetime firefighters (incl. Trades Unions)
  - Integration, tensions, sticking points and conflicts around management of sickness absence for retained duty system employees
  - Liaison and co-ordination – successes and challenges in achieving a co-ordinated approach; information flows
  - Integration, tensions, sticking points and conflicts around management of sickness absence among groups involved (e.g. between HR and OH or line managers and OH)
  - Any trade union involvement
  - Any sticking points in ways in which procedures/policies work in practice

- Examples (including highlighting good practice)
  - Management of short-term sickness absence case, common/typical obstacles
  - Management of long-term sickness absence case, common/typical obstacles
4. **Monitoring sickness absence**

- Arrangements in place for monitoring sickness absence
- Overview of data collection and data management, incl. use of IT systems
- Responsibilities for monitoring and disseminating that information
- Explore information collected, how collected, ease of collection, accuracy and completeness
- Explore in detail exactly what data is collected e.g. how length of absence is recorded (as hours lost per normal working hours, as a shift loss etc)
- How cause of absence is recorded – level of detail, source of information how and when work-relatedness is recorded, how determined
- Analysis of information
- How information is used to trigger specific interventions (incl. timescales of actions)
- Feedback mechanisms and their frequency for line managers and other staff (e.g. strategic managers) and whether different people get different levels of detail (e.g. line managers, HR, occupational health, the board, CFO etc)
- Who uses information; what information is used for (e.g. trigger points, identifying hotspots for preventative action)
- Point at which employee is identified long-term sick; how and what patterns of absence are identified e.g. repeated absences in set time period, patterns of cause

5. **Reflections on managing sickness absence**

- Reflections on policies, procedures, systems in place
  - Whether they work well, are effective and appropriate
  - Identify aspects of sickness absence management which FRS has ability/capacity to implement as intended and aspects where there are barriers to implementation
  - Whether occupational health arrangements, including the provision of OH advice are efficient and effective (whether regional operation of OH arrangements has been/will be considered and any cost/organisational benefits arising)
  - For County Fire Authorities, whether sickness absence management policy works in the context of the FRS and level of control of FRS in terms of policy development (ownership, input)

- Perceived need for development/further refinement of effective absence management process and procedures, (including data collection and use, communications issues) and issues service would need to address in order to improve its performance
  - How sickness absence management could be improved based on personal experience – suggestions for good practice, what employer could do better

- Explore where FRS wants to be in five years' time in terms of sickness absence management and what they'll need to do to get there (e.g. in terms of policy, procedures, practice/implementation)
  - Any learning from other areas

- Any other thoughts or comments
**Line manager topic guide**

**P6168 Sickness Absence Management in the Fire and Rescue Service**

### Objectives:
- To examine barriers and facilitators to the successful implementation of sickness absence policies and practices for line managers
- To elicit views on ‘what works’, areas of concern, and how policy and practice in sickness absence management can be improved

### Introduction:
- Introduce self and NatCen as independent research contractor
- HSE/CLG have commissioned the research to support FRS
- The interview will focus on successes and challenges in managing sickness absence in local FRS and how it relates to strategic priorities
- Confidentiality: in main report (quotations will be anonymised), but also make aware of written feedback to FRS
- Explain about digital recording and seek permission to record
- Confirm length of discussion (no longer than 90 mins)
- Any questions

### 1. Background
- Respondent job title and responsibilities
  - How long in role
  - Previous roles in current FRS and any other FRS
  - Any other experience relevant to line management
  - Number and type of staff respondent is responsible for line managing
  - Description of working conditions and working hours for staff

### 2. Performance of FRS in managing sickness absence
- Awareness of current position of FRS in terms of sickness absence rates and BVPI 12
- Key causes and nature of sickness absence in employee group (explore for short and long term, condition, whether caused by or related to work, and also explore other causes of absence attributed to sickness e.g. family/household circumstances, work-related issues (including those related and not related to health condition/injury)
  - Historical absence rates and reasons for change/stability (whether they get statistics, performance relative to other FRSs, if known, reasons why)
  - Aspects of job / working conditions that contribute to sickness absence or make it more difficult to manage (e.g. staff turnover, recruitment / retention, organisational changes)
  - Consequences of sickness absence (e.g. impact for managing the capacity of staff and any knock-on effects e.g. morale)
3. Managing sickness absence - practice

- Explore what typically happens when an employee is absent from work due to sickness or disability [establish chronology of what happens]
  - Process for employees to notify employer they are off sick, what is recorded, how & when this is documented; who it is sent to
  - Self certification period, GP certification period
  - Point at which OH and HR get involved in individual cases and what triggers this
  - First contact by employer, who does this and when
  - Frequency of contact (telephone and face-to-face meetings)
  - Home visits
  - Support offered including external support and rehabilitation (e.g. FSNBF rehabilitation services, counselling, Jobcentre Plus Access to Work scheme, Disability Services)
  - Disciplinary/capability procedures
  - Planning returns to work, how this happens, who attends meeting / return to work interview (e.g. line manager, HR, OH, employee)
  - Scope for adjustments, options available (e.g. modified duties, reduced hours, redeployment)
  - Process of managing and monitoring returns to work (e.g. frequency of meetings, OH assessment/test)
  - Explore any sickness absence management issues associated with early retirement, injury awards, financial arrangements
  - What works well and less well in terms of sickness absence management (e.g. what works in getting employees back to work)
  - Whether support available is appropriate / useful / adequate (explore for all conditions)

- Explore the role of the line manager in sickness absence management
  - Key functions, responsibilities and purpose of line manager role in managing sickness absence
  - How line manager role in sickness absence is managed/supervised
  - Perceived effectiveness of line manager role in sickness absence management (what works and what doesn’t work so well)
  - Ways in which role of line manager supports sickness absence management process (explore from line manager perspective and also from perceived employee perspective)
  - Liaison and co-ordination with HR and OH – successes and challenges in achieving a co-ordinated approach, communication issues and information needs
  - Integration, tensions, sticking points and conflicts around management of sickness absence among key groups involved

- Knowledge / awareness of / familiarity with procedures
  - Whether procedures are always followed in the same way (if not, why, explore any scope for discretion in following procedures)
  - Whether procedures are appropriate in context of employee group
  - Perceived balance between disciplinary action and support and rehabilitation and extent to which different interventions are offered on a voluntary or compulsory basis (explore decision-making process)
• Explore changes in priorities, culture, procedures and approaches relating to sickness absence management
  - Organisational culture relating to sickness absence and its management
  - Impact of changes to the Firefighters’ Pension Scheme (in dealing with injuries, ill-health retirements and other long term sickness issues)

• Two examples of recent sickness absence cases where a positive outcome was achieved (ideally one short term and one long term case)
  - Reasons why things went well, what facilitated success

• Two examples of recent sickness absence cases where the outcome was less positive (ideally one short term and one long term case)
  - Reasons why things did not go so well, challenges and sticking points

4. Monitoring sickness absence

• Arrangements in place for monitoring sickness absence and their adequacy
  - Role of line manager in reporting sickness absence (e.g. to HR)
  - Type of information received by line manager, frequency and level of detail
  - How information is used (e.g. to trigger specific interventions incl. timescales of actions)

5. Managing sickness absence – training and reflections on policies and procedures

• Training, guidance and support for managing sickness absence
  - Details of any formal training received
  - Details of any written guidance/procedures and awareness of content
  - Details of any supervision received (nature, frequency)
  - Details of any other support
  - Whether training / written guidance / supervision/ support is helpful / useful, to what extent
  - Whether there are additional skills that would help in managing sickness absence

• Health and safety – explore both what issues have an impact, and views on usefulness for prevention

• Health promotion

• Perceived need for development/further refinement of effective absence management process and procedures, issues service would need to address in order to improve its performance
  - How sickness absence management could be improved based on personal experience – suggestions for good practice, what employer could do better

• Any other thoughts or comments
Employees with experience of sickness absence topic guide

P6168 Sickness Absence Management in the Fire and Rescue Service

Objectives:

- To explore employees’ experiences of current sickness absence policies and practices in the case study fire and rescue authority
- To examine barriers and facilitators for engagement with sickness absence policies and practices
- To elicit views on ‘what works’, areas of concern, and how policy and practice in sickness absence management can be improved

Introduction:

- Introduce self and NatCen as independent research contractor
- HSE/CLG have commissioned the research to support FRS
- The interview will focus on successes and challenges in managing sickness absence in local FRS and how it relates to strategic priorities
- Participation voluntary
- Confidentiality: a) in main report (quotations will be anonymised) and written feedback to participating FRSs; and, b) re names of employees interviewed not being shared outside the research team
- Explain about digital recording and seek permission to record
- Confirm length of discussion (no longer than 90 mins)
- Any questions

1. Background and personal circumstances

   - Age

   - Personal circumstances,
     - Household composition
     - Dependents / caring responsibilities
     - Household income breakdown (whether respondent is sole / main / joint / subsidiary earner)

   - Explore current employment situation
     - Whether part-time / full-time / RDS
     - Normal shift patterns and / or contracted hours
     - If wholetime, any secondary employment
     - If retained firefighter, primary employment
     - If part-time, what else they do with their time (including any other jobs)

   If working…
     - Whether a return to work and when this was
     - Whether new job or original job (and whether the original job has included any adjustments e.g. temporary change of duties / levels of responsibilities) and length of time in post(s)
     - Current and previous (if applicable) job titles, duties, hours, contracts etc.

   If not working…
- Identify whether off sick or no longer in work
- If unemployed/early retired gain brief details of how job ended and when this took place in relation to start of sickness absence
- Also ascertain job title, duties, hours, contract etc. and length of time in post

2. **Reasons for and experience of sickness absence**

   • Reason for recent period of sickness absence
     - Factors leading to period of absence
     - Primary reason for absence
     - Anything else which led to absence e.g. secondary reporting conditions, family / household circumstances, work-related issues (including those related and not related to health condition / injury)
     - How factors leading to absence affected their life and work
     - Dates and length of absence (including any gaps e.g. returns to work etc.)
     - Identify point at which decision to take time off work was taken and why
     - Explore influences on decisions (e.g. circumstances, condition, GP, line manager etc.)
     - Whether sickness absence could have been averted / prevented, how and when (explore any steps taken to try and remain in work)
     - History of sickness absence (frequency and duration of absences and reasons for absences e.g. whether relate to same condition)

   • Explore impacts of experience of sickness absence
     - Thoughts and feelings associated with being ill and absent from work
     - Family roles and day-to-day life
     - Income / household finances and nature of income (sick pay and for how long, benefits etc.)
     - If absence is continuing, explore main reasons (e.g. too ill / injury prevents, e.g. waiting for treatment, lack of diagnosis, difficulties at work; fears related to health / work; financial) and anticipated impact in long term

3. **Experience of sickness absence policies and procedures**

   • Establish chronology of sickness absence monitoring and interventions – exactly what happened and when
     - Self certification period, GP certification period; when first reported in
     - Knowledge of the procedures to have follow and what can expect, and whether this happened
     - First contact by employer, who did this and when
     - Level and nature of workplace contact (who contact was with e.g. line manager, HR, how initiated, frequency, duration and form of contact e.g. telephone, face-to-face, home visits)
     - Point at which HR got involved and what triggered this
     - Content of / reason for workplace contact (e.g. suggestions, offers of help, discussion of ways forward, making plans; referrals to in-house/external support/treatment)
     - Reaction, feelings and thoughts relating to level and nature of contact (whether felt supported / not supported etc.)
     - Any changes to nature of contact / employer attitude over time
     - Any disciplinary / capability procedures
     - If applicable, whether early retirement has been considered and reasons for and against
4. **Contact with healthcare services and other sources of support**

- Explore nature of contact / treatment and timing in relation to workplace contact explored above
  - Who contact / treatment was with (GP, consultants, specialists etc.)
  - How contact was initiated, by whom, and any interaction between healthcare services and employer
  - Frequency, duration and form of contact / treatment
  - Chronology of help received (explore in relation to workplace contact)
  - Appropriateness and effectiveness of contact / treatment
  - Whether contact / treatment was focused on work / return to work
  - Impact on feelings / thoughts about returning to work

- Explore barriers to healthcare and needs in relation to services / sources of support
  - Any barriers to receiving treatment (e.g. lack of diagnosis, waiting lists for treatment)
  - Contact with any other services/sources of support (e.g. FSNBF rehabilitation services, counselling, Jobcentre Plus Access to Work scheme, Disability Services, union support, voluntary organisations)
  - Reflections on what services should be available to help people in similar situations (e.g. changes to existing services, new services, help available for people on sick leave)

5. **Returning to work**

- Explore return to work process

  *If employee has returned to work…*
  - Whether employee has returned to same job or different job, at what point, and nature of any changes made
  - Planning of return to work, how this happened, at what point, who attended meeting(s) / return to work interview(s) (e.g. line manager, HR, OH, employee)
  - Whether there was scope for adjustments, options available (e.g. modified duties, reduced hours, redeployment)
  - How return to work was agreed and organised (what was put in place, e.g. action plan, phased return, modified duties, redeployment), scope for employee input into plan (whether there was scope for flexibility/choice), whether time limits set for these, whether reviewed, whether it happened at the right time for them
  - Experience of process of managing and monitoring return to work (e.g. frequency of contacts, meetings, OH assessment/test, whether seen as happening at the right time; did they receive contradictory support/advice from line managers/HR/OH/GP)
  - Experience of / thoughts and feelings regarding return to work
  - Reflection on arrangements put in place, what worked and any aspects that proved more difficult
  - Sustainability of return to work
  - Whether anything else could have been done to better facilitate employee’s return to work
If employee has not yet returned / will not be returning to work…
- Whether there has been any planning of return to work, what has happened / will happen, at what point, including who has / will attend meeting(s) / return to work interview(s) (e.g. line manager, HR, OH, employee) (also whether offered and refused)
- Whether there is scope for adjustments, options available (e.g. modified duties, reduced hours, redeployment) and whether employee can negotiate these
- How return to work could be agreed and organised (what would need to be put in place, e.g. action plan, phased return, modified duties, redeployment)
- Thoughts and feelings regarding return to work, whether employee wants to return to same job or different job, level of confidence about returning to work
- Reflection on arrangements put in place, what worked and any aspects that proved more difficult
- Whether anything else could be / have been done to better facilitate employee’s return to work

6. Working conditions and sickness absence in the FRS

- Establish respondent’s perception of working conditions in the FRS and their impact on sickness absence and the management of sickness absence
  - Hours of work (shift system, hours, any flexibility)
  - Organisational culture relating to working conditions (e.g. scope for flexible working, stress management, Health & Safety issues, post-strike morale)
  - Union and other worker support (e.g. EAP)
  - Aspects of job / working conditions that contribute to sickness absence or make it more difficult to manage (e.g. staff turnover, recruitment / retention, communication, also assessment for NVQs, performance targets, community safety etc.)
  - Consequences of sickness absence (e.g. impact for managing the capacity of staff and any knock-on effects)
  - Impact of changes to the Firefighters’ Pension Scheme (in dealing with injuries and other long term sickness issues)
  - Health and safety and health promotion, whether there are other things which could be introduced which would improve sickness absence incidence

7. Closing reflections

- Whether experience of sickness absence policies and matched expectations and needs
  - Whether process was helpful, what employee wanted, what employee had expected
  - Whether what happened / is happening is meeting employee’s needs
  - What else could have been / could be done (or done better) to help manage employee’s sickness absence
  - How experience compares to any previous experience of sickness absence policies and whether anything has changed/improved

- Perceived need for development/further refinement of effective absence management process and procedures, issues service would need to address in order to improve its performance
  - How sickness absence management could be improved based on personal experience – suggestions for good practice, what employer could do better

- Any other thoughts or comments
Attendance management in the Fire and Rescue Service

Managing sickness absence and managing and supporting attendance

This study was commissioned by the Health and Safety Executive and the Department for Communities and Local Government (DCLG), and carried out by the National Centre for Social Research. It examined policy and practice in managing sickness absence within the Fire and Rescue Service. The aim of the study was to understand:

- the nature of current policies and practices;
- views and experiences of policies and practices among different types of staff;
- the degree to which policies and practices reflect recent recommendations;
- barriers and facilitators to adopting recommended practices; and
- practices that are considered useful and how policy and practice in attendance management might be improved.

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