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Attendance management in the Fire and Rescue Service

Managing sickness absence and managing and supporting attendance

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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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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 Continual 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.

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*

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)*