HSE

Health and Safety Executive

Managing sickness absence in the police service

A review of current practices

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Managing sickness absence in the police service

A review of current practices

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The Home Office and the Health and Safety Executive (HSE) are working together to reduce the number of working days lost to ill health and/or injury in the police forces of England and Wales. They commissioned this review of absence policies and management in seven police forces to inform the process.

This review is intended to be used by the Home Office and HSE to develop measures to improve current practice in line with the Ministerial Task Force (MTF) on Health, Safety and Productivity aims and the drive to improve public sector efficiency. It presents an in-depth analysis of absence management in the case study forces and identifies the clear themes and issues which are vital for the effective management of absence.

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EXECUTIVE SUMMARY

The Home Office and the Health and Safety Executive (HSE) are working together to reduce the number of working days lost to ill health and/or injury in the police forces of England and Wales. They commissioned the Institute for Employment Studies (IES) to conduct a review of absence policies and management in police forces to inform this process. This review is intended to be used by the Home Office and HSE to develop measures to improve current practice in line with the Ministerial Task Force (MTF) on Health, Safety and Productivity aims and the drive to improve public sector efficiency.

The specific aims of the review were to:

- explore how sickness absence data is used to manage and monitor absence
- explore views of the current absence management processes among police officers, police staff, line managers, HR and occupational health professionals
- identify barriers experienced by staff, line managers, occupational health staff and HR staff in following and implementing current policies and procedures in everyday practice, and how these barriers are addressed within the local force.

Guidance issued by the HSE, ACAS & CIPD (2006) and research by CBI (2006), CIPD (2006), NAO (2004) show that absence management cannot be viewed as just primarily policy and procedures. Successful absence management fundamentally depends on addressing wider organisational and management factors such as the culture of the organisation, their approach to well-being at work, communication skills and the ability of line managers to competently deliver policy. The project was, therefore, designed as a qualitative case study approach to embed the exploration of sickness absence management in the context of each force and to understand the surrounding issues that impact on absence, and absence management. The review is not a formal evaluation of each force's policies and initiatives but a 'snapshot' of perceptions of the situation at the time of the study.

METHODOLOGY

A sample of seven police forces were recruited on the basis of the following criteria:

- high, low and average absence rates for police officers and staff
- improving or worsening absence rates
- whether forces served predominantly urban or rural areas
- size of force
- geographical spread across England and Wales.

The Metropolitan Police were excluded from the project because their size and roles in policing made them atypical compared to other forces. However, other metropolitan forces were included for sample selection.

Data was collected using a range of data collection methods and staff and officers across a range of grades and functional roles. This included:

- a review of absence policies
- interviews with those who had a major responsibility for absence: Chief Officers, HR Managers, HR Business Partners, Absence Data Managers, Occupational Health professionals and Staff Welfare/Health and Safety Officers

- focus groups with officers and staff, line managers, trade unions and those recently returned from long-term sickness
- a short questionnaire to collect background and contextual data from focus group participants
- telephone interviews with long-term absentees.

ABSENCE POLICIES

A well-documented policy is essential for any force to successfully manage absence. This needs to establish the processes to be used and who should be responsible for their initiation and delivery. The allocation of clear roles to the individual who is sick, the line manager, occupational health, HR and any other support services is essential. All the policies from the forces met these requirements.

The accepted effective management approaches to absence were based on academic and practitioner reports, and published guidance, eg HSE (2004b), CIPD/HSE/ACAS (2006) and Bevan and Hayday (1998) were used to assess the contents of the policies.

The approaches of the policies varied from the very punitive to stressing the forces' duty of care to staff. The most effective policies accepted that ill health is unavoidable, recognised the importance of individuals feeling valued and had measures in place to encourage and support return to work.

This review showed that the policies would be improved by the inclusion of the following:

- Greater emphasis on the commitment of senior management to absence in the policies.
- The inclusion of an estimate of the annual cost of absence to the force to strengthen their impact.
- More use of process flowcharts to improve understanding of procedures and timelines.
- Unit attendance levels forming part of the line manager's performance development review (PDR), in line with the Ministerial Task Force's recommendation.
- A requirement that working conditions are more widely considered as a cause of individual absence.
- Managers allowed discretion on when attendance review is necessary to ensure that policies are not applied as rigid processes.

MONITORING ABSENCE

Reliable, accurate and understandable information on the sickness of individuals is the cornerstone for both monitoring and managing absence. These requirements depend on a number of factors:

- Line managers recording an individual absence correctly and in a timely fashion. Other pressures and priorities often interfered with their ability to do this.
- The software available to the force. The systems used frequently could not relate individual absence data to pay roll information which held the number of days lost, which seriously limited many potentially useful cross analyses.
- Home Office guidance *(Home Office Guidance on Statutory Performance Indicators (SPIs) for Policing, 2004-05)* requires forces to record hours lost to sickness for comparison. Most forces recorded time lost in days and a number of approaches were

used to convert days to hours which resulted in under or over-estimation. This is a source of inconsistency which means that absence figures are not comparable.

CAUSES OF ABSENCE

To manage absence effectively with targeted solutions, it is necessary to appreciate the reasons why people are taking sick leave and how long the condition may be expected to last. The causes of absence were seen as:

- Health related in the vast majority of cases with just certain individuals having attendance problems.
- For short-term absence, defined as up to 20 days, the most common causes were seen as colds, flu and stomach upsets. Cases where individuals took short-term sickness absence for domestic and caring responsibilities were also recognised.
- Long-term absences of over 20 days were seen to be related to psychological problems (such as stress, depression and anxiety), musculoskeletal disorders and serious or fatal illnesses.
- Work was perceived to be a contributory factor to both short and long-term sickness when individuals felt they were under pressure due to lack of resources, bureaucratic demands and organisational change. Sickness could also result if individuals felt that they had little or no support from the force, or were in negative work situations.

MANAGEMENT OF ABSENCE

The majority of the responsibility for managing absence rested with the line manager. For them to be effective it was necessary that the managers were:

- Knowledgeable about policy and had the confidence to use their discretion to handle individuals appropriately.
- Able to maintain meaningful contact with those away sick.
- Well trained in absence management and in using effective inter-personal skills.
- Supported by occupational health and HR.
- The contributions of occupational health were vital to managing long-term absence. It was found that:
- Under funding often led to slow or inadequate responses which could create barriers to staff returning to work.
- Line managers would like them to be more involved in short-term absence.
- Sanctions and incentives were used in all forces to encourage attendance. The sanctions were based on pay and access to training and promotion. The impact of these is unclear but staff often felt that they were unfair where individuals had ill health or were injured. The effectiveness of incentives, such as extra leave, special payments or recognition of good attendances by letters or certificates was perceived as variable.
- Managing and maintaining a successful return to work raised some challenges:
- The timing needed to be right for the individual so they did not feel compelled to return and were not delayed by occupational health professionals resourcing issues or waiting for adjustments to be made. This is particularly difficult in cases of mental ill-health where expectations of timescales for return are unclear.

- Flexibility in how returnees work is essential and needs to be supported by line mangers and colleagues. Line managers should clarify what is expected from the returnee, set targets and hold regular reviews.
- Recuperative duties need to be well designed and used for a limited time so that individuals get back to normal duties as soon as possible. Difficulties here were related to how the new duties were regarded by the individual and their colleagues.
- Restrictive duties were frequently misunderstood. They were confused with recuperative duties and not seen as a permanent means of retaining officers who would otherwise be retired on ill-health grounds. The increased use of these duties has led to some resentment as this reduces the number of officers that can be actively deployed.

WELL-BEING INITIATIVES

A range of initiatives aimed at increasing well-being, promoting a healthy lifestyle and preventing accidents were described as having been successful by the participants in the research. These tended to fall into three categories: special leave, flexible working and work-life balance initiatives; accident prevention; and health at work initiatives.

- Specific Home Office funded initiatives were identified in the forces interviewed for the research. These included:
- physiotherapy and rehabilitation equipment
- stress audits, safety and working life audits
- the use of private medical care for people needing scans or operations
- the funding of temporary additional occupational health posts.

Formal evaluations of the effectiveness of these measures were unusual, often owing to the difficulty of identifying and tracking appropriate data. Attendance at the activities was frequently considered as the only indicator of success.

- Some general frustrations and difficulties surrounding well-being initiatives were apparent:
- A basic lack of resources in some forces made it difficult to carry out any sustained campaign of health and well-being initiatives.
- The removal of measures when funding was exhausted gave rise to dissatisfaction among staff.
- The short-term nature of initiatives meant that they were not perceived as serious attempts to improve health and well-being.
- The closure of canteens in the forces owing to pressure on office space had a negative impact on the availability and quality of food for staff and had removed an area for relaxation.
- A similar widespread removal of force gyms owing to the fear of litigation arising from injury sustained has occurred. The gyms were seen as having a vital role in keeping staff physically and mentally fit.

1 INTRODUCTION

The Home Office and the Health and Safety Executive (HSE) are working together to reduce the number of working days lost to ill health and/or injury in the police forces of England and Wales. They commissioned the Institute for Employment Studies (IES) to conduct a review of the absence management in police forces to inform this process. The review will be used by HSE, the Home Office, National Police Improvement Agency (NPIA), Association of Chief Police Officers (ACPO) and other police stakeholders to develop measures to improve current practice in line with the Ministerial Task Force (MTF) on Health, Safety and Productivity aims and the drive to improve public sector efficiency. The objectives of the review are to provide in-depth information on:

- the approaches to absence which work and any difficulties in implementing the forces' sickness absence policies
- barriers to managing, preventing and reducing the incidences of sickness absence
- impediments to successfully managing an early and sustained return to work.

Specifically, the review has been designed to contribute to the study of these questions by conducting case studies in a sample of police forces. These case studies:

- explore how sickness absence data is used to manage and monitor absence
- explore the views of the current absence management processes among police officers, police staff, line managers, HR, occupational health professionals and local trade union representatives
- identify barriers experienced by staff, line managers, occupational health staff and HR staff in following and implementing current policies and procedures in everyday practice, and how these barriers are addressed within the local force.

Research and guidance on absence management (Bevan and Hayday (1998), NAO (2004), HSE (2004a and 2004b), CBI (2006), CIPD (2006) and CIPD/HSE/ACAS (2006)) show that absence management cannot be viewed as just primarily policy and procedures, which suggests a very mechanistic approach. Its success fundamentally depends on wider factors such as the cultural approach to well-being, communication and the ability of line managers to competently deliver policy. The project was, therefore, designed to embed the exploration in the context of each force and to understand the surrounding issues that impact on absence. The review is not a formal evaluation of each force's policies and initiatives but a 'snapshot' of perceptions of the situation at the time of the study. It does not involve extensive analysis of force absence data or aim to quantify the effects of any initiatives; its findings are primarily qualitative. The structure of the report is as follows:

- Chapter 2 discusses the methodology used in the review
- Chapter 3 describes the profile of the respondents in the case study interviews and focus groups.
- Chapter 4 presents the current consensus of views on effective absence management
- Chapter 5 reviews the written absence policies of the participating forces
- Chapter 6 addresses data management issues and use of data to monitor absence
- Chapter 7 discusses the perceptions of reasons for absences in the forces
- Chapter 8 considers the roles of different staff managing absence and the processes they use

- Chapter 9 looks at sickness absence prevention and well-being at work initiatives within the forces
- Chapter 10 concludes by identifying themes and issues arising from the review and makes specific recommendations about the management of absence.

A series of appendices contain the report bibliography, summary tables of the measures to manage absence, focus group and interview guides used in the review, and tables presenting the background attitude data from the focus group questionnaire responses.

2 METHODOLOGY

The review was designed to provide an in-depth understanding of the issues around absence management. A case study approach was adopted, and a range of research methods were used to cost-effectively provide information from all stakeholders in the management of absence.

2.1 SELECTION OF CASE STUDIES

Using absence data for police officers and staff from 2004/05 and 2005/06 and other information provided by the Home Office, IES selected and agreed a sample of eight police forces with the HSE and the Home Office. The Metropolitan Police were excluded from the project because their size and roles in policing made them atypical compared to other forces. Other metropolitan forces, however, were included for sample selection.

The initial eight sites for the study were chosen on the basis of the following criteria:

- high, low and average absence rates for police officers and staff
- improving or worsening absence rates (it was important to consider the absence trend as well as the absolute absence level as the current absence management practices may have been improving a poor situation or worsening a strong one)
- whether forces served predominantly urban or rural areas
- size of force
- geographical spread across England and Wales

The selected forces were initially approached to take part in the project by a letter sent to the Chief Constable. This was followed up by telephone calls to explain the project and what participation would involve in more detail. IES asked forces to nominate a senior manager, preferably in HR, to liaise with the Institute in managing the research activities in their force. As little burden as possible was placed on the participating forces but assistance was needed to identify participants, and suitable rooms in which to conduct the interviews and focus groups. All participating forces and individuals within the forces were assured of complete anonymity in any published reports. In return for their contribution to the research the forces were offered a review of their individual absence management practices

Of the eight forces initially approached, six responded quickly and positively. One force delayed making a decision, and finally decided not to take part. A further force wanted to be involved but was unable to find someone to help organise the fieldwork owing to lack of resources and pressure of work. Two substitute forces were approached that matched into the spread required from the initial sampling criteria. One agreed to participate, however, one force, despite considerable communication with them over a period of time, had not taken a decision about whether to commit to the project. Rather than delay the production of findings, the decision was taken, in consultation with the HSE and Home Office, to complete the review using the seven case studies.

The sampling criteria profiles of the seven case studies are given in Table 2.1.

Table 2.1 Absence profiles of the case study forces

	Size of force	*Type*	*Absence level*	*Absence trend*
Case study 1	small	urban	high	worsening
Case study 2	small	urban	low	worsening
Case study 3	small	rural	low	improving
Case study 4	medium	rural	low	improving
Case study 5	large	rural	high	improving
Case study 6	large	urban	high	improving
Case study 7	large	rural	low	worsening

Source: IES Survey, 2007

The majority of the forces in the sample were in the process of reviewing their approach to absence and commented that they were aware that improvements could be made.

2.2 DATA COLLECTION AND ANALYSIS

In order to explore the issue of absence management from a variety of perspectives, data was collected from:

- forces' absence policies
- interviews with those who had a major responsibility for absence: Chief Officers, HR Managers, HR Business Partners, Absence Data Managers, Occupational Health professionals and Staff Welfare/Health and Safety Officers.
- focus groups with officers and staff, line managers, trade unions and those recently returned from long-term sickness
- a short questionnaire to collect background and contextual data from focus group participants
- telephone interviews with long-term absentees

The information was then analysed using the accepted effective practices as a basic structure to discuss the approaches of the forces. These elements had previously been identified in IES' own research and extensive reviews of the literature (Bevan and Hayday (1998), NAO (2004), HSE (2004a and 2004b), CBI (2006), CIPD (2006) and CIPD/HSE/ACAS (2006)).

The details of each of the research activities will be discussed below.

2.3 REVIEW OF ABSENCE POLICIES

Before any research was undertaken, a review of the absence policy of each participating force was made. This enabled the researchers to understand the policy and how its processes were intended to be applied. IES assessed the absence policies against the accepted effective measures outlined in Chapter 4. This was conducted by researchers studying the policies in depth and using an Excel spreadsheet to record common features against a checklist. Unusual aspects were also noted. The analysis of the policies is also presented in Chapter 4.

2.4 INTERVIEWS AND FOCUS GROUPS

Within each case study IES planned to conduct face to face interviews, telephone interviews and focus groups.

2.4.1 Depth interviews with those who had a responsibility for absence management across a force

Face-to-face interviews were planned for all those who had a major responsibility for managing absence across each force. These were conducted with the HR manager, absence data manager, local HR liaison/HR business partner, and an Occupational Health professional and either a Staff Welfare Officer or Health and Safety Officer.

The interview guides are provided at Appendix 3

2.4.2 Focus group questionnaires

Two questionnaires were designed and used with all focus group participants, including focus groups with those who had returned from a spell of long-term absence. This was to provide contextual information on the participants, including age, gender, status, health, absence history and some individual views on attitudes towards taking time off work and perceptions of attendance management. One questionnaire was designed for line managers and another for police staff and officers. These short questionnaires were completed before the discussion began. Where people arrived late and there was not enough time for them to complete their questionnaires they were provided with a reply paid envelope to encourage them to send in their response later. This information gave additional insight into views expressed in a group setting by providing individual level information on the characteristics and attitudes of respondents.

The questionnaires are at Appendix 6.

2.4.3 Focus groups

For line managers, officers, police staff, and trade unions, focus groups were used to explore the views of all aspects of absence management. This approach enabled views to be collected from a larger number of respondents and provided the opportunity to explore contrasting opinions.

The focus groups gave a general overview of how absence was perceived in the forces. The participants were selected in consultation with the case study force. Suitable individuals were identified to represent the different areas of policing and the demographics of gender and age. Their individual sickness records could not be used as a selection factor as disclosure is prevented by the Data Protection Act. Those chosen were invited to voluntarily take part in the focus groups through a letter from IES.

In each force the following focus groups were planned:

- two staff line-manager groups: one from head quarters and one with managers from different police stations.
- three officer line-manager groups: one each for CID, Response, and Neighbourhood Policing with attendance from a range of stations across the force.
- two staff groups: one of administrative staff and one of operational staff eg Police Community Support Officers, Investigating Officers, and Designated Detention Officers from a range of different stations across the force.

- two officer groups of police constables: to include officers from CID, Response and Neighbourhood Policing.

The discussion guides used with these groups are at Appendix 4.

A key objective of the study was to review the management of the return to work of those who have been absent on a long-term basis. To do this, focus groups and interviews were planned for:

- Staff and officers who had recently returned from a long-term sickness absence spell
- Staff and officers who were still off work on long-term sickness absence

For the purposes of this study, participants were selected for inclusion in this part of the research if they had been off work for over four weeks. This meant that the research targeted those who had greater opportunity to be exposed to the procedures for managing long-term absence.

In recognition of the sensitivities in discussing a recent or current spell of absence, potential respondents were asked if they would prefer an individual interview or whether they would be willing to take part in a focus group.

Two focus groups per force were planned for those who had recently come back to work after more than four weeks of absence:

- one with those returning from mainly physical illnesses
- one with those returning from mainly psychological disorders.

The discussion guide used with those who have returned from a recent spell of long-term absence is at Appendix 4.

Telephone interviews were proposed for police staff and officers currently on a spell of long-term absence in each force. Owing to data protection requirements relating to the release of personal details and individual information on sickness absence, the IES research team was unable to select sample participants and was, therefore, reliant on the force to select an unbiased sample of respondents to be approached. The forces were asked to approach 12 possible interviewees selected for differing lengths of absence and both physical and mental conditions bearing in mind the need to represent job roles, age and gender. To ensure that those interviewed had all voluntarily opted into the study and that the force did not know who had volunteered to take part, the force sent a letter from IES inviting them to take part in the research with a form which was to be returned to IES in a pre-paid envelope. Those on sickness absence were asked to provide a telephone number and suitable times to call. A researcher then contacted them and a time for the interview was arranged. No follow-up was made if a response was not received to the initial letter. The telephone interviews allowed the views of this important group to be thoroughly explored with as little intrusion as possible. The interview focussed on the management of their case and what they saw as aiding or hindering their return to work. The telephone interview guide used is at Appendix 5.

2.4.4 Details of the interviews and focus groups achieved

Not all of the forces were able to arrange all the activities requested, although IES believe they received a high level of cooperation given operational requirements. Some forces also suggested other interviewees who they felt would be relevant to the study, such as data analysts, the force medical adviser and physiotherapist and these were included.

Table 2.2 Planned and achieved case study interviews and focus groups

	Planned participants	*Achieved participants*
	Number	**Number**
Interviews:		
Senior managers	42	47
Focus groups:		
Staff line-managers	84	68
Officer line-managers	126	54
Trade unions	21	31
Police staff	112	51
Police officers	112	49
Staff returned from long-term sickness	84	27
Total focus group participants	**539**	**280**
Telephone interviews		
Long-term absentees (telephone)	42	8

Source: IES, 2007

Table 2.2 shows the research interviews and focus group participants achieved in the research against the numbers planned on the basis of the seven case studies. The interview response was better than expected as the forces were able to make definite appointments with the senior managers which were convenient for them. This group was also keen to contribute to the research. The response from officers and police staff was disappointing due partly to operational requirements, the difficulties of bringing participants together in one place and possibly some reticence about discussing absence. The trade union participation was also greater than anticipated with more than one representative attending from each union.

As expected, the greatest challenges were encountered in gaining the participation of those away with, or who had returned from, long-term sickness. All forces were offered the option of telephone interviews rather than focus groups for returnees from long-term sickness. In one case study the HR manager preferred such interviews rather than focus groups as they felt that long-term sickness was better discussed on a one to one basis. In all other forces two focus groups were conducted with those who had experienced a recent spell of long-term absence. However, the attendance was frequently low, often only two to three people, but the researchers involved reported that this did allow the issues to be explored in more depth. Respondents were also unconcerned about discussing their cases in a group setting and several of the sessions overran.

Telephone interviewing those away with long-term sickness proved to be difficult to arrange and conduct and only eight interviews took place. A variety of factors reduced response. Some of the forces found it difficult to identify respondents as their databases could not provide lists of suitable individuals. In some of these cases, line managers were approached by the force research co-ordinator to nominate individuals. Some line managers were unwilling to do this for reasons that are not known, as researchers did not approach the managers directly.

In total 49 letters were sent out to which 14 positive replies were received and eight interviews were conducted. Where people had agreed to take part, it often then proved difficult to contact them by phone. Messages were left with contact details after several attempts to speak directly had failed, but frequently they did not respond. It was important, given the potential sensitivity of changing conditions, that we did not pursue calls after two attempts. The researchers believe that the more thorough exploration of the experiences in the focus groups of those who had returned from long-term absence, made possible by the smaller numbers of participants, went some way to compensate for the low number of telephone interviews achieved.

Both positive and negative management experiences were freely discussed by focus group attendees and those taking part in the telephone interviews, so there is no reason to believe that the achieved sample was unduly biased to those who had had more positive absence management experiences. The caveat must, however, be made that it cannot be known with certainty whether the views of those who were being sanctioned or moving from sickness absence into disciplinary or early retirement procedures have been captured.

Of the 280 focus group questionnaires issued a total of 128 line manager questionnaires were collected and 132 from non managers. Therefore, questionnaires were completed by virtually all those who attended the focus groups (93 per cent). The questionnaire data went through a thorough 'data cleaning' process and a check for missing items. IES then carried out detailed explorations using the Statistical Package for Social Scientists (SPSS) software. To maintain confidentiality and statistical robustness the data is only presented at the aggregate levels for line managers and non line managers. Attitudinal statements are analysed in terms of the spread of response. The complete findings can be seen in Appendix 7 for managers and Appendix 8 for non managers. In addition, Appendix 9 presents a comparison of the views of both groups where the same questions were asked.

2.5 ANALYSIS AND REPORTING

All focus groups and interviews were recorded using digital dictaphones and were fully transcribed to provide a fuller record which can be used for in-depth analysis. This follows good research practice for qualitative research. All recordings and transcripts were held in completely anonymous form without the names of the respondents and, in line with guidance from the Social Research Association and the Market Research Society, will be destroyed by IES in June 2009.

The data from focus group questionnaires was analysed using the statistical package SPSS. Owing to the relatively small sample size no analyses by sub group were undertaken. The free text comments were also entered into Word. The questionnaires will remain with IES and will not be seen by anyone from the participating forces, the Home Office or HSE until they too are destroyed in June 2009.

This report has been prepared by combining individual force reports prepared by the case study managers. Each individual force report has been based on extensive analysis of the transcripts, questionnaire data and the absence policy documents collected using a specified analysis schedule based on the objectives of the research. The combined use of information from the forces, the transcripts of interviews and groups with senior managers, police staff and officers and trade unions plus the questionnaire data has enabled all the various viewpoints concerning absence to be collected. Over the past decade this blending of quantitative and qualitative data has become an emerging research approach, referred to as 'triangulation'. This seeks to provide confirmation of findings by relating different sources of data to minimise their individual validity issues. Each method can be regarded as bringing an additional piece of information to the research and providing greater overall insight. On this basis the study contained interviews, focus groups, analysis of policy documents and the survey of focus group participants.

2.6 SUMMARY

This chapter has described the methodology used to collect the data on which the remainder of the report is based. It uses a wide range of data collection techniques from which data was triangulated in analysis to capture the issues from various viewpoints. This was then analysed using a structure based on the issues identified from published guidance and research on absence management. The views and experiences collected in all the interviews and groups were used to inform the discussion in the main body of this report.

3 PROFILE OF THE PARTICIPANTS IN THE REVIEW

This chapter will describe those who took part in the study and their roles in the absence management process. A profile of the interviewees will be given, and a description of the features of both the long-term sick returners who took part in focus groups and those interviewed who were away with long-term sickness. The profiles of the focus group participants from their questionnaires will then be presented in more depth as there are sufficient numbers of these to analyse more fully. In this way the comprehensive coverage of the review and its representativeness can be understood.

3.1 PROFILE OF INTERVIEWEES

Representatives of all senior managers with a role in creating or taking responsibility for absence policy were interviewed. Chief Constables were asked to take part as they had the overall vision of absence in their forces and the strategy for its management. HR managers were included as they had an understanding of the policy and its practical application. It was critical to have the views of absence data managers as they had in-depth knowledge of how the data was collected, processed and used. The local HR liaison or HR business partner's views were also important to understand the support supplied to line managers and how this was utilised. The viewpoints of the forces' occupational health professionals were necessary to appreciate their vital role in the absence management process. Finally, Staff Welfare Officers or Health and Safety Officers were interviewed to gain insight into the operation of absence processes from a welfare or safety perspective. Additionally interviews with two absence data analysts, a force medical adviser and a physiotherapist were offered by the forces as they felt that the views of these professionals were also relevant.

The final sample of those interviewed is given in Table 3.1 and shows that the target number of interviews was more than achieved.

Table 3.1 Planned and achieved case study interviews and focus groups

	Planned participants	***Achieved participants***
	Number	**Number**
Interviews:		
Chief Officer	7	7
HR manager responsible for absence policy	7	6
Absence data manager	7	8
Local HR liaison/HR business partner	7	7
Occupational Health professional	7	8
Staff Welfare Officer/Health and Safety Officer	7	7
Absence data analysts	0	2
Force Medical Adviser	0	1
Physiotherapist	0	1
Total interviews	**42**	**47**

Source: IES, 2007

3.2 PROFILE OF THOSE RETURNED FROM LONG-TERM SICKNESS

The participants in the focus groups conducted with 27 of those returned from long-term sickness were made up of 15 staff returned from physical sickness and 12 from mental health conditions. On average they had been absent for 84 days. They were roughly divided by gender and just over two-thirds were officers. Their ages ranged from 19 to 59 with just under half being in the 40 to 49 age group. It is not possible to say if this represents all those returning from long-term sickness in the forces, but they do cover the full range of respondent types and conditions.

3.3 PROFILE OF THOSE AWAY WITH LONG-TERM SICKNESS

Eight interviews were conducted with those that were away with long-term sickness. These predominantly had physical conditions, which suggests either a reluctance of those with mental ill health to take part in the interviews or a concern in the forces about researchers approaching such individuals. For reasons of confidentiality it is not possible to give further details of the respondents' conditions. They were divided between staff and officers and were mainly non managers. The lengths of time they had been absent varied between two months and a year of continuous absence; one interviewee had been absent intermittently since 2000.

3.4 PROFILE OF FOCUS GROUP PARTICIPANTS

The focus group questionnaires asked for some biographical and employment details to monitor the representativeness of the group participants. The figures presented cannot be taken as representing either the overall characteristics of staff, officers and line managers or absence spells in the police forces involved as they are based on those selected to represent certain groups rather than the whole force, and those who then went on to participate in the focus groups.

Table 3.2 shows that the focus group participants were roughly equally divided by gender and that the most common age range was 30-49. Slightly more line managers than non managers attending the focus groups were in the older age range, but this is to be expected as managers are usually those with more experience, which is related to age.

Table 3.2 Respondent profile

		Line Managers		**Non Managers**	
		Count	***%***	***Count***	***%***
Gender	Male	67	52	67	52
	Female	61	48	62	48
Total		**128**	**100**	**132**	**100**
Age Group	Under 20	0	0	1	1
	20-29	10	8	21	17
	30-39	38	30	48	34
	40-49	54	42	34	28
	50+	26	20	27	20
Total		**128**	**100**	**132**	**100**

Source: IES focus group questionnaires, 2007

Table 3.3 details the job role and working patterns of focus group participants. There was an approximately equal spread of officers who were line managers and officers who were not line managers, 42 per cent of the line managers that took part were officers and 39 per cent of the non-manager groups were officers. Similarly there was an equal spread of police staff with line management roles and police staff without line management functions participating in focus groups. Just over a third of line managers worked shifts or variable duties compared with almost half of the non managers.

Table 3.3 Job details

		Line Managers		*Non Managers*	
		Count	**%**	**Count**	**%**
Staff/Officer	Police Staff	74	58	80	61
	Police Officer	54	42	52	39
Total		**128**	**100**	**132**	**100**
Typical Working Pattern	Days	82	64	67	52
	Shifts	34	27	54	42
	Variable	12	9	9	7
Total		**128**	**100**	**130**	**100**

Source: IES focus group questionnaires, 2007

The number of years that focus group line managers had spent in a management role and the number of people they managed is given in Table 3.4. There was a good spread of experience, with those of less than one year being represented as well as the larger group of those with extensive experience of over ten years. Similarly the number of people they managed ranged from one person to over 500. The most common number of staff line managers were responsible for was between five and nine, representing 39 per cent of managers.

Table 3.4 Line management experience

		Count	**%**
Line Management Experience			
	One year or less	21	17
	Two to four years	33	27
	Five to nine years	26	21
	Ten or more years	44	35
	Total	**124**	**100**
Number of whole time equivalent (WTE) police staff and officers directly and indirectly under your supervision?			
	less than 5	13	10
	5-9	48	39
	10-19	26	21
	20-39	19	15
	40-99	11	9
	100+	7	6
Total		**124**	**100**

Source: IES focus group questionnaires, 2007

The participants in the focus groups were also asked about their own sickness absence history to give a perspective to the views expressed. Their responses are shown in Table 3.5. Non managers were more likely to have been away sick in the last twelve months with 55 per cent affected compared to 37 per cent of managers. It should be borne in mind in the following chapters that just under two-thirds of managers and under half of non managers have had no personal experience of being absence in the past year

Among those participants in the focus groups that had had a spell of sickness absence in the last 12 months, the majority of people were only away once: 76 per cent for managers and 47 per cent for non managers. Of all the spells of absence, most were for five days or less (74 per cent of the managers and 50 per cent of non managers).

The non managers only were asked if they had been away because of having to provide care for a child or family member, and 17 per cent of these respondents had found themselves in this situation. Seventy per cent had taken one or two days to manage their responsibilities.

Table 3.5 Absence profile of respondents

		Line Managers		*Non Managers*	
		Count	**%**	**Count**	**%**
Whether away from work due to own sickness or injury during last 12 months					
	Yes	47	37	72	55
	No	80	63	60	46
Total		**127**	**100**	**132**	**100**
Number of times absent during last 12 months due to own sickness or injury					
	Once	35	76	33	47
	Twice	8	17	21	30
	Three or more times	3	7	17	23
Total		**46**	**100**	**71**	**100**
Number of days away with own sickness or injury in last 12 months					
	5 or less	35	74	35	30
	6-10	3	6	9	13
	11-20	3	6	9	13
	Over 20	6	13	17	24
Total		**47**	**100**	**70**	**100**
Whether away from work because of someone else's sickness or injury (that is through having to provide care for a child or relative) in last 12 months					
	Yes	+	+	22	17
	No	+	+	110	83
Total				**132**	**100**
Number of days away because of someone else's sickness					
	1-2 days	+	+	14	70
	3 days and over	+	+	6	30
Total				**20**	**100**

+ Managers were not asked this question

Source: IES Survey, 2007

These figures show that those taking part in the manager and non-manager focus groups represented a spread of short and long-term absence and included those who had taken sick leave for reasons that were not to do with their own health status. Therefore, the attitudes expressed by focus group attendees reflected the experiences raised as issues in the literature on how to manage absence.

3.5 SUMMARY

This chapter has described the profiles of those that took part in the various groups and interviews. It shows that the participants represented the views of all senior managers and professionals with responsibilities for absence strategy and policy, those who were experiencing long-term absence and those who had successfully returned from such absences. The larger number of those who took part in the manager and non-manager focus groups covered all aspects of gender, age, job role, managerial and personal absence experiences. The review is therefore based on contributions from all staff groups involved in absence, whether from the viewpoint of managing it or being affected by the application of absence policy.

4 CURRENT CONSENSUS ON GOOD PRACTICE IN ABSENCE MANAGEMENT

This chapter, as a background to the remainder of the report, will review current thinking on the range of approaches available to organisations to manage absence which have been identified in academic and practitioner reports. Verifying the efficacy of these methods is often difficult as much of the supporting evidence is anecdotal and opinion based rather than derived from empirical studies. As Spurgeon (2002) said, current good practice is 'consensus based rather than evidence based'. Much of the published literature assumes the validity of an approach and focuses on the extent of its use, rather than the effectiveness of the policy. It should not be concluded from this that the recommended approaches are ineffective, but that there is often little evidence to show if they are effective or not. The full references for the articles and reports discussed below are given in the bibliography in Appendix 1.

It is not possible to identify one easy solution to managing absence but there are common features among organisations that are handling absence well. Practitioner papers and surveys such as those from the Confederation of British Industry (CBI), Chartered Institute of Personnel and Development (CIPD), HSE, Advisory Conciliation and Arbitration Services (ACAS), Industrial Relations Services (IRS), Incomes Data Services (IDS), National Audit Office (NAO), and the Work Foundation do supply case studies and ways of dealing with absence that are perceived to be effective in organisations. These will be brought together in this chapter to discuss the overall approach to absence, the roles in managing absence and the procedures to address it.

4.1 ORGANISATIONAL ABSENCE STRATEGY AND CULTURE

A successful absence management policy will focus both on absence and promoting well-being. A policy is needed that emphasises preventing non-health related absence while also giving sufficient priority to those who are absent for health reasons and aiding their return to work. The background to these measures is an organisational culture where the importance of absence is accepted and the business case for addressing it is recognised. The methods available to support attendance and reduce absence are described in the sections that follow.

4.1.1 Measures to support attendance

An organisational culture where employees feel engaged and are committed to their work has been demonstrated to result in reduced absence (Bevan, Barber and Hayday 1998). The driver for this is good management and ensuring that staff feel valued and involved. This aspect is widely covered in absence literature and will not be explored further here as this chapter is concerned with specific tools to address absence rather than its causes. Its importance should not, however, be overlooked as it forms the background against which all absence management activities take place. A summary of measures from the NAO (2004) is provided at Appendix 2.

Health promotion

Employers are increasingly focussing on health promotion to help their staff lead healthy lifestyles to prevent them becoming ill. UK employees spend up to 60 per cent of their waking time in the workplace and this is therefore an appropriate place to tackle the issues. According to the British Heart Foundation, physical activity programmes at work reduce absenteeism by up to 20 per cent and physically active employees take 27 per cent fewer sick days than their

less active colleagues. Employees who are more physically active were also found to be better able to manage stressful situations at work.

It is methodologically difficult to prove that health promotion activities are successful because of the many other influences on employee health. Health promotion does remain largely an act of faith, but should not be dismissed for this reason. Health promotion activities can complement attendance and rehabilitation policies. In addition, such activities contribute positively to the 'employer brand' as perceived by current and future employees.

Flexible working

The provision of flexible working hours is popular as a means of allowing staff to manage their work-life balance better. These arrangements include more flexible start and finish times, job-sharing, term-time contracts, annualised hours and the ability to move from full to part-time working. They can also involve greater flexibility in shift rostering, providing carer's leave and special leave, where employee circumstances suggest this would help them to attend work.

The 2006 CIPD employee absence survey showed that absence due to home or family responsibilities was the third and fourth most common reason for absence for non-manual and manual employees respectively. A study by Dalton and Mesch (1990) showed clearly the impact that flexible working could have on absence. Over a six year period a flexible working programme was introduced to one group of workers in a public utility company but not in another. The study showed that absence fell among the intervention employees by 2.5 per cent during the time flexible working was available to them, but that this returned to the previous high rate when the trial finished. In the control group no significant reduction occurred.

The Industrial Society also found in 2001 that just over half the HR professionals responding to a survey attributed a reduction in days lost per employee to flexible working. Rochdale Metropolitan Borough Council in 2002 introduced flexible working across the authority after a pilot in which it reduced absence by more than one-third. In America in 1992 researchers from the University of Connecticut discovered that 75 per cent of companies surveyed found that flexible hours reduced absence (Cole and Kleiner, 1992).

Rewarding attendance

Rewarding attendance by giving financial incentives is an approach that has recently increased in use. Using bonuses essentially relies on paying employees twice for fulfilling what they are already contracted to do. By financially rewarding those who are not sick, those who are genuinely ill are penalised through no fault of their own. Another major drawback is that once the threshold for receiving a bonus has been breached any incentive effect is lost. Reward based approaches also tend to motivate employees with good attendance records, but have little impact on chronic absentees (Cole and Kleiner, 1992). The 2006 CBI and CIPD surveys on absence showed bonuses as being perceived as one of the less effective measures, but the CBI survey discovered that where they were used absence was on average half a day less.

Many unions, for example Unison, do not support the use of financial incentives to lower absence rates as they are concerned about ill employees being in the workplace and the effect this can have on health and safety. Supporting this view, Jacobsen (1989) found that teachers in a North American school, when offered a reward paid to those with the best attendance, changed their behaviour and improved attendance depending on their personal desire for the monetary reward. Despite the initial success, the trial was halted because of concerns that teachers who were clearly ill were coming to work and were providing a reduced quality of teaching.

Although rewarding attendance financially may not be the best approach, it is still appropriate to recognise good attendance. Markham, Dow Scott and McKee (2002) in a study in US manufacturing plants found evidence to suggest that personal recognition reward programmes can reduce absenteeism and can be low cost options which bring significant gains.

Acknowledging good personal attendance can be achieved by senior management writing to staff and congratulating them, or mentioning them in staff magazines or papers. This has been shown to be effective at the University of Illinois at Chicago (Cole and Kleiner, 1992). The approach here also involved the bottom ten per cent for attendance also receiving a letter, urging the use of good judgement in the use of sick time with beneficial results.

Duvet days

The use of 'duvet days' is something that has become more popular. These are days that can be taken off by phoning in on the day, unlike annual leave that has to be agreed in advance. They are used in the circumstances when individuals feel that they just cannot face work on that day, but are not ill enough to warrant a sick day. Employees usually have a limited number of days, typically two to four, which can be taken at short notice. These are not counted as sick leave but are frequently deducted from annual leave entitlement. If these are introduced in addition to holidays they effectively become a sick leave allowance which can be costly for employers and promote the acceptance of absence.

The use of duvet days is only appropriate where organisations can cope with an increased level of absence at short notice. It has not been possible to find any research on the efficacy of duvet days, but they do ensure that employees do not have to claim that they are ill when they just cannot face work for whatever reason. This method ensures that absence figures are more likely to be measuring genuine sick absence.

Provision of medical services on site

To enable sick employees to be treated speedily and effectively, many organisations now provide access to medical services such as occupational health nurses, counselling, physiotherapists, self referral health checks, back pain clinics and 'flu vaccinations. These measures make treatment or preventative services readily available to staff, so they do not have to wait for or travel to appointments. By providing on site occupational health nurses, Proctor & Gamble were able to reduce one-day absence by six per cent. This type of approach also has the beneficial side effect of demonstrating that the employers care about their staff and improves morale and productivity.

Private medical treatment

Dealing with absence promptly leads to less time away from work and reduces disruption to working patterns. Research clearly shows that the longer a member of staff remains away from work the more difficult it is for them to return. The use of private healthcare ensures early treatment of employees with potentially long-term conditions and gives them an earlier return to work. Some organisations offer private healthcare as a benefit to all staff or fund the cost of treatment themselves. The CBI 2006 absence survey showed that those companies which provided access to medical care or treatment had a mean absence level of 1.7 days less for manual staff and 0.8 days less for non-manual staff compared to those not using this support.

Both Humberside Police and Centrica, for example, carry out cost benefit analyses based on the cost of private treatment and NHS waiting times and decide whether cost of quick return outweighs cost of treatment. At Centrica this has contributed to halving the number of days lost and cut the cost of absence by £7 million a year for expenditure on private health services of

£650,000. The scheme has also been highly valued by employees. The use of a fast track physiotherapy services at Humberside Police Force is also estimated to have saved £60,000 for an expenditure of £6,000.

Disability case management approach

The disability case management approach focuses on facilitating the return to work of people with long-term sickness or injury. This approach brings together all the individuals who can facilitate the development of actions that can contribute to the return to work (Kearns, 1997; Bruyer and James 1987).

Whilst it has its roots in America, the approach is being used in public sector organisations within the UK to reduce long-term sickness, though there appears to be limited research in the UK to evaluate the outcomes. The key elements of the approach are clear communication, and effective monitoring and review processes in order to ensure that all parties carry out their agreed actions or the actions are reviewed if they are not working.

Reporting on a 2000 a survey by the Washington Business Group on Health and Watson Wyatt Worldwide, Robinson (2002) saw that companies using a disability case management approach involving both line managers and a separate absence manager had absence rates at 74 per cent lower than companies not managing absence. She found that a total absence management programme which incorporates elements of HR and of risk management approach were most effective at reducing absence levels.

4.1.2 Preventative measures

In contrast to the supportive approaches described above there is the alternative of punitive methods. The recent CBI survey (2006) shows that disciplinary procedures are the most popular means of tackling absence, but that they are perceived as the second most effective after return to work interviews.

Absence policies are usually composed of disciplinary measures and procedures, the details of which will be discussed in more depth later in this chapter. However, there are some approaches which are less widely applied and these will be highlighted below along with any evidence of their value in controlling absence.

No pay for sick days

The removal of pay for the first two or three days of sickness is being used by some organisations, such as Tesco and Wandsworth and Haringey Council, as a means of tackling frequent short-term absence. There is no published research evidence to support this, but IES work with employees in the public sector suggests that it is likely that staff will take over three days away to 'justify' their absence, resulting in higher absence.

Sick notes needed for all absence

Some organisations have experimented with requiring a sick note to be produced after every absence no matter how short. This was unsuccessfully tried at Marks and Spencer. The scheme at a West London store initially reduced the number of sick days, but staff then realised that they could easily get a doctor's note and absence rose again. During the year of the trial the store had 20 days of sickness leave in the first quarter, but this had quadrupled to 80 by the end of the year. The 2004 CBI absence survey found that there was no evidence to support the use of sick notes under seven days.

The use of attendance criteria

The screening of recruits' past attendance records before offering them employment was shown to be a good means of reducing overall absence by Scott and Markham (1982). Although this research is relatively old it is rigorous and showed that organisations using screening had an absence rate of 4.2 per cent compared to that of 4.7 per cent for those without. The CBI in 2004 found a similar pattern for non-manual employees.

At Humberside Police, employees' absence records over three years are used to select or deselect not only for initial recruitment but also career progression, promotion, transfers, service extensions, probationary periods, secondments and non mandatory training courses. This firm policy has led to absence falling by one-quarter in 2004 which is claimed to have saved £750,000.

Absence can also be incorporated into appraisal systems as a factor in assessing and rewarding performance. If this is done it is essential to recognise that some staff will have disabilities which will affect their attendance.

4.2 ROLES IN MANAGING ABSENCE

Effective absence management is recognised to require a combined effort between HR, line management, senior managers and health professions, supported by a good information base. The roles of these key players will be discussed in the next section.

4.2.1 Primary responsibility for absence

The responsibility for managing absence over the past two decades has moved from the HR function to line managers. Line managers are now primarily responsible for handling absence in most organisations, and the CBI absence survey in 2006 found that this was the case for just under 69 per cent of their respondents. The remainder of the sample was almost equally divided between HR managers and senior managers.

The CBI 2006 survey explored the relationship between absence rates and those with the prime responsibility for managing them. This revealed that the average days lost were lowest at 5.1 days when HR managers were responsible and highest at 6.9 when line managers were handling absence. The involvement of senior management was also effective in reducing absence to 6.2 days, although this figure is influenced by this occurring most often in small companies where absence is often at a lower level.

The findings above do emphasise that line managers clearly need support to deal effectively with absence. The IRS survey in 2003 found that almost 90 per cent of the HR practitioner respondents agreed that line managers were not keen to take an active role in absence management because they did not feel competent to deal with it and had other priorities. A more disturbing finding by the CBI in 2004 was that only 54 per cent of the organisations agreed that their managers had specific training in absence. This lack of training, it can be assumed, contributed to the managers' less successful figures and lack of enthusiasm, underlining the essential part that well designed training for managers plays in a good absence policy.

Although line managers deal with absence on a day to day basis, their success depends on the support and joint contributions made by HR, senior management and health specialists. This means that for any absence policy to be effective, the exact roles and relationships between these key players need to be defined and understood (Bevan and Hayday, 1998).

The HR function has moved their involvement in absence away from directly managing to one of providing guidance and advice to line managers. Their role is to give staff managers the confidence and ability to deal with absence as they are now accountable for the attendance of their teams and units.

Senior management have a different part to play by showing their commitment to controlling absence and making it a business priority. Their support can create an organisational culture where absence is not accepted as inevitable and give a proactive approach to its management (Reynolds, 1990). A need for senior managers in the public sector to monitor absence management much more closely in order to demonstrate their personal commitment to the policy was identified by Dibden et al. (2001). The involvement of senior managers emphasises the concern that the organisation has for the welfare of their employees.

4.2.2 Occupational Health Services

Occupational health services consist of a range of occupational health practitioners including physicians, hygienists, psychologists, ergonomic experts and occupational health nurses, all of whom can have a positive impact on sickness rates. They play a major role in evaluating the reasons for absence, conducting health assessments, assisting HR professionals and line managers in planning returns to work, and promoting good health.

The use of occupational health provision was assessed to be one of the leading means of reducing absence for both manual and non-manual employees in the 2006 CBI absence survey. The CIPD in its 2006 survey found that the involvement of occupational health professionals was very clearly considered the most effective tool in managing long-term absence. Their early involvement in a case is seen as essential in aiding a speedy return to work.

4.2.3 Employee Assistance Programmes

According to the Employee Assistance Professionals Association (EAPA), employee assistance programmes (EAPs) in the UK covered nearly ten per cent of the working population in 2004, with over two million employees having access to a scheme. The CIPD absence survey showed that in 2006, EAPs were used by nearly 28 per cent of organisations as a tool for managing short-term absence, and 29 per cent for long-term absence.

The EAP providers in the UK provide a range of services to organisations and according to the EAPA a programme ‘includes a mechanism for providing counselling and other forms of assistance, advice and information to employees on a systematic and uniform basis, and to recognised standards’. There are several problems associated with the evaluation of these programmes, including issues of confidentiality, lack of control groups and commercial sensitivities. However, in a review of the literature McLeod (2001) reports that those studies examining the effect of EAP intervention on sickness absence found that the majority showed reduced levels of absence, and this reduction was in the order of 25-50 per cent. In conjunction with the consideration of reduction of sickness absence it is also necessary to consider the cost implications. In this same review (McLeod, 2001), it was found that all published cost-benefit analysis studies of EAPs showed that they at least covered their costs.

4.2.4 Absence management procedures

Clear absence procedures have been found by many employers to have an immediate effect on sickness levels by their very existence and consistent application. Failing to have procedures in place lends support to the idea of a ‘leniency’ effect in which employees’ perception of

indifference to absence among line managers can be interpreted as acceptance of time off for sickness. Procedures that are well understood focus attention on absence, but these must be supported by communication and training. There is also a need to constantly review policies to keep up-to-date with new and changed legislation and best practice from elsewhere.

Clarity concerning the processes below has been shown in the literature to be a requirement for good absence management to ensure that each case is treated the same way, defined approaches are used and standardised information collected (eg Bevan and Hayday (1998), Scott, Markham and Taylor (1987)). The processes are:

- measuring absence
- conducting return to work interviews
- using trigger points
- handling short-term absence
- managing long-term absence.

Each of these processes will now be discussed in turn.

Measuring absence

The provision of accurate, timely and accessible information is the cornerstone of a successful absence policy. Without good data, managers have no grasp of what they are trying to control. Research has shown that the active monitoring of absence is effective in reducing it by demonstrating that managers are taking the issue seriously, and enabling them to better understand the characteristics and causes of absence.

Accurate reporting and recording of absence and its causes are essential and require the integration of IT systems such as personnel and payroll. Ideally line managers should be able to both update the system and perform their own analyses of the information. This reinforces their role in absence and gives them the ability to effectively monitor their staff. The CIPD in 2006 identified providing sickness information to line managers as the third most popular tool for dealing with short-term absence.

There are a surprising number of ways of measuring absence – a study in 1995 noted more than 40 (Seccombe, 1995). The problems are made worse by a confusing terminology which uses different names for the same measure. As a result many organisations cannot make the best use of the data available to them and benchmarking can be completely misleading. Care must be taken to ensure that comparisons are made between information calculated on exactly the same basis.

The variety of measures has the benefit of providing different ways of looking at the data so that trends can be identified, variations highlighted and causes diagnosed. A good example of such a measure is the Bradford Factor, which is now widely used as a trigger point for management action. The origin of this formula is unclear, though it is believed to come from Bradford University's School of Management during the 1980s. It measures an individual's irregularity of attendance by combining absence frequency and duration as below:

Bradford Factor=**SxSxD**

(S=number of spells of absence and D=total number of days)

This gives particular emphasis to frequent short absences and make the factor of use in settings where the disruption caused by this type of absence is greater than that caused by occasional

long-term absences. For example, the Bradford score for a total of ten day's absence varies considerably depending on how this was taken:

10 individual days=1,000 (10x10x10)

5 absences of 2 days=250 (5x5x10)

1 absence of 10 days=10 (1x1x10).

The benefits of such a measure have not been formally assessed but its effectiveness is influenced by culture and management style. The Bradford Factor is essentially an analysis tool and should not be used as a rigid trigger point for managerial intervention. Its most appropriate use is in combination with other measures to look at the overall absence patterns of groups of employees. This will clarify what type of absence is occurring. For example:

Low Bradford score+High absence rate=Small number of staff with long absences.

High Bradford score+Low absence rate=Small number of staff with frequent short absences.

Bradford Factors do have their place in managing absence, but should not be the only measure used as they draw attention purely to short-term absence and the disruption it causes. They can easily distract attention from long-term absence, which in terms of cost, is the most expensive form of absence if not managed properly.

Return to work interviews

Most absence policies recommend that managers hold return to work interviews with employees on the day that they return from absence. The purpose of these meetings, held after every absence, no matter how short, is to welcome the individual back, check that they are recovered and review their absence record. The interview also provides the opportunity to discuss any problems or underlying difficulties that are causing the employee to stay away from work. Additionally, they show that the person has been missed and the effect on the organisation can be highlighted. Targets can be set for improvement and the actions to be taken if there are further problems with absence can also be outlined.

This simple, but vital, act of talking to employees after all absences has been shown to improve attendance without any further action being taken (Muir, 1994). The research shows that to be effective the manager's approach should be sympathetic, and the studies emphasise the need for managers to receive adequate training to handle these interviews successfully (Reynolds, 1990).

Both CIPD and CBI surveys in 2006 found that return to work interviews were seen as being the most powerful tool in tackling absence. The only dissenting evidence found was an IDS case study of RS Components in 2004 where because of inconsistency in the way the interviews were conducted they were creating a 'feel bad' factor, particularly where staff had previous good attendance records. They were replaced with Welcome Back Forms which were completed by the employee and serve as statutory sick pay record, self certification of absence and a record of fitness to return to work. The line manager then checks the form when completed but is not required to discuss it with the employee. This example actually illustrates the need for managers to be supported and trained in absence management, rather than using alternative impersonal methods which do nothing to engage the employee.

Use of trigger points

To control absence, organisations need to make clear what level is 'unacceptable' and most set trigger points based on variety of measures. There is a need to ensure that these are not used

rigidly without taking into account the circumstances of the employee concerned. Line managers should have the confidence and training to be able to use trigger points with discretion. It is undesirable that sick staff should be compelled to come to work when they should rightly be away ill. This is bad for the employee and may prolong their ill health and also for their colleagues who may be infected. The CIPD survey in 2005 found that 74 per cent of their respondents used trigger points to review attendance and that 28 per cent thought that they were one of the most effective tools in managing short-term absence. In the public sector, in particular, they were seen as the second most effective measure after return to work interviews.

Short-term absence

Most absence policies clearly recognise that the management of short and long-term absence require different approaches and have separate procedures. Short-term absence is generally defined as less than four weeks and long term anything in excess of this.

In 2004, IDS reviewed absence management and found that organisations that were successful in managing absence had similar approaches. Early notification of absence to the line manager was always important, as was the manager being responsible for finding out as much as possible about reasons and the likely length of the absence. At the same time the manager took the opportunity to express concern for the individual's welfare. When an employee's absence record appeared to be unsatisfactory and action was needed there was usually a staged approach to ensure that managers could investigate any underlying causes and give the employee a chance to improve.

The importance of the line manager in handling short-term absence was highlighted in the CIPD absence survey for 2006. The most effective management tool was clearly seen as return to work interviews, nominated by just under three-quarters of respondents. This was followed by roughly a quarter of respondents giving trigger points and disciplinary procedures for unacceptable absence as the next most effective methods.

Long-term absence

Managing long-term absence was cited as the greatest health and safety challenge facing HR professionals according to an IRS survey in 2003. They placed it well ahead of short-term absence and stress management.

One of the most important actions is to maintain regular contact with the absent employee, either by telephone or by home visits. This reduces feelings of isolation and shows the employee that both they and their contribution at work are missed. It also demonstrates the employer's concern for their welfare and increases the probability of them returning to work. If an individual is not contacted it gives the impression that the organisation is not concerned about them or their absence and that there is no reason to return to work quickly.

Robinson (2002) reported on a survey of employees who were absent due to sickness and injury and found a strong correlation between communication, satisfaction and return to work. Employees who had been contacted more than once during their time off work were more satisfied with their case management process and satisfaction rose the sooner they returned to work. Spurgeon (2002) in her evidence-based review of absence procedures also found support for the efficacy of early contact with absent individuals.

In a Swedish study, Nordqvist, Holmqvist and Alexanderson (2003) questioned people who were off sick with back disorders and found that they emphasised the importance of an employer having a specific policy for maintaining contact with employees on sick leave. This policy should include: clear procedures to identify a person who is responsible for setting up and

maintaining the contact, a procedure to identify a replacement if necessary, feedback to colleagues about the nature of the sickness and the planned approach to returning to work, and routines around the contact and feedback which are clear to everyone. It was the role of the supervisor to maintain a positive emotional atmosphere throughout the process.

Managing long-term absence requires staged procedures in the same way as short-term absence does. These allow employees time to recover, give them targets to meet, enable medical evidence to be collected and permit a dialogue about how the return to work is managed. The need to resort to medical severance or ill-health retirement is only used as a last resort.

The CIPD in its 2006 survey found that the involvement of occupational health professionals was overwhelmingly seen as the most effective means of dealing with long-term absence. This was particularly true for public services where 53 per cent saw occupational health services as most effective compared to only 31 per cent in private services.

The CBI asked their respondents in 2006 if they operated a rehabilitation policy as part of their management of long-term absence, and almost 84 per cent indicated that they had a policy in place. This is a substantial increase over 2001 when only 28 per cent had a formal policy. Of those having a rehabilitation policy, 96 per cent had a flexible working policy as an integral part and 74 per cent included counselling support for employees.

Nordqvist, Holmqvist and Alexanderson (2003) found, in accordance with other studies, that employees who are offered modified tasks return to work twice as often as those who are not. If this is done promptly, the time lost from work can be reduced by at least 30 per cent.

4.3 SUMMARY

The above chapter has reviewed the current approaches to the management of absence in organisations. It is apparent that there is often a lack of hard evidence in the literature; much of it assumes that an approach is effective and focuses on the extent of its use rather than its validity. Current good practice is, therefore, based on consensus among HR practitioners who are dealing with absence. Practitioner papers and surveys have been used in this chapter to identify the measures to deal with absence that are perceived to be effective in organisations. The main conclusions from this analysis are:

- A positive organisational background where employees feel engaged and committed directly results in reduced absence. The main driver of this has been identified as good line management which is key to staff feeling valued and involved.
- Accurate, timely and accessible information is essential for successful absence management. Managers need information at an individual level, but also an overview of how other team and units are performing across their organisation.
- An absence policy needs to emphasise both preventing non-health related absence and the provision of support to those who are genuinely ill and aiding their return to work. A range of measures has been discussed to support attendance and to reduce absence. A summary table of these measures and comments on their effectiveness from the NAO 2004 report is given in Appendix 2 for easy reference.

5 REVIEW OF POLICE FORCES' ABSENCE POLICIES

This chapter is based on a review of the contents of the policy documents collected from the participant forces. A brief discussion of the formats of the documents is made followed by an outline of good practice in formulating absence policies to put the contents of the documents into context. The general approaches of the case studies were assessed and are also discussed. In addition, the forces' policies were systematically analysed using common accepted good practice. Finally the views of those working with the policies and the staff who are affected by them are presented.

5.1 FORMAT OF POLICY DOCUMENTS

The forces' policies were all available as documents and on their intranets. They were, of necessity, lengthy as they sought to deal with all eventualities and outcomes. Only one force had separate policy documents for police staff and officers, otherwise the policy was identical for both. The longest policy was over 80 pages but the shortest was 29 pages including specimen documents. Generally the shorter documents, in the opinions of the reviewers, were easier to understand. The analysis was unable to include how manageable the policies were on the intranet, but clear linkages and ability to search for key words would be of value here.

Four of the forces' policies provided flowcharts of the processes to be followed in managing attendance. The written documents outlining the processes were complex and the flowcharts were an ideal means of showing how the activities relate to one another and how they should be worked through. The inclusion of elapsed trigger times for each intervention also enabled an absence case to be managed effectively and swiftly without unintended delays.

5.2 POLICY DOCUMENT GOOD PRACTICE

The points made in the literature concerning the approach of absence policies and their contents are summarised below. These are derived from the toolkit created by the HSE, CIPD and ACAS in November 2006 (www.cipd.co.uk/absencemanagementtool) and the reports of the CBI (2006), CIPD (2006), NAO (2004) and Bevan and Hayday (1998). From these it is apparent that effective absence practice needs to be based on a clear absence policy which states the organisation's expectations regarding absence and gives the procedures which will be applied. They recommend that an effective absence policy should have the following key elements:

- Statements concerning the attendance levels expected which explain that:
  - the organisation pays employees to attend and that attendance is accepted as the norm
  - any absence is costly in terms of reduced efficiency, temporary coverage and impact on customer service
  - it is recognised that some limited absence is unavoidable and that appropriate support is available to those who are legitimately absent with the aim of aiding return to work as soon as possible.
- Clear management commitment to the organisations' absence policies, standards and procedures demonstrated by:
  - explicit senior management commitment to the absence policy
  - a good understanding of the real costs of absence to the organisation.

- clarity of roles and procedures for managing absence:
  - notification and certification requirements from employees
  - role of the line manager and the procedures to be followed by them
  - role of occupational health and the support they can provide
  - processes for managing short-term absence
  - processes for managing long-term absence
  - use of absence data for selection purposes

These elements will be used in the review of the contents of the case study forces' policies.

5.3 THE APPROACH OF THE POLICIES TO ABSENCE LEVELS

Most of the policies' titles chosen by the forces refer to the 'management of attendance' with only two documents being described as about 'sickness absence management'. In practice they were all almost exclusively about sickness absence, only a few paragraphs were specifically devoted to encouraging and recognising good attendance, or to promoting an attendance culture. One force had recognised this omission and is planning to rewrite its policy. In another case study, the policy was outdated and no longer in line with the force's current views and processes towards supporting attendance and, as a result, the policy was not being actively promoted for staff to read or to become familiar with.

The approach of the policies was varied. In one case, the first sentence of the policy was that *'The guide is about managing for improved attendance with an emphasis on tackling persistent absenteeism'* (force with low absence but worsening). It then went on to stress that *'managers must balance their concern about employees who are sick or injured with their responsibility to ensure efficient and regular service delivery'*. This focussed on service delivery rather than the force's duty of care towards their staff and officers which may have led to a more robust approach towards absence.

Two forces had a more balanced view:

> *'It is vital to achieve a culture where individuals feel that attendance is important in order to maintain high standards of service. However, it is recognised that a certain level of absence due to ill health is unavoidable. It is also necessary to consider the effects of frequent or long-term absence on the operational effectiveness of the force. An active approach to attendance management encourages staff to feel valued and highlights the individual's contribution to the force'*. (force with low absence and improving, and high absence and worsening)

In contrast, absence management was placed within the context of duty of care by one case study force. Its policy document began by recognising that it '*has a duty of care to all its staff, and provides a range of support services through line managers, Occupational Health, welfare and HR managers to help those in need of advice, assistance or support in a wide range of circumstances'*. (force with low absence and improving)

Another approach used in one force was to describe a balance between the responsibilities of staff and managers. For example, staff have a right to:

> *'Be treated with care and consideration for their welfare when unfit for work and receive full support from their supervision and the organisation.'*

Alongside this the staff have a responsibility to:

> *'Recognise their own and others' health and welfare needs, where possible and seek the relevant help and support via their manager or Occupational Health.'* (force with low absence but worsening)

A further policy was clearly measured and considerate and attempted to create a balance between supporting people in their endeavours to return to work and emphasising that in some cases sickness absence cannot be avoided. It sought to promote attendance and support those who were sick but did not prohibit sickness. It emphasised consistency of approach, training, health promotion, the provision of accurate and timely advice and information and the adoption of a 'day one absence management philosophy'.

5.4 DETAILED ANALYSIS OF ABSENCE POLICIES

Table 5.1 shows the features of the forces' absence policies and the variable number of forces using them. This forms the basis of the discussion in the next two sections.

Table 5.1 Content of forces' absence policy documents

	Number of policies including
Objectives of policy defined	6
Senior management commitment stressed	3
Cost of absence policy mentioned	2
Notification requirements from staff given	7
Certification requirements from staff given	7
Line managers responsible for implementing policy	7
Return to work interviews to be held by line managers	7
Return to work interviews to be held after every absence	5
Effects of absence on unit to be discussed in return to work interview	3
Line manager to stay in touch with individual during absence	7
Short-term work changes to be considered to aid attendance	7
Working conditions to be considered as a cause of absence	3
Carer's leave included	3
Role of occupational health defined	7
Role of HR defined	6
Long and short-term absence differentiated in terms of approach	7
Trigger points used to identify unacceptable levels of absence	7
Managers to use discretion of review meeting is needed	3
Attendance to form part of individual's PDR	7
Unit attendance to form part of manager's appraisal	4
Attendance taken into account in promotion	6
Attendance considered in selection for training	2

Source: IES, 2007

5.4.1 Management commitment to the organisations' absence policies, standards and procedures

When the contents of the absence policies were assessed, six of the seven clearly defined their objectives for the policy and made clear what they were intended to achieve. Less than half of the case studies mentioned the commitment of senior management to effectively managing absence. This is important to emphasise the concern that the force has for the welfare of their staff and their attendance at work.

A rather neglected aspect was to include an understanding of the costs of absence to the force and the overall impact of this loss of resources. Only two forces included an estimated annual cost of absence in their policies. The inclusion of this is needed to stress the significance of absence and the potential benefits of managing it successfully by releasing resources for other activities.

5.4.2 Roles and procedures for managing absence

Most of the content of the forces' absence policies, as would be expected, was about the procedures and processes to be followed to manage cases of absence.

All the forces' policies defined the notification and certification requirements from employees which are a key requirement as prompt notification of sickness enables decisions to be made about how the absence will be covered and managed.

The role of the line manager was made clear in all the policies: line managers were made responsible for implementing absence policy. This required them to conduct return to work interviews using a sympathetic approach, although not all forces required this after every absence. A discussion in the return to work interview of how the individual's absence had been managed in their unit was only recommended by three of the forces. This is an effective means of again stressing that attendance matters and that the contribution of the individual is valued. The policies all emphasised the importance of managers staying in touch during an absence and recommended suitable frequencies for such contact. The managers were also to consider work changes, such as flexible working, to maintain the attendance of staff or to aid their return to work. However, only three forces explicitly stated that working conditions should be considered as a cause of absence. The use of carers' leave was made available to the line managers in three forces to avoid staff taking sick leave to deal with family and domestic responsibilities.

The important role of occupational health was explained in all the policies, along with the stages in their sick leave at which staff should be referred to them. Occupational health was supported in all the forces by internal counsellors and, additionally, in three forces there was access to external Employee Assistance Providers. The function of HR in terms of when their advice should be sought and what could be expected from them was made explicit in six of the policies.

There was a distinction between long and short-term absence and the processes to use. Short-term absence was generally defined as 20 days or less while long-term absence was seen as any period above this. The management of both long and short-term absence required defined staged procedures but these had different emphases. The management of short-term absence focussed on notification procedures, trigger points for unacceptable levels of absence and disciplinary procedures and stressed the importance of return to work interviews conducted by line managers. In contrast, long-term absence management centred on maintaining regular contact with the absent employee, early intervention by occupational health and action plans for return to work.

Each of the seven case study forces used trigger points to manage short-term absence by prompting a review of attendance with the line manager. In four of the forces these reviews were compulsory but the remaining forces gave their managers the opportunity to use their discretion as to whether such action was necessary. Two of the forces were using Bradford scores as triggers while the remainder considered either how many days' absence had occurred or how many incidences had taken place in a 12-month period.

The policies made use of absence performance data to varying extents for purposes of appraisal and selection. All forces used attendance as part of an individual's performance development review (PDR) and four of the seven forces used the unit's absence figures as part of a manager's PDR. The latter is recommended by the Ministerial Task Force on Public Sector Absence (MTF) as a means of improving the focus on good attendance management as managers also have other objectives and targets to meet. Six of the forces also took past attendance into account when selecting staff for promotion and two forces considered it when choosing individuals for training.

It can be seen from this that the majority of the basic requirements of an absence policy are in place in the case study forces' documents. The areas that could be strengthened include more emphasis on senior management commitment to successfully managing absence and the cost of absence to the organisations. Working conditions could be more widely recommended to be considered as a cause of absence so that appropriate remedies are used. The consideration of the unit's attendance should also form part of the line manager's PDR in line with MTF recommendations. Allowing managers more discretion on when an attendance review is necessary is important to ensure that such meetings are conducted when necessary and not as a fixed process which undermines the effectiveness of absence management.

5.5 GENERAL VIEWS OF THE ABSENCE POLICIES

The views of the written absence policies of participants in the focus groups and interviews will be presented in this section. This is based on the actual discussions and the questionnaires completed before the focus groups began.

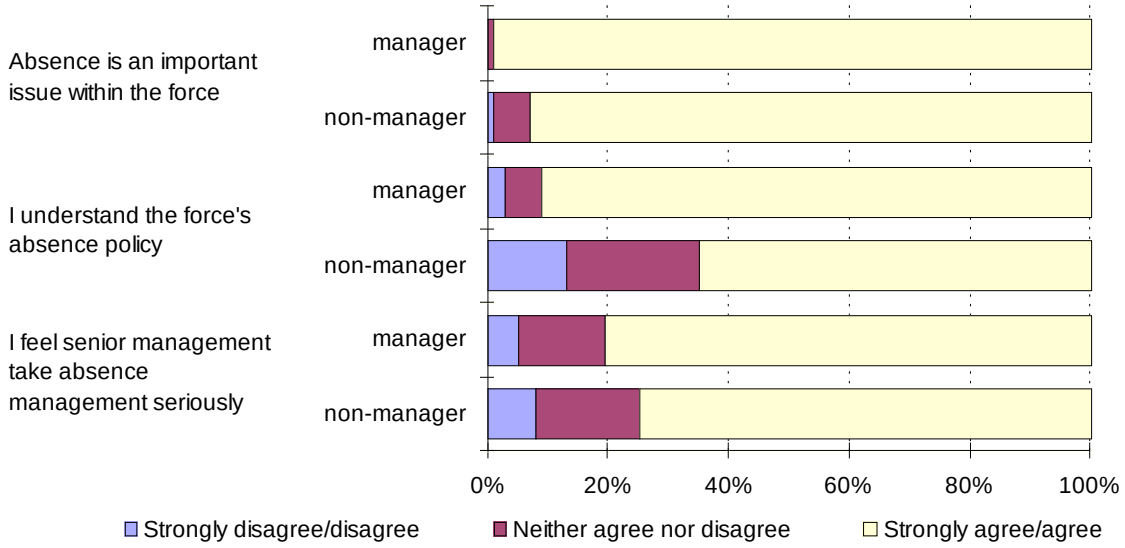
The respondents in the focus groups were not overtly critical of the presentation of the policies and did not make many comments on the actual documents or information on the intranet. More general comments were made about the overall role of the policies and their impact on absence. These stressed that a policy alone was not enough to influence absence and that the general culture of the organisation had a major impact. One Chief Constable commented:

> *'I don't think it's about detailed policies. I think policies are just a mechanism through which you either check or ensure, it is about climate.'*

> *'I'm not saying it isn't policy driven. We take quite a mechanistic and linear approach to reduce absence, say – you need a return to work interview. Yes you do need all that but park that for a minute, let's talk about creating an organisation where people don't want to be off sick. Let's talk about creating an organisation that when people are legitimately sick they can rely on being supported and encouraged and helped back into the workplace so they have a sense of valuing what they do.'*

> *'If you want to do anything in policing you need your sergeants, inspectors and police staff supervisors with you, the rest is detail. If they believe in where you're trying to get to they're the men and women on the ground who lead the men and women who do the job and that's where you get your leverage from. No matter how many fine words I use or how many interesting policies we write, if the sergeant with his or her team of ten constables doesn't motivate and support, guide and challenge, these people appropriately, the rest is a waste of time.'*

Figure 5.1 Views on absence policy



Source: IES, 2007

Figure 5.1 shows the questionnaire responses of managers and non managers. It can be seen that there is clear agreement that absence is an important issue within the force from both managers and staff. It is also understood that senior management take absence seriously, although managers tend to be more certain about this. This shows that there is clearly general awareness of the significance of absence to the forces. When absence policy itself is considered, over 90 per cent of managers were confident that they understood their force's policy but a lower 65 per cent of non managers felt that they understood the policy.

5.6 SUMMARY

The preceding chapter has described the results from an in-depth analysis of the seven case study forces' absence policies. In summary, the main conclusions from this are:

- The approach of the policies was very varied from one that immediately stated its '*emphasis was on treating persistent absence*' through to another whose first lines stressed that the force had '*a duty of care to all its staff and provides a range of support services … to help those in need of advice, assistance or support*'. The best policies recognised that a culture is needed where individuals feel their attendance is important, that ill health is unavoidable and where appropriate support measures are in place.
- The analysis of the policies showed that greater emphasis on the commitment of senior management to effectively manage absence would be beneficial. The wider inclusion of an estimate of the cost of absence would also strengthen the impact of some of the policies. The use of process flowcharts would have also have improved the understanding of three of the policies
- Working conditions could be more widely recommended to be considered as a cause of absence. In line with the MTF's recommendations, the consideration of the unit's attendance should also form part of the line manager's PDR. Allowing managers more discretion on when an attendance review is necessary would ensure that these are conducted when necessary and not as a rigid process which undermines the effectiveness of absence management.

- It was recognised that an absence policy alone was not sufficient to manage absence and that the general culture of the organisation had a major impact. It was necessary to create a force where people wanted to attend and felt supported and motivated.
- Absence was clearly recognised by both managers and non managers to be an important issue in the forces with senior management taking it seriously. However, the managers were more confident that they understood the policies than the non managers.

6 MONITORING ABSENCE

This chapter will consider the following aspects of monitoring absence: the reporting of individual absence, how time lost is recorded, recording of the reasons for absence, the quality of data collected in the forces, the reporting of absence data and finally how the information is used.

6.1 REPORTING OF INDIVIDUAL ABSENCE

The recording of the details of each individual's absence is key to understanding and managing absence in the force as this is the basis for all reports used to monitor absence in any organisation. In all the forces line managers were responsible for completing, either online or on paper, the notification details of an individual's absence and the date of their return to work. In the cases of long-term sickness, occupational health and HR could also have a recording role.

6.1.1 Software used to collect and analyse data

All but two of the forces in this study used the National Strategy for Police Information Systems (NSPIS) which is used in total by 22 forces in England and Wales. This can link duty management data to absence data which is vital for identifying working time lost to absence.

People had different views of the usefulness of the NSPIS system:

> *'We are now up to one of the latest versions of NSPIS and that's providing us with some really good quality data.'* (Absence Data Manager)

> *'I don't particularly like it myself, it's not as user friendly as the old one we had. But the data is there and it's recorded, and that links to our Duty Management System where everybody's availability is logged …. So the link between the two is now working, so the data is much, much more accurate than it ever used to be.'* (Absence Data Manager)

The remaining two forces each used different systems. One used Delphi which was primarily a pay roll system with HR functions added to it. One user of this system commented:

> *'We are crying out for an HR system that accurately reflects the information we put in and Delphi doesn't do that.'* (Absence Data Manager)

The other force had their own system which was currently being revamped and a new wave of training was about to be carried out. This system was designed for line managers and covers a whole range of HR functions.

6.1.2 Automatic alerts for actions

The absence data managers were asked if the system for recording individual absence could produce automatic alerts for action. This was the case in only two of the forces. In one, individuals were highlighted where they have exceeded the trigger points of four short-term absences in a year or if a Bradford score of 350 was near to being reached. These would prompt a review meeting with the line manager. The other force had a more complex and relevant system of alerts related to the various conditions which prompted the line manager to think about various courses of action such as home visits, referral to occupational health or the HR department, but the decision was left to them.

'That's the only way it can sit, because you couldn't say for example, that a broken leg would trigger this response in every case, it might not.' (Absence Data Manager)

In the other forces the systems did not offer any automatic assistance to sickness monitoring and managers were expected to check for themselves. As one data manager said:

'We're trying to delegate that responsibility back out rather than spoon-feeding them every step of the way, because they are the people who know their staff.' (Absence Data Manager)

This view is in contrast to the Ministerial Task Force's recommendation that agreed trigger points should be incorporated into absence management systems. The use of triggers is intended as an aid to managers in identifying when intervention is needed in a case of absence.

6.2 HOW TIME LOST IS REPORTED

It is possible to report the time lost to absence in terms of hours, shifts or days lost. Each approach will produce slightly different figures. To accurately assess the amount of productive time lost it is necessary that any calculation recognises that people are working different contracted shifts and reflects the actual number of hours that an individual was not at work. This is essential for planning purposes and decisions on efficient staff deployment and management by basic command units, and guidance and statutory bodies such as the Association of Chief Police Officers and the Home Office.

Previous research by Price Waterhouse Cooper (*Home Office Police Standards Unit Report: Requirement for Updated Guidance on Sickness Absence, 2004*) recommended that consistent performance measures should be used for reporting, and that this should be expressed as average hours lost to sickness per officer per shift pattern hours. The *Home Office Guidance on Statutory Performance Indicators (SPIs) for Policing 2004-05* requires forces to record hours lost to sickness. However, hours of absence are not currently required to be expressed as a function of contracted hours or shift pattern hours.

Whether the data on sickness absence could accurately calculate working time lost depended on whether the forces had a Duty Management System (DMS) in place that records the actual number of hours staff work and whether this was linked to hours lost to different kinds of absence e.g. leave, sickness, training, etc.

This seemed to be done in one case where one system:

'Used the different shift patterns to calculate hours. All shifts are logged onto the system, so that when individuals go off sick, the working days are calculated taking account of rest days. At the end of a sickness period the DMS and personnel system look at those working days and take account of rest days. It will provide the number of working days that are lost based on the shift pattern of the individuals and also the number of hours lost by taking account of their shift pattern.' (Absence Data Manager)

However most forces were using variable methods of recording time lost. They were recording days or shifts lost and using different methods to calculate this in hours. Four of the forces were collecting time lost in terms of days and then converting it to hours by various methods, as is shown by the following statements.

'The system will do it in days and then we will convert it into hours. It's not totally accurate because it isn't a shift system so we don't know what shifts people are working. It's just seven days divided by five to pull the average off. This is the case for all reports whether for internal or Home Office use.' (Absence Data Manager)

'It becomes very difficult. So if police officers are taken the average of eight hours and police staff the average is 7.4 hours. So it's multiplied the days lost by one or the other of those two figures. It gives you a fairly accurate idea of the hours lost. We're just not geared up at the moment to report in hours. I don't know why.' (Absence Data Manager)

'The data for internal use in the force is calculated in terms of shift days lost. The calculation is: total days lost x 0.69 for police officers and total days lost x 0.692 for police staff.' (Absence Data Manager)

This has implications for the comparability of absence data across forces and means that some figures will be inflated or deflated by the application of different factors to produce an estimate based on hours.

Where the hours lost by each individual were not collected the data managers were asked how difficult it would be to create an automated system that collects the hours accurately. Two replied that it would be 'impossible' and another thought 'possible' but one of these stated that it would be costly. Their views were due to the complexities of integrating, changing or upgrading their software systems.

One force illustrates the difficulties of correctly recording time lost to sickness and the impact this can have on both the recording of absence and the attitudes of individuals. The way that absence during shift work was treated had been changed, a partial absence from a 12-hour shift was now treated as a complete absence whereas previously it was not treated as absence.

'Before, one of the rules was that if you came into work and reported for duty and did an hour, then if you went home later that day because you weren't well it wasn't classed as a day's sick, which I think helps a lot of officers, because you might feel bad but you come in, you can do six hours out of the 12-hour shift and you've got the file done that you know was needed for court. If you've got something you wouldn't get out of bed … unless it was something you needed to do … They've now taken that away. It doesn't matter if you go home … it goes down as sick on your personnel report, which has upset quite a lot of my colleagues, because they do come in on restricted hours because of health problems. Now if they go home halfway through a shift it's classed as a full day sick. Why should I bother coming in then?' (Long-term absence returnee)

6.3 RECORDING REASONS FOR ABSENCE

To manage absence effectively it is essential to understand the reasons for absence, so that appropriate measures can be used to address it. A general intervention that is not based on an understanding of the background to absence is less likely to be effective in reducing absence levels. Special leave and flexible working should be available to ensure that staff do not resort to claiming sick leave to manage domestic or family issues. This ensures that sickness absences relate to incidences of ill health.

In terms of recording the individual's reason for ill health absence, the Dorset 12 classification was used in the forces. This is a standardised classification that enables national comparisons to be made. From April 2005, police forces have been required by the Home Office to report absence under 12 categories which are supported by 81 sub-categories to guide data entry. These are:

- Cardiac/circulatory
- Digestive disorder
- Ear/eye problems
- Genito-urinary
- Headache/migraine
- Infectious diseases
- Miscellaneous
- Musculoskeletal
- Nervous system disorders
- Psychological disorder
- Respiratory conditions
- Skin

The Dorset 12 are very broad categories which do not provide any detail about the actual condition, its severity or cause of the condition eg work relatedness.

One interviewee commented:

> *'What the Dorset 12 gives you is a standard classification that can be compared nationally. That's the positive. But I know that often, what I see as the reason for absence, actually on the system for example, versus what might be on the sick note, probably the two don't match and the reason for that is because there isn't that Dorset classification for that illness and somebody's had to find something that is broadly linked to it. So the answer is no, it isn't broad enough, because there is disparity between the two. What the Dorset 12 has given us is a standard approach. If you were to go to a revised list it would need to be a nationally revised accepted list, rather than something that we did internally within the force.'* (Absence Data Manager)

At least two forces had overcome this by having drop down menus of the guidance sub-category conditions under the main headings. The Dorset 12 classification of 'miscellaneous' conditions, attracted a large number of entries covering any kind of hospital treatment, miscellaneous injuries and anything that does not obviously fit elsewhere. For forces with no sub categories this was a problem and they had to refer to the original form to understand the actual condition. It was common to all the systems that only one condition was able to be recorded, although this could be over-written at a later date if the original diagnosis was revised. However, this means that the development of a condition cannot be tracked or lessons learned about apparently minor conditions masking more serious illnesses.

6.3.1 Disability-related absence

Home Office guidance issued in 2004/05 recommended that absence related to disability should be clearly identified in absence recording systems. This can be of two types: disability leave or disability-related sickness. Disability leave covers any absence for rehabilitation, assessment and treatment and should be recorded separately from sickness absence data. It involves staff who are working a reduced number of their contracted hours as part of a graduated return to work. In contrast, disability-related sickness absence is any absence due to a condition that impairs activity and is likely to last for at least 12 months. This is often difficult to identify until a year has passed, when a retrospective change of category would have to be made.

The forces' practices with respect to disability absence varied considerably and it was clear that this was probably the least well monitored form of absence. It is unclear whether disability leave was being recorded separately from other absence data. The methods used to collect the disability-related sickness data differed by force. One force said that it could be recorded on NSPIS as an absence type, but only if the individual recorded it as such on their return to work form. However no details of return to work plans are recorded on the system. Other forces were unable to separate out disability sickness on their IT systems and relied on the line managers knowing their staff in order to manage it effectively. A further force was waiting for an upgrade to their reports to record such sickness more clearly. Currently there was only a field saying disability or maternity-related absence which was ticked. Once the upgrade has occurred the force planned to start such reporting and back date the information.

6.3.2 Recording return to work interventions

Recording return to work interventions is important in order to follow individual cases to ensure that plans are enacted. If forces had NSPIS then this information is held in a separate component on the system and the time limits on recuperative duties were recorded. A separate field is

available for recording reduced hours and dates for review. However, there were some reservations about how well this worked and difficulties with access. It holds changes to hours and in duties but is not integrated with the rest of the system. When referrals are made for external counselling the outcomes are not necessarily recorded and the self referral by staff and its outcomes were also not captured by the system.

One force used an individual sickness case file approach which stood alone from other systems. This documented their cases in detail, including any memos from HR or occupational health and 'every step that has been taken', so that there was a clear audit trail for decisions made under the Disability Discrimination Act, return to work and medical retirement.

> *'Because what you often find when people return from long-term sick, they'll have a staged return to work, so they may work two hours a day, then three hours a day, etc., depending on the nature of the illness or the absence. All of that is recorded so that it's monitored closely, so that after the given period of time we would then quite reasonably expect them to increase their hours as per the advice from our Occupational Health Department. And they can then see that it is clearly documented and therefore the expectation is reasonable, so everything is documented to the nth degree.'* (Absence Data Manager)

6.4 DATA QUALITY

Accurate data entry is essential for the integrity of the whole process of monitoring absence. When the question of reliability of the data was raised with the line managers themselves, 47 per cent had confidence in the reports they received, but almost a quarter did not. The reliability of the reports critically depended on the information being entered by the line managers themselves in a timely and consistent manner across the force. In all the forces there were some obstacles to this taking place due to the diligence with which this was done being subject to other work pressures and priorities:

> *'Where for an HR person it's top of the list, or one of the top-of-the-list things other than servicing pay roll … for other people it may not be as high on the list, so there may be some issues.'* (Manager)

There was a recognised problem with line managers inputting shift details wrongly and inflating the hours lost. This presented some difficulties as one Chief Constable reported:

> *'People don't understand because police staff and police officer working days are different …. Police officers 8 hours and police staff 7.4 because they get paid for their lunch hour … if you've got a police officer line manager dealing with support staff they put down 2 days lost – 16 hours so you have to send it back.'* (Chief Constable)

> *'Do the forms properly, that's the major one. Unfortunately do the damn forms properly. It's not the only area. It's amazing how you can simplify the forms and they're still not done right by people.'* (Chief Constable)

Failure by the line manager to close an absence by completing a return to work form inflated absence figures in the short term. One data manager referred to many forms not being filled in or being completed incorrectly. They reported having to 'wait weeks' and that there was 'a lot of chasing' which has implications for the accuracy of reports, and also for individual's pay. This was seen as being due to the forms being complicated and the managers being busy.

Some of the reporting problems of the line managers were due to the design of the forms:

> *'When you're doing the return to work it says how many absences but you don't know because that information is held by HR. But to be honest the form is badly designed anyway. It's a very old form.'* (Manager)

Two forces with these problems thought that they were due to lack of training and were taking steps to address this. They were thinking of using electronic forms which could be emailed back to speed up the process. In another case study, where the reporting by line managers was poor, an alternative solution was proposed.

> *'The system reverts back to the police staff handling it. I'm not saying that the line management of absence comes away from police officers, that stays, but the data entry goes back to police staff and they have a computerised form with just a few details in and appointments, everything, sick notes are populated by admin staff. Police officers are out on the streets, they're not computerised sickness management systems.'* (Chief Constable)

6.5 REPORTING OF ABSENCE DATA

Table 6.1 shows the responses of line managers to questions about their views of the absence data provided for them. It can be seen that just over half the managers used the absence reports they were given to identify staff with attendance problems. In contrast, approximately a third of managers were using their own observations to recognise the absence patterns of individuals.

Table 6.1 Views of managers on absence data

	Strongly disagree/ disagree	***Neutral***	***Strongly agree /agree***
	%	%	%
I rely on absence information to identify staff with attendance problems	34	14	52
I find the absence data I receive useful	16	33	51
I would like to have more detailed information on the absence of my staff	32	24	44
I would like to have more frequent information on the absence of my staff	32	29	37
I would like more information on the absence of staff elsewhere in the force	33	37	29

Source: IES Survey, 2007

The preference for having more detailed information on their staff's absence was expressed by 44 per cent of the managers. Similarly 37 per cent would like to have more frequent information about their staff. Finally 29 per cent expressed the view that they would like to know more about the absence of staff elsewhere in the force.

This does present a picture of some unmet demands from the managers, with a requirement for better information as the basic tool for their absence management. The data supplied needs to be more meaningful and to include more detail and to be more frequent.

6.5.1 Absence reports available within the forces

This section considers the reports available to senior and line managers for them to base their decisions on managing absence. All the forces routinely sent out reports on absence to senior management as this was regarded as a key force performance indicator and targets were set. It was not unusual for both force-wide targets and individual area, command or department targets to be set. The figures were reviewed usually monthly or, more rarely, quarterly in senior management meetings.

Line managers typically received monthly information on the absence of their staff. There was an expectation that managers were already aware of any individual problems and that the reports confirmed these rather than being used to highlight problems. In one force the information was cascaded down, which did not always work efficiently as there were reports of managers not having the information. In another, each individual service unit manager decided what was disseminated and in what detail, so that no standard line manager report existed.

Two forces had software that allowed managers to interrogate the system to find the details they needed on individuals. In one force this supplemented an aggregate report but in the other there was no standard reporting. This unstructured approach tended to give too much information, as everyone was provided with everything without any analytical thought. A clearer indication of the key indicators was needed.

Examples of the reports circulated were collected from the forces where possible. The sophistication of presentation varied widely between them. Some reports were Excel spreadsheets while others included graphs and charts, traffic light systems for highlighting specific areas and commentaries. One of the most complete examples of absence reporting in one force included absence by cause, an estimate of the cost of absence and occupational health referrals.

One of the case study reports on one force's data makes the following points about their information:

> *'The reports are not particularly focussed and provide far too much information in the wrong format and without commentary, only a few senior managers, if any, will be using the information properly. It was observed that the data manager spends most of his time producing various types of reports for different audiences, but his time is spent manipulating the system rather than sorting out the data into a useful format or providing some interpretation of it.'*

The data manager in another force had similar difficulties:

> *'I would much prefer us to be able to provide a lot more meaningful data on a more regular basis. The ability to have a lot more slicing and dicing in terms of management information and it being a bit more user friendly, graphs and charts and that sort of thing. High impact information.'*

The depth of information that can be provided is totally dependent on the capacity of the forces' recording systems to supply it. Having accepted this, it is still clear that some forces are more conscious of their end users and their requirements and have endeavoured to produce comprehensible reports. In others, consultation with those using the reports to ensure that they both use and understand the reports would be of benefit.

When the data managers were asked if they worked with the line managers to ensure they understood the reports, they frequently replied that they would answer queries if asked. One commented:

'I think this is probably the big problem. No one really understands the reports at the moment. Line managers are given coaching on the systems, etc. but not specifically on the data side of things.'

It appears that, in addition to producing more accessible reports, there is scope for those responsible for providing absence data to work more closely with the users to ensure that they fully understand the data and can make the most use of it. This would be preferable to waiting for the line managers to raise their own queries.

6.6 USE OF ABSENCE DATA

The specific use made of the absence data depended on the role of the recipient. Senior management were predominantly using the reports to monitor absence and to identify areas of the force where there were higher levels. As one Chief Constable said '*If you don't keep on top of absence it grows'*. He also checked on a monthly basis with divisional heads so that '*people know you're doing it and there's a focus*'. The HR department were generally responsible for any further action arising from the senior management team meetings to manage absence. The monitoring of the management of the long-term sick back to work was routinely undertaken by the forces by HR or occupational health.

In one force HR held monthly meetings across each division to focus on getting absent staff back into work and used the reports to monitor patterns of absence:

'What we also have within the department, which is mirrored across the force is a local health management group, so we have on an individual level managers dealing with individual absences. However, when those absences exceed the trigger points, 3 or more absences in 12 months, or long-term cases, then the local health management group, which is the SMT, or key members from the SMT, meet on a monthly basis and review those cases. And what we are looking for are basically where the managers haven't picked up, or haven't done the action that's required, or any additional support that as an SMT we can provide. So what you have basically for example, is if there is a pattern of absences, so let's say an individual has 3 or 4 or 5 short-term absences, if the manager hasn't picked up on what looks like a pattern, the local health management group will and in long-term absences as chair of the local health management group, what I'm looking for is that those cases are being tightly and robustly managed as closely as possible.' (HR Manager)

6.6.1 Benchmarking

The forces were asked if they benchmarked their absence levels against other forces. The forces used the annual national target absence figure set by the Home Office of eight days for officers and nine days for staff in their own analyses. They did not routinely benchmark with other forces as there was concern that the statistics would not be directly comparable.

Home Office returns giving the absence performance of officers and staff for every force in the country were received by all the forces, but there was some scepticism about the figures. It was recognised that the forces used different calculation systems. One Chief Constable commented:

'It gives you a picture of where you are in relation. Tells you whether you're at the wrong edge of it. Makes you wonder about how they're managing in other forces, because their sickness is staggeringly low. It can't be can it? So you wonder how they do it. We did find out that we were measuring things wrongly …. We were overdoing it. We were overemphasising it. We were doing ourselves no favours at all.'

6.6.2 Calculating the cost of absence

The absence data managers were asked if they attempted to estimate the cost of absence in their forces on a routine basis. Only one force could immediately quote the figure of approaching £7 million per annum based on days lost and average salaries. Some forces were also using very broad salary averages and excluding pensions, overtime and any other related costs to arrive at an estimate. However, generally this was seen as too onerous a task to be undertaken regularly. In one force, the finance department calculated the cost annually for a report to the police authority. This was based on hours lost by grade with the appropriate salary payments being applied; however, it appears that no further use was made of the information. Other forces had estimated the cost in recent years to make the case for improved occupational health facilities or to identify the cost of mental illness. It appears that the high cost of absence was not, in most of the case studies, a statistic that was widely known or implemented to stress how significant absence was for the force. This is reflected in its omission from most of the absence policies.

6.7 SUMMARY

This chapter has considered the data collection and information available to managers in the case study forces on which to base their management of absence. The following main points were made:

- The software used to process the absence data was usually the National Strategy for Police Information System (NSPIS) which can hold demographics and payroll data but is not linked to payroll, which limits the amount of cross analysis possible.
- The reporting of time lost to absence in hours or shift days lost was approached in various ways across the forces and was not standardised. Where absence was expressed in hours, as in Home Office reports, this was commonly calculated by multiplying the number of days lost by a factor to convert to hours. However, again there was no common method.
- The Dorset 12 categories used by all the forces, although useful for providing overall national data, were too broad for use at force level. To be effective the categories required sub menus of more specific conditions.
- Disability-related absence was the least well monitored form of absence. The forces were generally unable to separate it out on their IT systems and relied on managers knowing the staff involved to manage it effectively.
- Line managers were typically responsible for completing the absence forms of their staff. The integrity of the absence data was dependent on them accurately entering the data but there were recognised problems in their ability to this. It was not a priority task for them and there were difficulties with timeliness and accuracy.
- The managers' views of the data provided for them showed that there was some unmet demand for improvements in usefulness, reliability, details on absence and frequency of reporting.
- Managers could be better informed about the basic statistics of absence concerning their own teams and other parts of the force.
- The presentation of absence reports varied widely in the forces; some were just Excel spreadsheets while others contained graphs, charts and commentaries and were far more user-friendly. This depended both on the capacity of the forces' systems to provide the data and also on the customer awareness of those responsible for data processing. Often they were reactive and did not ask the user if they understood the reports or if improvements could be made.

- The forces did not routinely benchmark against other forces but measured their performance against the national target figures to measure their performance. The Home Office returns data was routinely received but there were some doubts about the comparability of the figures, as it was known that the forces calculated their figures differently.
- The monitoring of the management of long-term sickness was routinely undertaken by HR or occupational health and held in a separate part of the forces' systems, which meant that it could not be integrated into the standard absence data analyses.
- The forces did not routinely calculate the cost of absence to them, as this was seen as too onerous a task.

7 REASONS FOR ABSENCE

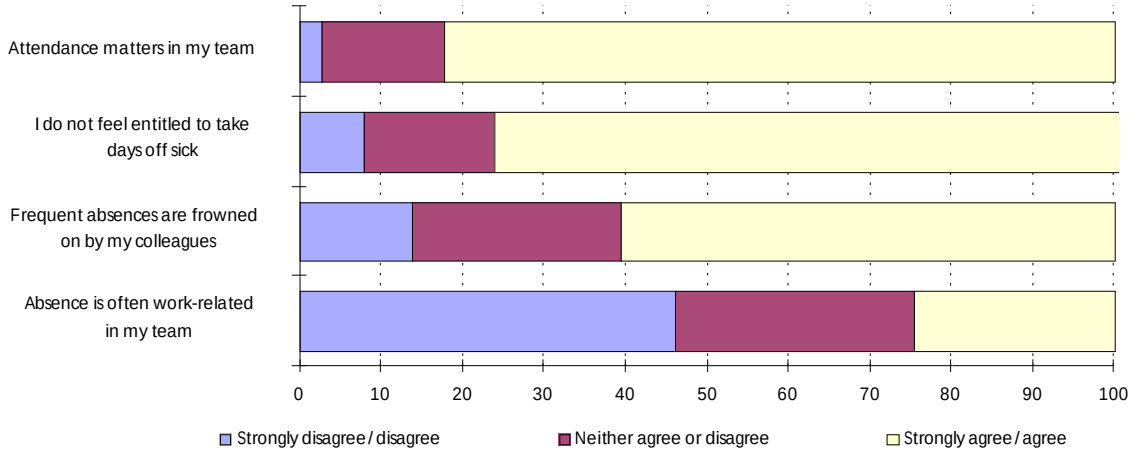
Taking forward better absence management requires an understanding of the factors driving absence. In this chapter the views of staff at all levels are examined to determine perceptions about the causes of absence. Sickness absence data may not accurately reflect the reasons for absence as people may report in sick for non-health related reasons. This stresses the need for good absence monitoring systems as a vital part of any successful policy to allow management to make decisions and offer appropriate support.

7.1 VIEWS ON REASONS FOR ABSENCE

An overview of both manager and non-manager perceptions on absence issues was available from an analysis of the questionnaires completed by focus group participants, their discussions and also the views of staff interviewed.

Firstly, the non-manager focus group survey asked how participants felt about taking absence. They were asked to rate a number of statements from 'strongly disagree' to 'strongly agree' with 'neither agree or disagree' as the mid point. The results are presented in Figure 7.1.

Figure 7.1 Non manager attitudes towards absence (%)

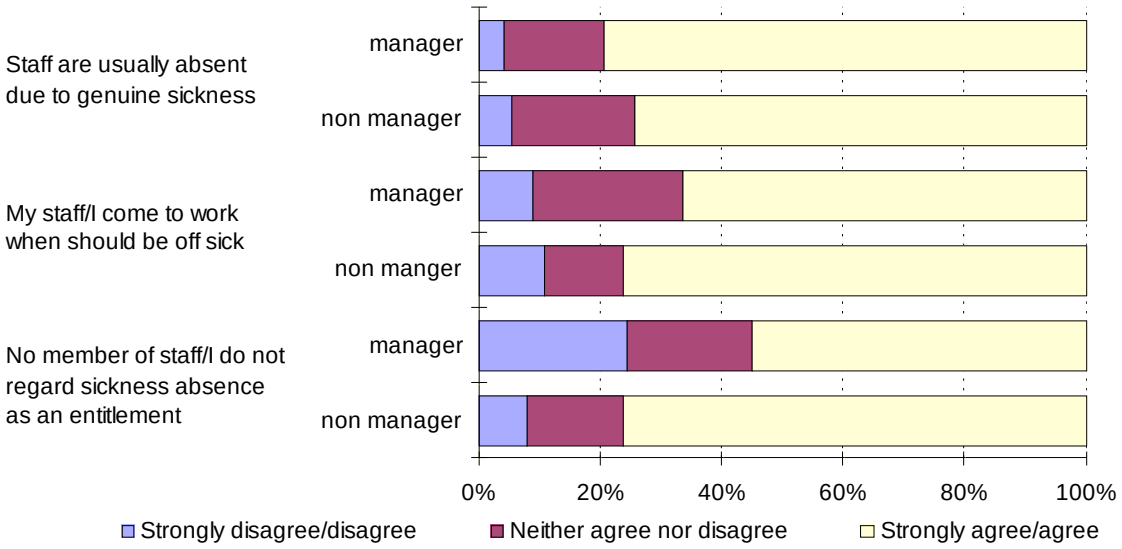


Source: IES, 2007

The figure shows that 82 per cent of non managers believe that attendance matters in their team and 61 per cent think that frequent absences are frowned upon. Just over three quarters of respondents, 77 per cent, do not feel entitled to take days off sick. Absence is generally not perceived to be work-related, with only one in four agreeing with the view. It is clear from this that non managers have general positive attitude towards attendance.

This is also supported by comparing the attitudes of managers and non managers towards taking sick leave, in the case of managers for how they thought their staff felt, and for the non managers how they themselves felt. This is shown in Figure 7.2.

Figure 7.2 Views of managers and non managers towards taking sick leave



Source: IES Survey, 2007

The figure shows that both the managers and non-managers agree that absence is generally due to genuine sickness and that there is a reluctance to stay away when ill. The non-managers were clear that they did not feel that they were entitled to an amount of sick leave. This could indicate the phenomenon of 'presenteeism', where individuals attend work whilst ill and whose work performance suffers as a result. Thus, simply considering the levels of absence to understand the impact of illness on work, may underestimate the problem as the effect on performance is overlooked.

Managers were only slightly less likely than staff and officers to think that absence was due to reasons other than sickness, less likely to say that people come to work when they are sick and far less likely to say that people do not regard sickness absence as an entitlement. However, overall there does appear to be a commitment to come to work and most absence is perceived as being due to sickness.

Interviews and discussions also revealed that some employees would rather take annual leave or time off in lieu than call in sick. Such actions were caused by a range of factors. For example, individuals often wished to avoid accruing a sick leave record. There was also a general commitment to colleagues and a reluctance to increase the workload of others by being absent. In some cases this reluctance was due to the force putting pressure on employees to reduce absence. This was particularly the case where strong measures to reduce short-term sickness absence were in place.

> *'We're at the stage now where we have people who book an annual leave day rather than go sick, or they'll be at work when they are sick and therefore they jeopardise not only their own health and safety but the others who they're working with and the public.'* (Trade union representative)

Some focus group participants said that they were proud of their sickness absence record and would also rather take a day's leave than a sick day, particularly if they were managers and wanted to set a good example to their team. Others said that they made the effort to go in to work even when they were sick as the general atmosphere was positive.

> *'Speaking to a lot of people I work with in my own environment, a lot of them go out of their way to get into work even when they're sick, because we've got a good working atmosphere.'* (Police staff)

Whilst, overall, respondents seemed to view this positively, there are also a number of issues why individuals coming into work when they are actually ill could be a problem. These include:

- bringing infectious illness into work with the result that others become ill
- operating in challenging roles whilst not feeling physically 'up to it', which could impact on performance
- the fact that such cases mask the true extent of absence and make it more difficult for management to understand and deal with it appropriately
- not taking time off when it is needed could lead to long-term absence through fatigue or a build up of psychological issues.

Another section of the questionnaire asked respondents to provide more detail about what they viewed as the reasons behind absence. It asked respondents to specify, in their own words, what they considered the three main causes of absence to be in their unit. Individuals were invited to think of 'all the possible causes of absence, not just sickness'. The results are presented in Table 7.2.

Table 7.2 Manager and Staff views on causes of absence

Causes of absence	***Managers (%)***	***Staff/Officers (%)***
Physical illness/sickness/ill health (colds/flu/virus)	80	63
Stress/exhaustion/burnout/mental illness	37	57
Injury	32	25
Other family care/illness/problems/issues	23	17
Childcare issues	15	14
Workload/poor staffing	10	8
Planned appointment/surgery/medical procedure	9	4
Skiving/need a day off/ malingerers	9	8
Annual leave/time off	7	3
Other personal problems	5	–
Other out-of-work commitments/issues	5	4
Maternity/pregnancy	4	3
Lack of job satisfaction/mundane work	3	12
Bereavements/compassionate leave	3	4
General work-related/lack of support/criticism	3	12
Working hours/shift work	2	4
Recurring problems/terminal illness	2	3
Disability related	2	–
Poor work/life balance	2	3
Run down	1	2
Poor working environment/conditions	0.8	2
Maternity/paternity	–	3
Total (N)	**124**	**147**

Source: IES Survey, 2007

Most managers and staff and officers cited the same main reasons for absence. The data show that the main perceived cause of absence amongst both groups was physical illness/sickness/ill health (eg colds, 'flu and viruses, infections etc). A far higher proportion of respondents identified this than any other cause. Almost 79 per cent of managers and 63 per cent of staff consider this to be a cause of absence, The next three most commonly cited causes of absence were: stress/exhaustion and burnout (57 per cent of staff and 37 per cent of managers); injury (24 per cent of staff and 32 per cent of management); and family care/illness (17 per cent of staff and 23 per cent of management).

A broad range of other factors were also raised by respondents, but by increasingly lowering proportions. Nine per cent of managers and eight per cent of staff and officers thought that people would take sickness absence because they 'needed a day off'. Other reasons given included bereavement and maternity/paternity.

7.2 HEALTH REASONS FOR ABSENCE

There were a number of reasons identified by staff across grades and job roles, in group work and interviews, as contributing to both short-term and long-term absence.

7.2.1 Short-term illness

Typically coughs, colds, stomach bugs, headaches and flu were viewed as major contributors to short-term absence. The season impacted on the types of illnesses that were most commonly presented (eg colds and 'flu common in winter, with stomach bugs common in summer).

> *'January is a big month for 'flu and colds. The summer is big month for stomach upsets, when barbecues and things. And you know the seasonal variations and fluctuations that there are going to be. And you can actually put them down to those reasons. You see a huge leap in stomach upsets in the summer months from uncooked food and barbecues. Whereas January, never before Christmas, it's always after Christmas and New Year, huge increase in flu and cold. People are depressed, they don't want to come back to work after Christmas and New Year, etc. etc. and flu and colds go through the roof. Plus it's the main time of the year, when you're going to catch a cold or the flu, you're going to get it then.*' (Police Staff)

There was also a feeling that some people reported upset stomachs or headaches as a reason for not coming to work to avoid having to admit to stress or anxiety. Therefore other problems could be masked by people reporting common causes of absence when the actual cause was something else. Picking up individuals before the problem became acute was felt to be important, but also very difficult.

7.2.2 Longer term conditions

The nature of long-term absence is very different from short-term in terms of its effects on individuals and forces. From the interviews and discussions the main conditions that caused long-term absence were seen as:

- psychological problems (such as anxiety, stress, depression)
- musculoskeletal disorders (including Repetitive Strain Injury, back pain and damage due to wearing body armour).
- serious/fatal illness (eg cancers or degenerative diseases). These were felt to be more common now as the age profile of people working in forces was increasing.

'It would appear at that moment that it's kind of gone full circle. At one point I would have said the main reason for absence was short-term absence. Now it's the old favourite 'stress' and 'bad backs'. So, not just stress. I mean, if you're looking at the whole mental health issue it could be stress, it could be depression, it could be anxiety, nervous debility; any one of the top four, if you were …. And the next big reason for absence has always been musculoskeletal, so thereby you've got your bad backs, shoulders, knees, whatever, joint problems generally.' (Staff)

7.3 NON-HEALTH REASONS FOR ABSENCE

Data from the focus group questionnaires did not reveal a widespread opinion that people take sick leave for reasons other than sickness. Neither was this highlighted as a major problem in the interviews with senior management in terms of the number of staff involved. However, there was some acknowledgement across all staff groups that certain individuals were a 'problem', or could cause difficulties, because they took sickness absence for non-health related reasons. The complex interplays between personal and work factors in the way that individuals respond to work pressures was often discussed.

Some forces believed that staff took sick leave for non-health related absence even though other types of leave arrangements were available for this.

'Certainly some absences may be due to domestic circumstances and we created within the force a few years ago with one particular department, there was a warts and all review – an amnesty if you like – where we wanted to make improvements.' So tell me whether you've ever taken a day's sick leave because your washing machine's exploded' and people were saying 'well yes I have' …. As it is people just have an off day or they've got a hangover I dare say those absences take place as well but we continue to try and improve procedures. So when you look at our suite of family friendly procedures they're good. It's not just working reduced hours, we've got time off for dependents, we've got emergency leave, we've got compassionate leave, one hour reduced at short notice leave. So if you wake up on Monday morning with a hangover and you don't want to come in then within reason you can ring up and say 'look I know its Monday but can I take the day off. We are making improvements around work life balance all the time.' (Chief Constable)

Childcare arrangements were also felt to be a factor in short-term absence, particularly by line managers, some of whom had experienced staff taking 'the odd day here and there' if they had problems with childcare.

One force, had analysed the days of the week when absence was taken. They found that 25 per cent of staff absence and 19 per cent of officer absence involved time off on a Monday. It was suggested that individuals may take time off sick because they have been refused leave or because they believe that they have some 'right' to take sick leave.

'… you will inevitably get the people who, after a weekend, when they're supposed to be back in on the Monday and they're still far too hung-over and poorly to come in. They'll ring in with a stomach upset or a cold or something, and take just that one day off, or they don't want to work the shift and they've been refused leave. That happens occasionally, depending on staffing levels; if they have a reason that they want to be off, say on a Friday or a Saturday and there's not enough other staff in to provide the adequate level of cover and leave is refused, people do go off sick, because of that and always will.' (Staff)

7.4 ROLE OF WORK FACTORS IN ABSENCE

The extent to which individuals were affected by illness or other conditions was often considered to be related to a range of factors.

Absence related specifically to the working environment and working conditions was discussed in the interviews and focus groups. These were felt to either cause short-term absence or to perpetuate an absence spell, or to have other negative impacts on staff motivation, morale or well-being which may, over time, affect attendance. However, it is also worth noting that the view of many of those interviewed was that work, whilst a trigger for absence in some cases, was often not the only cause. A complex mix of personal and work factors were often felt to be responsible .

7.4.1 Effect of physical work environment and type of job

The physical working conditions and nature of work in the police forces were felt to have an impact on the health of officers and police staff. Recent changes, such as the closure of canteens and gyms within some forces, were seen as affecting health and fitness, including general resilience to injuries and infections.

> *'There's very little done in terms of recreational rooms etc where people can go. Everybody eats at their desk. You don't get a lunch break.'* (Officer)

Canteens were felt to be important venues for informal debriefing, particularly by those dealing with serious crimes. It was felt that in closing canteens (and other communal venues such as gyms/bars), the implications for team-building and general well-being were overlooked. One view was that this could affect less experienced staff the most, when they were dealing with their first experiences of traumatic scenes or events, and doing so without any access to informal support. This lack of informal debriefing could lead to individuals 'bottling things up' and, if left unchecked, then could potentially lead onto long-term absence problems.

The closure of gyms was seen as counter productive in terms of maintaining staff and officer fitness and their subsequent resistance to illness. The alternative use of commercial gyms, sometimes with negotiated fee reductions, was patchy. There was also some reluctance to use commercial gyms as officers in particular did not want to have to work out alongside people they had arrested.

Several officers described work-related injuries that had occurred on duty, either to themselves or colleagues, eg stabbings, broken jaws, car accidents. There was little evidence that individuals felt that their forces could do much more to protect them, however.

Interestingly, for some, it was important to distinguish such cases of work-related psychological trauma from other mental health problems where the cause was less 'obvious'.

> *'… there will be some individual cases that we're managing where somebody's seen something really unpleasant at work, a traumatic incident or they've been assaulted in a nasty attack or they've just dealt with too many fatal road traffic accidents, or they've investigated too many homicides and they're suffering post traumatic stress and there should be no doubt that for people like that, its work related.'* (Manager)

Whilst colds and 'flu were accepted as a non-work related illness, the extent to which individuals were likely to be exposed to and/or recover from such illnesses was felt to be related to:

- The extent to which their job exposed them to the 'elements' (ie outside working). Police Community Support Officers (PCSOs) were felt to be particularly susceptible because they were not based in vehicles.
- Their uniform which could inhibit ability to keep warm, or mean that in stuffy conditions it was difficult to keep cool.
- Exposure to air conditioning leading to poor air quality and the circulation of viruses from one infected staff member to the rest of their team. Call centre staff were felt to be those most likely to be affected by this.
- Contact with the general public and the likelihood that an infection could be picked up in this way.
- Shift patterns, including the lengths of shifts, the numbers of hours off between shifts and the number of days off per week.

> *'We've got pockets of sickness absence problems which I expect other forces have. One is the communications centre. It's quite a complex issue in terms of resolving that. We have to consider whether the working practices have any impact on absence in there. They have a system of 12 hour shifts so one argument is that a 12 hour shift, at the end of it they're tired, possibly more susceptible to illness, if they're feeling below par in the morning they may say I just can't work a 12 hour shift. From the staff view, they argue that isn't the case. They argue 'I'm very seldom sick on the first day and I only ever work 4 days and then I've got 4 days off so I've got longer to recover so it works well for me. There are arguments on both sides.'* (Manager)

7.4.2 Work pressures

A common issue which was felt to contribute to absence and to stress was increasing work pressures, exacerbated by a lack of resources. Some individuals admitted that the pressure the job now places upon them means that they feel the need to take a day or two off when they feel ill, whereas before they would have been able to come to work feeling 'below par' and been able to cope.

> *'There's less people, certainly, in all stations, where I work, but in every single station there's probably half the number of officers on duty now … on the basis of what there were 10-15 years ago.'* (Manager)

> *'Like everybody else I think we are under resourced. The public have to realise a 24-hour police service costs money. The money we could be saving on sickness if it was funded properly in the first place would be like putting money in the bank and gaining interest on it.'* (Trade union representative)

Performance targets were also thought to have a role in increasing work pressure, particularly among operational staff . They often described the nature of their work as generally 'more crime-oriented' as a result of this. A related issue was the increased level of bureaucracy faced by officers and the demands of keeping up with paperwork. A 'massive increase' in the number of forms that needed filling in for each incident was viewed as a significant strain upon individuals.

> *'People's biggest concerns are that when they make an arrest these days they have to complete several amounts of paperwork, even if the arrest is going nowhere and there's not sufficient evidence for that person that's going to be arrested, all this paperwork has to be completed and it's completely unnecessary'.* (Officer)

A general lack of flexibility in work arrangements was also felt to contribute to short-term absence in a wider sense. It was suggested that more advance warning of anti-social hours duties, such as supervising football matches, would improve people's sense of being valued and would have beneficial effects upon their general well-being. Shift systems were also acknowledged as contributing to the problem in some cases, where the shift pattern wasn't flexible enough to cope with sudden changes of plan in home lives. This had caused resentment amongst staff who did not have such commitments.

> *'I feel sometimes the work becomes secondary for some people. It's not what I can do for work, but what work can do for me.'* (Manager)

A number of individuals also raised the issue that staff took time off sick in the short-term to express their dissatisfaction with, or reaction to, a decision or situation at work.

> *'You could never prove it, but you know it, because you'll overhear throw-away remarks from people. You know, something may have happened work-wise that just hasn't been to their liking. Next thing you know is: some people will just go off sick, throw in the towel and go off sick. I wonder if they see it as a way of getting back at the organisation.'* (Staff)

Pressure to meet targets, which is sometimes made worse by the need to cover for absent colleagues, combined with changes to the way that resources are allocated, was often mentioned as having a negative impact on mental health and therefore long-term sickness absence for some. Return to work could be hindered if a work situation causing 'stress' was not changed sufficiently, or relationship issues between managers and staff dealt with. For example, this was seen as particularly detrimental in cases where individuals were asked to return to the same line management relationship that had initially caused the problems.

If individuals had difficult home circumstances, or a history of mental ill-health, the view was that their reaction to work pressures could be more extreme. A number of those interviewed following a return to work after long-term absence mentioned issues in their personal lives such as bereavement or a tendency to depression which made them more sensitive and less resilient when a workplace problem was encountered. In terms of force actions, the main issue was that treating the work factors alone might not always facilitate a successful return to work.

7.4.3 Low morale/sense of worth

There was a general sense that absence levels were affected by individuals not feeling 'valued' within the force. This was attributed to poor working conditions, not just in terms of increased job demands, but problems in the actual work environment as well. This view appeared to apply more to officers doing reactive work. The problem could be made worse by lack of training and inexperienced management who were felt to offer inadequate support in some situations.

> *'The problem is you've got so many young, inexperienced sergeants who have no skills in managing teams and their own workloads … they are understaffed and over worked …. Some sickness is derived from not knowing what they're doing so panic sets in … they are treated like the lowest of the low.'* (Manager)

> *'These people [civilians] are put into exalted positions …. It means some managers don't have the faintest idea what we do.'* (Officer returning from long-term sick)

In one force the Occupational Health representative was quite specific that short-term, non-health related absence was '*very much related to motivation and job satisfaction whether they are happy in their job in their role*'.

7.4.4 Lack of support

Unsupportive management was seen by staff as a factor in both causing long-term absence and in exacerbating problems or hindering return to work. From a management perspective, the challenge was often managing the balance between robust absence procedures which allowed non-health related absence to be dealt with and dealing with staff empathetically when they were in real need of support.

> *'Sometimes it's how people are dealt with and spoken to. The number of times I get people into the office complaining about how they'd been supervised …. And those people get themselves so worked up and so stressed about it that the likelihood is that at a drop of a hat they will go off sick …. There's always a fine line between managing and supervising, and bullying.'* (Trade union representative)

A number of individuals returning from long-term absence discussed how they felt bullied at work. This force was felt to have an organisational culture of bullying, which was in part driven by 'intrusive' absence management procedures.

> *'The reason I became ill wasn't through one to one bullying, it was organisational bullying because the way that the regime has now been adopted no one trusts anybody to get on with their job …. My line manager and it's not his fault because he was being asked those same questions. It was so intrusive … it was that kind of bullying that made me start to get anxious … it started when the new regime started and … coupled with that I've had no staff … I was just overwhelmed ….'* (Police Officer)

7.4.5 Organisational change

Within a number of forces, the issue of organisational change was raised as a contributor to absence, often as a direct result of its impact on morale. The effects of this were often felt to be most significant for those working closer to front line activities with increased pressure regarding performance and meeting targets. In one force in particular, people felt *'backed into a corner … and going sick was their only voice'* due to feeling not listened to or supported. Such pressure in the system was felt to increase the risk of people from all roles having to go sick.

> *'We've got to save lots of cash and I'm sorry if that person's gone and you've lost that vacancy, we just have to manage'. In certain areas that would have created some challenging situations for individuals who may have really struggled to deal with the impact. Looking at our own function we've seen reductions in staff at manager level and also at assistant level yet we're still trying our best to provide a service.'* (Manager)

Senior management were often blamed for this, in that they were driving through the changes. However, the impact was generally felt to be less severe on individuals who had more control over their work roles.

Within one force, a modernisation process had resulted in a number of factors working in combination to trigger sickness absence.

> *'… people were moved from job to job with little or no control; there were redundancies, early retirements, a reduction in the number of chief superintendents …. Predominantly the force was very short of cash and the impact was on young police staff. People lost their jobs and were moved round, to a lesser degree on police officers, so that may be the particular trigger for police staff. Police officers had less supervision, sergeant and inspector rank having to do more; greater numbers to manage …. So performance appraisal slips, supervision slips, because the increasing*

numbers on a shift mean that a sergeant or inspector still has to meet the performance indicators but instead of maybe dealing with the six people they were dealing with this time last year, they've now got 12 or 18 on the shift. That could be another reason for sickness absence: people don't know their staff as they used to. Before, they'd know what was going on in their private lives, what triggered things.' (Manager)

7.5 SUMMARY

- The most common causes of short-term sickness absence were identified as illnesses such as colds, 'flu and stomach bugs. There were a number of work-related factors which were felt to affect how likely it was that individuals would become ill, including their exposure to the elements, poor air-conditioning and shift patterns. Out of work commitments such as childcare were also felt to have an impact on short-term absence, particularly when the individual's job lacked flexibility.
- In relation to long-term sickness, the most commonly identified causes of absence were psychological problems (such as stress, depression and anxiety), musculoskeletal disorders and serious/fatal illness. Work-related injuries were also acknowledged as causing absence, as were psychological trauma, either from a single traumatic event, or a build up of exposure to such events over time.
- The main ways in which work was felt to affect both long and short-term absence was in terms of how individuals felt about their jobs and themselves. Work pressure, including high administrative demands, and feeling under resourced, particularly when combined with organisational change, were felt to affect individuals in a number of ways. In some cases, taking short-term absence was seen as a way to express dissatisfaction with a situation or decision. In particular where morale and/or an individual's sense of worth is very low, being absent may be one way in which they can express their dissatisfaction with the situation, or 'find their voice'.
- If individuals feel that they have little or no support from the organisation, or negative work situations persist over time, this contributes to long-term sickness. It was felt to be important that absence policies acknowledged the impact of both home and personal issues in attendance at work. Also, if line management relationships had broken down, it was important that this was addressed and individuals were able to report to a new manager.
- Overall, no force felt that they had a particular issue with non health-related absence and management recognised that the majority of absence was genuine. The importance of maintaining a fine balance between punitive measures for those whose absence was without real cause and the provision of support for those in need was widely acknowledged. Some existing systems, however, were felt to restrict the ability of managers to deal sensitively with individuals on a case by case basis.

8 MANAGEMENT OF ABSENCE

There are different factors at play relating to the management of long-term and short-term absence. In particular long-term absence management requires the cooperation of staff with different roles in the process, including occupational health, HR and line management. Below, we examine the roles and procedures used in the management of short-term and long-term absence.

8.1.1 Role of senior management

Although senior management members were often seen to have a fairly limited role in hands-on management of long-term absence, their input was acknowledged by some to be very important. In some forces, the role of senior management was felt to stop once they had signed off the policy. Elsewhere they went further by encouraging the implementation of policy, and introducing and implementing training programmes.

In one case, an individual police officer, whilst overall considering his long-term absence had been dealt with well, attributed this to the involvement of his Chief Constable. However, he felt that this had only come about because of his own persistence – he had insisted on speaking to the Chief Constable about his situation and, from then on, felt that he had received exemplary treatment.

> *'My beef really is the lack of the organisation's sympathy, empathy and their attempt to get me back to work which amount to that. I fought for, and got, myself an audience with the chief constable. I'm a PC, he's a chief constable and for the tape, I'm doing a thing where I'm low and he's high and he had an hour at my house listening to me and my other half, who is a police officer. We let him have it in a respectful way but with both barrels and he totally agreed and understood what I was saying. Promised various moves to sort the problem out and I said to him 'doesn't it concern you, sir, that I'm a PC, you're a chief constable and there's all these people in the middle and none of which have been able to talk to me and get me back to work, it's come down to a chief constable coming round to a PC's house?' And he said 'noted'.'*(Long-term absence returnee)

In the same force, it was now the policy of management for a senior member of the management team, including the Chief Constable, to visit individuals in all cases of ill-health of a certain length. This was seen as a very good way for them to intervene. However, in this case, it had been introduced as part of a broader programme of culture change.

> *'I don't think we're very good at supporting people when they're off sick. I think we're an organisation that sometimes allows bureaucracy to get in the way of commonsense where we can just sort someone's issue out.'* (Chief Constable)

> *'Quite often I'm disappointed when I go and see someone who's been off sick for months and they'll say they've had little or no management contact. I'm the first manager that's visited, it can't be right that the Chief Constable is the first person to go and visit a PC. There's an issue about maintaining contact. There's a big issue about managers feeling sufficiently empowered just to do some sensible things.'* (Chief Constable)

In another force, one individual's experiences of being on long-term sick leave were, overall, fairly negative. She described feeling 'forgotten' by the force for most of the period in which she had been absent. She also did not feel that the force had shown any recognition for the work she had done while carrying out a highly specialised and technical role. Contact from her line

manager had been infrequent and she had not received a home visit. However, she began to feel more positive about returning to work after her surgery following a visit from the Assistant Chief Constable, demonstrating how important the involvement of senior management can be for individuals.

One activity which most senior management was attempting to take forward was the monitoring of sickness absence trends and then taking appropriate action based on hard data rather than just perceptions. However, their ability to do this successfully was often limited by the quality of data available to them (see Chapter 6 for further details on data management systems).

8.1.2 Role of line management

In all forces, line managers were given the majority of responsibility in terms of managing absence. This was generally supported by some form of training and by the HR function. However, there were a number of issues which were seen to affect the ability of line managers to successfully deal with those on short and long-term sickness absence. These included:

- their understanding of the force's policy
- their ability to use discretion within the policy to ensure the best procedure or individual fit, balanced with the need to be seen to apply policy consistently and fairly
- the extent to which absence management formed part of the line manager's performance appraisal
- their ability to get the balance right in maintaining contact with those off sick
- their understanding of the specific issue causing long-term sickness. This was felt to be particularly poor in relation to mental ill-health, particularly when an individual's work situation was a major part of the problem
- the support they received from HR and occupational health professionals.

> *'The main challenge and the reason I stalled answering this is because I don't want to be critical of any of my colleagues, but the reality is it's management ownership. Until we get to the point where everybody clearly understands that managing their people is absolutely critical to the success of the organisation and that's to every single manager in the force, not just those good ones that we already have, or those ones who are doing a perfectly adequate job. Until we get to that point I don't think we will have succeeded …. For us that's the real criticality moving forward is getting it embedded into day to day practice so that everybody clearly understands what their responsibilities are and are managing according to these and are held accountable.'* (Senior Manager)

For line managers, there could be some tensions in working with other departments, who were not always felt to help clarify roles or move things forward in the best way.

> *'Line managers have a higher expectation that occupational health will give them the answer and actually manage it for them. Whereas, there's a constant battle really, occupational health only advise and line management takes the decision.'* (Manager)

In one force, a senior manager suggested that insensitivity on the part of line managers can be a negative issue, and that more training in interpersonal skills might improve the situation.

> *'You're working in an environment where you're taught to question and question robustly. The police officers who work on the streets and deal with aggression and violence: they have a presence: it's part of the culture. When you try and take somebody out of that type of environment and you put them in an environment on a one to one*

basis with staff requiring more empathy and warmth, it's difficult – that transition sometimes is very difficult for some individuals to make. And they'll ring them up and say 'You're off sick. How are you? …. Well, when are you coming back then?' and the 'When are you coming back then?' comes long before it should as part of the process, because the manager thinks 'I'm interviewing somebody.' (Senior manager)

8.1.3 Role of HR

The HR function was widely viewed as existing to provide support and guidance to line managers in their implementation of the sickness absence policy. The tasks that it carries out include checking data and running regular meetings on absence at which individual cases are discussed. The function also chases line managers for accurate information and liaises with line managers and occupational health on a case by case basis. It also provides support to line managers who are unsure of the best steps to take.

There was on occasion some evidence of higher than realistic expectations among line managers, some of whom did not feel that they got adequate support from HR. There was also a perception among line managers that the HR function was overworked and therefore could not devote the time to absence management that line managers wanted.

In one force, the central HR function was judged by line managers to be largely invisible and unaware of the real day-to-day pressures for front-line staff in the force's divisions. However, local HR at divisional level was viewed more positively in this force, being typically involved at the start of the absence process and working with managers to identify those who had hit trigger points and linking the informal and formal stages of the sickness absence policy. In another force, there was some separation between how HR operates and what senior management appeared to want in the future. In this force, HR had been rather mechanistic and line managers and staff felt that they did not understand the absence management policy.

8.1.4 Role of occupational health

The role of a force's occupational health provision was, without exception, a key part of the processes in place to manage long-term absence – but little used in short term absence, even though there was a desire on the part of managers for occupational health to be more involved in the management of short-term absence. There also seemed to be some confusion about the duties and capabilities of the occupational health role.

For example, in some forces, there appeared to be a mismatch between the expectations of users at various levels and how the service was actually resourced and what it was able to provide. This could increase the pressure felt by occupational health units.

'We still constantly get referrals (from line managers or self referrals) for people suffering from things like marriage breakdown, bereavement etc. So we can refer people on, but that is at a cost to the organisation and because our budget is so small we've had to go back saying it can only be provided if its work related or injury on duty.' (Occupational Health)

In some cases, clarification of the roles of personal GPs and the occupational health was needed. For example, in one case study there was confusion about the role of the occupational health department in relation to their own doctor, with employees not knowing which should take precedence and why. Some felt frustrated that the judgement of their own GP was not sufficient. There was also no evidence that any liaison took place between the two parties.

'They could have a standard form that you could take to your consultant, which says 'Yes' you are fit for work, these are the questions the force have to get answered, a big box, ticks yes. Then you could hand that to occupational health.' (Returnee from long-term absence)

There was conflict in another case between the opinion of the GP and the occupational health department.

'Trying to get back to work was a nightmare. My GP said I was fit for work if I felt I was fit. I get packed off to see a psychiatrist in OH who says 'you're not fit – go and tell your GP you're not fit.' (Long-term absence returnee)

The timeliness with which occupational health were seen to, or were able to, act was also perceived to be problematic in some forces. This was often also related to the resources available to support the work of occupational health units. Some returnees, for example, felt that the support from occupational health that they had received, whilst well-meaning, had been minimal.

Nevertheless, a large proportion of returnees from long-term sickness absence praised their contact with occupational health, in terms of the services on offer, the people delivering them, and the care with which employees felt they had been treated. In particular, the role of occupational health in dealing with cases of mental ill-health and facilitating access to third party specialist support was seen as particularly beneficial. Individuals were particularly positive about the role of occupational health in 'normalising' illness experiences, reducing the isolation of employees and in helping to reduce the feeling of stigma attached to having mental health conditions.

'Occupational health … have been brilliant, I can't rate them highly enough.' (Returner from long-term sickness)

'I was well-supported, nothing but admiration for occupational health.' (Returner from long-term sickness)

Where occupational health were seen as most helpful, this was often related to the fact that individuals were experiencing difficulties with their line managers, particularly where they felt that other departments had failed to provide adequate support. Occupational health, including counselling where this was available, was seen as introducing a level of independence, and often enabled individuals to feel more in control of their situation as they were able to explain their position to a neutral and independent party.

One example of this was an officer who had tried to resolve problems with his manager, senior officers and HR whilst he was still working but finally took sick leave on the grounds of stress and depression. However, once he was on sick leave, managers and colleagues maintained contact with him, and he then felt that the force was taking his situation seriously. He was referred by occupational health for counselling sessions, which he rated very highly. He came back to work on a structured plan after three months and was very satisfied with how his absence was managed.

'The [assistance provider] arranged and structured everything and were excellent. To the credit of the force, there was no expense spared and it was quite an expensive process. It was never questioned. I wanted to get back to work as fast as possible, how do we do this? There was no expense spared by the force and that was good.' (Officer, returned from long-term sickness)

Policies require occupational health departments to sign off employees as fit for work before they can actually return to work. There was some frustration around this: for example, there were a number of cases where it took individuals many weeks to get an appointment with the force doctor or where they felt that their return to work had been delayed by the time it took to get occupational health to 'sign off' their return.

> *'Occupational health here are overworked and underpaid. You leave messages for them and they don't get back. There are a select few who will make a decision over the phone and they will try and fight your corner but the one that looks after us is rushed off his feet. I'm still waiting for a response to a phone message I left last week.'* (Police officer, currently long-term absent)

Other individuals specifically identified under-resourcing and consequent slow response of occupational health departments as a barrier to their return to work. Several individuals in one force said that they had spent several more weeks than necessary off sick while they waited for occupational health to give them the all-clear, as they could not get an appointment with the chief physician. An interviewee in another force recounted delays in returning to work because the force doctor role was outsourced.

> *'The problem is we don't have our own in-force doctor. It's outsourced and he comes in once a fortnight. I had a knee injury and I couldn't come back to work until I had seen the force doctor because he was on manoeuvres with the TA. I had to spend another 6 weeks on the sick. What a nonsense. Again, everybody was saying I was fit, the consultants, the physiotherapist. No, because I hadn't seen the doctor, I had to spend another 6 weeks on the sick.'* (Police Officer)

Such delays were also often a result of 'bottlenecks' in the return to work process caused by limited resources, or problems with resources, within occupational health. One force commented on their experience of outsourcing occupational health support and how it had been difficult to obtain access to occupational health physicians. In another, the size of the occupational health team had been severely reduced over the last five years, but with the same requirements on delivery.

> *'I would suggest that longer-term sickness absence is a bigger problem than short-term, because the short-term could be managed by managers, give them some training and some skills to do that, whereas the longer-term stuff, we've not got the occupational health support in place that we did have. The doctors couldn't manage the transition, couldn't manage the different regime and they left hand over fist. So we were left with a contract with a company that couldn't provide us with occupational physicians. They could give us a GP, but they couldn't give us the type of nature of physician that we need to manage our occupational health.'* (Senior manager)

> *'It feels like you're continually not getting anywhere and people say, well I referred so and so and they haven't got an appointment yet, initially we were bending over backwards and really struggling but then we said hang on a minute …. I will prioritise my workload … and it was a big change for everybody because it meant that we all had to take a step back and look at the way we were working as individuals ….'* (Occupational Health)

8.2 PROCEDURES USED TO MANAGE ABSENCE

The following sections look at the specific procedures used by the forces to manage absence and their importance and effectiveness. These will cover appropriate contact with the individual, trigger points, the use of sanctions and incentives, managing work-related accidents and injuries and the return to work

8.2.1 Maintaining appropriate contact

Whatever the nature of the sickness absence, the way in which contact was maintained by the force with those off sick was seen as vital. Most forces recommended some form of written, telephone and face to face contact, but it was often seen to be difficult to balance these components effectively in relation to individual cases, particularly when the individual in question was suffering from mental ill-health.

There were contrasting views of those who had experienced periods of long-term sickness in terms of what constituted appropriate levels of contact with their force. A number of interviewees stated that they had felt isolated while on long-term sick leave and wished that there had been more contact with colleagues and their managers. However, there were also those who found visits intrusive and were suspicious of management contact, viewing it as management 'ticking boxes' rather than genuine concern.

> *'They knew what the situation was – I wasn't going to die, I was just bored. My line manager would often give me a call and say, I'll come and see you as soon as I get the chance, I was coming to see you yesterday, but something happened. He was very good about it. He'd come and sit down for an hour and chat in general. Very supportive.'* (Police Officer, returned from long-term physical sickness absence)

> *'It's 'Come back to work, come back to work.' It's nothing about 'Are you ready to work? What can we do to get you back to work?' It's just to get you off the books.'* (Returnee from long-term sickness absence)

> *'When I was off three months with back problems, the first month I was off, three weeks in, I was getting at least two, if not three or four phone calls every single day: 'Where is this? What's that? What's happening?' I was off sick. They didn't knock that off my sickness.'* (Returnee from long-term sickness absence)

One returnee acknowledged how difficult managing contact can be for managers, who need to find the right balance between support and not being intrusive. Further, this returnee expressed the view, echoed by many, that much depends on the individual and their relationship with their manager, rather than the illness itself.

> *'That phone call to you. The 'non' phone call to you. The 'cover your back' phone call …. A lot of managers find it really difficult to broach the subject and they're fearful of visiting people at home in case they upset them or people close their door on them or in case their partner says 'I don't want you in my house'. They back-pedal.'* (Returnee from long-term sickness absence)

Many other interviewees said that their experiences were very positive, maintaining that contact had been good, a range of measures to help them had been offered and support had been provided in order to help them get back to work when the time was right. One example of this is an officer who had been off long-term with a serious infection, and who thought that his absence had been managed 'excellently'. He received visits from occupational health to see if he needed any assistance and felt fully supported by his supervisors.

> *'I had visits from both my direct supervisors and the management team in the hospital, both telling me I had no worries and my job was safe and just to concentrate on getting well …. Even the Assistant Chief Constable came in to see me.'* (Police Officer)

One key area to aid return to work after short-term absence was to ensure that relationships between staff and their line managers were good and that the staff felt valued and motivated.

Where this is the case, staff will be less likely to take short-term sick leave and if they do, they will be more likely to return as soon as possible.

In addition to good relationship building, it was important that line managers knew what their role was and had the necessary skills and training to carry it out. These included listening to their staff and working with them to help them reduce their short-term sickness absence.

> *'Focusing on supervisors and managers, training, people skills are important, looking at why in certain departments the staff are going off. Why they're repeating sickness. Better back to work interviews. I don't think they've got the right skills in talking to a person in saying, 'Why you were off? Welcome back, how can we help?'* (Trade union representative)

8.2.2 Use of trigger points

Trigger points related to an individual's number of sickness days or episodes were used in all the forces to prompt management actions. These were usually defined as a specific number of days or incidences.

Views on the general effectiveness of using trigger points to improve management and therefore reduce absence were not clear cut. Almost half of non manager respondents (48 per cent) had no strong views, with 41 per cent agreeing or strongly agreeing that there were effective and 12 per cent disagreeing. Line managers tended to be more positive about the use of trigger points, with 60 per cent agreeing or strongly agreeing that they were effective in reducing absence, 30 per cent holding a neutral view and ten per cent disagreeing. The line managers were therefore more confident than non managers that trigger points had an impact on absence management and could be used to instigate action.

Bradford scores were used in two forces. In one of the forces where absence was improving, the use of Bradford scores was generally disliked by focus group participants, who mainly expressed the view that they were draconian and counter-productive. People also felt that if they were going to have one or two days off sick, they might as well stay off for a whole week, as this would be treated more leniently under the Bradford system than having one day off, coming back too soon and then needing to take another couple of days. However, senior management in this force said that the system had helped to reduce absence levels significantly when it was introduced. In the other force using Bradford scores, where absence levels have also improved significantly, HR viewed them as useful, although the view of the trade union was that it could not solve all absence problems.

Getting the trigger points right was seen as key in the efficacy of managing absence, including the application of suitable interventions. However, it was seen as equally important by managers that, whatever the nature of the trigger points, that they were applied within context. Sensitive and informed use of interventions was vital in maximising their efficacy. The use of Bradford scores was felt to significantly limit the ability of managers to manage appropriately as it did not support discretion.

8.2.3 Use of sanctions

A range of sanctions were used by forces to manage absence, usually around issues such as pay and access to promotion and training. There were mixed views on the efficacy of these sanctions, with some focus group participants viewing them as unnecessarily harsh, doing nothing to deter those who had genuine reasons for being off sick and sometimes obliging people to go into work when they were sick.

Common examples of the main sanctions used by forces to manage short-term absence included:

- withholding payments (eg Special Priority Payments (SPP) or Competency Related Threshold Pay for Police Officers and salary increments for Police Staff)
- blocked access to promotions
- blocked access to training
- reduced pay rates – normally half pay after six months
- the removal of the right to self-certify absence.

Senior managers believed that sanctions can play an important role in managing short-term absence. For example, in one force, it was reported that staff on short-term sick leave were returning to work just before the point at which sanctions would be applied.

Individual sanction approaches are discussed in more detail below.

Withholding special payments

The withholding of special payments – payments over and above normal pay – was used by some, although not all, forces. This practice was criticised in some cases; for example, in one force, the trade union representative discussed how, whilst the removal of special priority payments (SPP) for officers constituted a loss of a 'bonus', removing increments for staff was more serious as it affected their actual salary and could therefore impact on the following year's pay as well as the year in which the absence had occurred.

There was a widespread view that removal of payments where individuals were 'genuinely' ill or injured was unfair, and a step too far. However, focus group participants from a number of forces made the point that the issue was competence rather than any doubts about the nature of absence: if a person was not fit for duty because of illness or injury, they needed to be absent on sick leave.

Access to an appeals process was seen as an important component of any sanctions system.

> *'We've had officers injured in road traffic accidents and they haven't got their increment. People who've had broken limbs …. With road traffic accidents, we've had people coming in to work suffering from whiplash and they could not do their job, so were sent home. And yet they didn't want to give them their increment, they had to go home for maybe two weeks so they didn't get their increment and that to me is … it was a road traffic accident, it wasn't even their fault and yet they were being financially detrimental for 12 months.'* (Trade union representative)

Limiting career progression

In some forces an individual's attendance record was taken into account when they applied for promotion. There were differing views on this. In favour was the view that promotion should be given to those who were reliable and unlikely to cause disruption. However, the opposing opinion was that some absences were unavoidable and that a good officer or member of police staff should not be held back because of this. One respondent recounted their experience with one of the staff they had recruited.

> *'I had a very talented female member of staff … and she had a back injury and it meant she had to stay off for 3 months for it to heal. There was no question about it, it was an injury. But it was touch and go whether it would be repaired or not and you have to stay*

off it. And when she came back she went for promotion and it was blocked and she said 'How long am I going to be blocked?' and they went until October next year. 18 months away. Put her life on hold. She applied to (another organisation) locally and they were: 'That's nonsense; you were injured'. And they [gave her a job] … and we lost her. She was a real strong team player and … on her last day, the head of department at the time, instead of congratulating her on her promotion and wishing her well, spent ten minutes saying sorry you had to go. So we did fail her big time.' (Police Staff – line manager)

Reducing pay

A further common experience which could cause problems was that of reduced pay. This tended to occur after the 'trigger point' of six months of absence. In a number of cases, people had received standard letters informing them that they would be moved on to half pay without any reference to their circumstances. This caused a considerable amount of stress and anxiety, particularly among those who had been in discussions with individual managers about the nature of their illness and whether it should warrant an exemption from the half-pay rule.

8.2.4 Use of incentives

Most forces used some form of incentive, such as extra leave and access to special payments. However, there were mixed views on the efficacy of these and how well these worked in practice was variable. In one force, the reward for those with no sickness absence over a twelve-month period is a certificate. Some within the force were pleased to receive the certificate but there was a view among others that such a low-level incentive could be counter-productive. One respondent identified this incentive as 'insulting' and 'insufficient'.

'All I get is a certificate every year that just goes straight in the bin.' (Manager)

Another force gave an additional day of leave to staff after a 12 month absence free period, and an additional day added to the end of their service (ie they could effectively retire a day early). The HR manager within this force believed the incentive worked well, particularly for those close to retirement age, but some focus group participants did not feel it went far enough. One particular criticism was that, where officers had been injured on duty, it was unfair that they did not receive an extra day.

In terms of what individuals felt would be the 'ideal' reward, some form of pay bonus was often mentioned. One force did apply some form of additional payment as officers with good attendance could become eligible for Compensatory Threshold Pay, which had become known in the force as a 'bonus for officers'. However, whilst this was felt to be effective by some of those interviewed, for others it was a source of irritation and discontent, particularly amongst police staff. There was felt to be a lack of parity as amongst staff there was no recognition for low absence rates. One individual expressed the view that they '*didn't even get a thank you*' and there was no good will gesture at all, '*even at Christmas*'.

Overall, therefore, whilst a few incentives are in use, it is difficult to say which approach is the most effective. There are always going to be problems for those who do not get the reward and in administering the rewards effectively. The level at which an incentive works is also unclear, although offering no reward at all for a good absence record is not helpful either.

8.2.5 Managing absence caused by work-related accidents and injuries

The main issue relating to absence from work-related incidents was the way that the management processes dealt with those affected. There was a strong feeling that in these cases

there should be a more flexible application of any sanctions, and that affected officers should be treated more sympathetically by the force.

> *'Where you've got front line police staff who can be injured they have to make a clear defined policy and where you are penalising people who have been genuinely front line injured by putting them on half pay, that doesn't help them come back. Then they're worrying about 'How am I going to pay the mortgage?'* (Trade union representative)

A number of training programmes were discussed that had been specifically designed to alert individuals to potential risks inherent in their jobs and to allow them to protect themselves more effectively. To some extent, these risks were seen as 'part of the job' for those in the front line.

> *'We've gone through an exercise with the training skills to see if we can do anything in terms of the training models that the officers get in self defence and restraint and there's little else we can do other than manage their sickness absence. Essentially we've reached a point where the training is to a high standard and that's being supported by HMI.'* (Manager)

8.2.6 Managing the return to work

Managing the return to work, from both short-term and long-term absence, can be a sensitive area. When the return is managed well, this can have a positive impact on an individual's relationship with the force.

The research found that the majority of those away sick were keen to get back to work and were frustrated if they could not do so when they felt they were ready. Views about returning were most positive where good contact had been maintained between the force and the individual (see above for more details on maintaining appropriate contact).

The research found a range of interventions that helped people to settle back into work after a period of absence. These are outlined below.

- Ensuring that the workload was appropriate was seen to be a crucial factor. Linked to this, phased return and back to work plans, involving restrictive duties and/or reduced working hours were seen positively. A gradual and planned approach to the return also allowed an employee's confidence to return.
- Sensitivity in handling the situation, particularly on the part of managers, was also seen to be an important factor. In some cases, although there may not be a visible sign of the illness, the employee may still have vulnerabilities. However, managers also needed to recognise that a balance needs to be found – interviewees in one force said that some managers can be afraid to give tasks to returnees, fearing that they would overload them.
- Non managers agreed that return to work interviews were generally conducted. They were thought by them to be not especially useful, although the overall view was still positive rather than negative.

In some cases, the actual process of taking sick leave, being managed whilst off sick, and the sanctions which eventually came into place all added to the difficulties in returning to work.

> *'The thing with long-term sick is you then start to get into the absence policy, then the capability policy which in itself generates stress.'* (Trade union representative)

Timing the return

A common issue was the timing of an individual's return to work. As noted above, the majority of those participating in the research expressed a strong desire to return to work while they were away and in some cases, frustration that they could not go back as soon as they would like. Many returned on the basis of some kind of reduced working hours or restrictive duties, which was mostly appreciated. Whether returnees subsequently moved back onto full duties and/or full working hours depended on the nature of the illness or injury.

The process breaks down where individuals feel hampered in their efforts to return, or where they feel they are being asked to return too soon. Often, the occupational health department was more cautious about the return than the individual themselves. The most positive experiences tended to reflect individuals being fully involved in the decision about when to return.

> *'I was hoping to go back for a few hours a day last week but I saw the force medical officer and he said no and that I need to pace myself or I will fall ill again. He said he will review it in a month.'* (Police staff/officer, currently on long-term sick leave)

> *'There has been no pressure whatsoever. I know from other members of staff, I've been a difficult case, but there's been no pressure for me to return back to work. It's been a case of 'look, everybody's coping very well without you. That's from my inspector right through to chief inspector and superintendent. Everybody is coping, please don't worry about it. Please get well and come back when you're ready.'* (Police Officer)

> *'My line manager was ringing me, calling to see me, colleagues were coming to see me … I'm coming back to work now and I'm not off light duties and he's saying look, go home if you're not feeling well. And you want to be in work, you want to be there because he's been so reasonable.'* (Police Officer)

Handling the return appropriately

Another issue was how the return to work was managed. A number of interviewees said that they could not fault their force on how their absence had been handled and that there was nothing further that they could think of that had not already been offered. Such cases tended to involve regular discussions with line managers and role adjustments (where relevant) that were seen to be appropriate and sensitive.

The majority of forces encouraged the use of back to work plans, either on a temporary or permanent basis. They were drawn up upon an individual's return to work, in discussion with the individual, and were held to be helpful in aiding return to work, as they gave individuals an opportunity to ease themselves back into their working life. In terms of those with physical ailments, plans contained elements such as desk working only, regular physiotherapy appointments, hospital visits and reduced working time.

In one force, returnees spoke of changes in their job, shift patterns, or office space, which made the transition back to work difficult. In the case of one returnee, they reported problems with 'hot desking', a situation that still had not been resolved at the time of interview.

> *'I was shunted round from desk to desk, if somebody was absent from work for a week I'd use that desk and then I'd use somebody else's desk and somebody else's desk until they actually ordered some furniture and got the furniture in to an office and they had to squeeze me into a corner of an office. And that's where I am at the moment.'* (Police Staff)

One focus group participant recounted a positive experience of how his sickness absence had been managed. He took long-term sickness absence as a result of heart attacks. The contact that managers and colleagues initiated was good and he reported not feeling under pressure to return to work. He was phased back into work and recounted that this went well. Initially, some adjustment needed to be made to his role. However, he then returned to his full former role, although was careful not to overdo things. One observation that he made was that it was possibly easier for him and for the force to deal with his long-term absence as his illness was physical rather than mental, and that he was not on front-line operational duties and could take his time in carrying out his job.

Making sure that there is enough flexibility built into an employee's return to work is key, to enable them to ease back into their former role, or a different role, as appropriate. One example of a barrier to this was a lack of facilities to work at home, which was seen as a potentially beneficial measure that forces generally failed to take up. This would also have helped in the case of those people who were fit to work, but could not drive, and therefore had practical difficulties getting to work, which blocked their return.

Awareness training for other colleagues may be beneficial, as the research found that returnees sometimes did not feel that they could carry the same workload as before from the start, but did not want to be treated too differently.

> *'Colleagues were talking to me slowly, in slow motion as if I was totally mental. For months after going back to work they were talking to me as if I was.'* (Returnee from mental health condition)

Difficulties after returning to work

Many of the difficulties that individuals had encountered after to returning to work involved how they felt about their return and how they perceived the views of others. Some returnees expressed a low level of confidence, in addition to feeling uncertain about being able to cope with their return. Further, some expressed concern that their physical impairment was restricting their ability to contribute. Linked to this, others said that they felt physically exhausted once back at work, and a few said that they experienced a range of side effects from the medicine they were taking, such as memory loss.

Fitting back in again was a concern for some returnees and they said that they appreciated time with managers on the day of the return and a prompt return to work interview. This also addressed any skills needs that they might have, such as a refreshing of computer skills. A key action following a return was also felt to be communication between the returnee and their line manager. This involved actions such as constant monitoring of individuals to see how they were coping, and the discussion of tailored interventions such as flexible working arrangements. Further, managers made sure that objects and targets were agreed and fully understood, including the time-frame to assume full duties. Regular reviews took place to see whether the targets were likely to be met.

Some employees who had returned to work on a full-time basis expressed the view that this was a bit of a shock, in terms of the change of pace. In the case of one returnee, a gradual return to work could perhaps have helped.

> *'I was that bored at home I just wanted to do something. People think 12 weeks off, it's great, but when you can't physically drive anywhere you're stuck at home and it's, 'What can I do today? I'll watch daytime TV again.' You get to a point where you are so desperate to come back to work and people don't understand. It's like, I want to come back, get me back.'* (Returnee after long-term sickness absence, physical complaint)

This links in with the frustration that many people on sick leave felt at the delays in getting the occupational health department to sign them off as fit for work (see section 8.1.4).

Employees in some forces provided examples of where staff had been offered a phased return to work, but that this was not managed well by the occupational health department.

> *'I know officers that have stayed off sick when they've been fully fit because the organisation can't pull their finger out to get them back on a planned return to work.'* (Trade union representative)

A phased return to work was welcomed by returnees, but disliked by some managers, since they felt at the mercy of limited information from the occupational health department. Further, managers sometimes felt that they would rather not have the person back until they were well enough to return full-time, as they found the situation of a partial return to duties more difficult to manage than the absence itself.

> *'I thought … well, are you coming back or aren't you? You're no use to me 3 days a week.'* (Manager)

8.2.7 Recuperative duties

All forces made use of recuperative duties to enable people to return to work after a period of sickness absence, usually as part of a back to work plan. There were mixed views from line managers on the general usefulness of recuperative duties. While many said that this was a good way of helping people back to work, some felt that the occupational health department can overlook potential knock-on effects on other staff when recommending adjustments and return to work measures.

A trade union representative of one force stated their belief that recuperative duties were something that worked well and were effective in easing employees back into their full role.

> *'They're intervening at an earlier stage, saying 'Listen, you can't come back on full operation duties, there's an office there in whichever department, you can work in that a few hours a day or a week', get them back in and sometimes that is beneficial, they come back into the family then, get their fitness back and then resume duties when they're fully fit.'* (Trade union representative)

Those who were on or had experienced recuperative duties expressed mixed views. The majority were frustrated that they could not do their former job fully, due to their illness or injury. Some, who felt fully fit, were also frustrated, although they understood the reasons for the restrictions. For example, a police officer attached to a traffic unit was able to appreciate that being on anti-depressant medication was a justifiable reason to curtail authorisation to drive outside the highway code (for example carrying out car chases).

A returnee from a physical injury accepted that she needed to be fully fit before she could resume her former operational role effectively.

> *'If you're an officer on the street it's more liable for them if they let you back too soon and you do yourself more of an injury or hurt yourself even more, then they have to cover themselves. If you're not ready to go back out I don't think you do a proper job anyway. You'll always have in the back of your mind, thinking, 'Should I run after that person? If I jump over that small wall, am I going to twist my knee again?'* (Returnee from long-term sickness absence, physical conditions)

Another returnee, while grateful that they had been able to come back to work, questioned the usefulness and meaning of the role that they had been given.

> *'It's more difficult to get something meaningful. If you want to come to work with an injury and they say you shouldn't really be … I should still be off now but because I'm in a role which allowed recuperative duties and restrictive duties, I've been able to come to work and probably saved the force about 6 weeks of sickness time. When I look around at our colleagues in the same department, the little bit that I'm doing is tiny compared to what they're doing. While you might say, 'Yes, well, come into work', they wouldn't necessarily find some meaningful work for you to do. You'd just be twiddling your thumbs around the office.'* (Returnee from long-term sickness absence)

The chance to go back and perform a slightly different role before moving back into his former role was appreciated by another.

> *'Work have been really good, they know the nature of the injury and they said, come back when you're ready, so I ended up having 12 weeks off and went straight back full time, which was a bit of a shock to my system. They've been really accommodating since I've gone back. I kept in close contact with my sergeant and inspector and since I went back they've got a role at my station for me which I'm enjoying. It's not as mundane as it could be. Hopefully, I go back [in a few weeks' time] in uniform. Not a day too soon.'* (Officer, returned from physical condition)

Some returnees said that they felt uncertain about their job role, as they were back at work, but unable to take on full duties. In some cases, people said that they were perceived to be fine, but were not feeling that way, as they needed time to adjust. Some recognition from managers and colleagues would have been welcomed that aspects of the job that would not have been problematic in the past now required a great deal of effort.

A greater focus on recuperative work may be needed in some forces, where there appeared to be not enough suitable roles for operational staff to let them feel that they were making a contribution when they were suspended from operational duties. Further, some officers and staff felt that their managers had had ample time to plan for their return, but despite this, no arrangements had been put into place for their return.

> *'There is an unwillingness to think outside the box and find you something to do … there should be back-up roles for returning officers.'* (Returnee from long-term absence, mental illness)

Another point made in the focus groups of one force was that even though it is the individual who has been on sick leave and is returning, there may still be a need to assess the strains of their previous post, rather than individualising a problem. This would ensure that attendance is maintained and may prevent sickness absence among other staff.

8.2.8 Restrictive duties

Restrictive duties are defined as a permanent change of role or job content for an individual officer who has had a health condition, with the aim of preventing retirement on grounds of ill health. Restrictive duties were used to aid return to work by all forces participating in the research.

There was a general view that this approach was successful, although in one force, there were concerns that some officers would probably never return to full front line duties. It should be pointed out here that there was some confusion on the part of interviewees in the research concerning the definition of recuperative duties and restrictive duties. While recuperative duties

are intended to facilitate an individual's return to their former role if possible, restrictive duties are a permanent change of role and/or job content and there should be no expectation that an individual will return to their former role.

An additional point is that where teams were small, having individuals on restrictive duties placed additional pressure on those at the front line, increasing their risk of becoming sick due to overwork. In one force, there were restrictions on being able to medically retire officers. This was viewed by many interviewees as aggravating the situation and blocking recruitment, while allowing an employee to remain on the payroll even though they were doing a different job or only carrying out some of the tasks in their original job description.

This view was echoed by the HR operations manager in another force, who stated that as the focus of the Home Office is on retention rather than retirement, this can cause problems within the force by reducing the number of officers available for operational duties.

> *'The number of people on restrictive duties reduces the number of people available to deploy in the event of day-to-day policing but also in the event of a major incident, which is a concern. If the focus is the advice we got from the Home Office, the focus should be on retention rather than retirement. That's fair enough, but we've got to also accept that then that has an impact potentially if we make reasonable adjustments and give officers a role where they're not required to take on operational policing duties.' (HR operations manager)*

In the force, particular problems were perceived with officers who were on restrictive and usually office-based duties. Several longer-serving respondents agreed that restrictive duties used to be viewed and applied as a privilege for people in their last few years of service. Thus, for example, after 25 years 'on the beat', an officer could 'wind down' to their retirement. These officers felt that this was generally justified, and it was backed up to some extent by the intention of the restrictive duties policy. Officers in their 50s would be less fit and strong and more susceptible to injury than officers in their 20s and it was only fair to recognise this in the roles they were designated. However, they felt that restrictive duties were increasingly being seen as a 'cushy number' by staff who did not want to do front-line police work. Thus, concern was expressed by some interviewees that the force was in danger of 'carrying' officers on full pay but on restrictive duties for the greater part of their career after only a few years' full service.

Staff and line managers in one case study outlined what they saw as a typical case of restrictive duties. This was a younger officer with a 'less honest' work ethic, who obtained support from occupational health to go on restrictive duties for his medical condition, either after a period of sick leave, or to prevent sick leave. He would implicitly use the threat of going (back) on sick leave to stay in that restricted post, which held influence with his supervisors, who had absence targets to meet: they would conclude that it was better to have him on restrictive duties than off sick. In the meantime, much to the chagrin of his colleagues, the individual would stay on full officer's pay to do a job that could have been done just as well or better by civilian staff on less pay.

Further, it was perceived that some officers moved around from one restrictive duties post to another, gaining experience in a range of areas, 'miraculously' becoming fit for full duty again for a period so that they were eligible for promotion, and going back on restrictive duties after promotion.

It was not possible to glean to what extent these illustrations actually portray officers on restrictive duties. However, the *perception* that this was the case throughout the ranks was common. A wide range of respondents felt that it was unfair and was detrimental to the morale of the force. Nevertheless, as pointed out above, there appears to be some confusion about the

purpose of restrictive duties, in that many had the expectation that individuals on these duties would move off them and back into their former roles. In reality, restrictive duties represent a permanent move to a different role or job content that aims to retain staff and officers rather than oblige them to retire on grounds of ill health.

Underlying these assumptions was the view that some people who were employed as officers did not want to, or could not fulfil their duties as an officer and thus should not hold their positions. For example, one line manager said that for this reason, he had banned discussion of a certain individual, or even mention of the individual's name, because it aroused such indignation among his staff.

Many of these sentiments were echoed by staff and officers in a force, who felt that people on restrictive duties could be difficult to deal with.

> *'They want to come back, they're doing their best, but … in some ways they are antagonising the situation, because they're not actually doing their job, so they seem to be just hovering or sitting round, and there's a lot of speculation, 'What are they doing?'* (Police Officer)

In terms of those actually on restrictive duties, there was a mixture of feelings. Gratitude was expressed for the accommodations made, but there was also a concern to be seen as a normal employee within the workplace. Some returnees also expressed pride in putting their uniform back on following a return from sickness absence, even though they were on restrictive duties.

8.2.9 Retirement on grounds of ill health

There was a view that the absence of historic early retirement options was driving up long-term absence. This was seen as partly the result of an ageing workforce, but also the repeated long-term absences of some individuals who, in the past, would have received a medical retirement. It was now considered difficult to medically retire officers who would be unlikely to be fit enough to return to duties, owing to restrictions on such retirements. This presented the need to redeploy such individuals elsewhere in the force. The resultant impact on absence was that some of these officers were felt to be more prone to bouts of long-term illness.

> *'If you wanted to sort out a lot of long-term sickness … if they fell in the disabled box and you couldn't redeploy, you've got massive costs. The quirk on the police pensions, for a civilian, is if you're disabled, and you can't do your job you'd normally qualify for an incapacity pension. The police regulations don't work like that: if you're disabled, and you can't do the ordinary duties of a police officer it then falls on the authority to decide if they can redeploy you. If they can, you don't get a pension even though you're permanently disabled in the meaning of the regs. That's why the police service has lots of people on recuperative duties, permanent and temporary restrictions.'* (Police Officer)

8.3 FACTORS AFFECTING THE MANAGEMENT OF ABSENCE

In addition to the different roles and procedures used within the absence management process, there were a number of specific factors which were seen to affect the success of forces' approaches to absence management. These included the way in which individuals were treated with different health conditions and the extent to which the organisation was seen to understand the issues faced by them.

Perceptions of what was causing absence and the perceived difficulty of managing this was another issue that surfaced during the research. For example, the issue of shift work was

commonly discussed by research participants across a range of forces as a cause of absence with the result that in some forces active steps were being taken to change shift patterns. However, from the questionnaires, only two per cent of managers and four per cent of staff specified this as a problem. This could reflect differences in the way that individuals respond to face-to-face interviewing versus a written survey. However, it could also reflect the fact that the most common causes of absence are not those that are the most emotive for staff or most difficult to deal with by managers. Therefore dealing with the most common causes of absence alone may not be enough to affect real change in attitudes. The main causes, such as infections or back conditions, are often not those which individuals tend to talk about as most pertinent or problematic.

8.3.1 Non-health related absence

The way in which the matter of non-health related sickness absence was handled, however, was felt to be very important by research participants. It was acknowledged that taking frequent absences for non-health related reasons could affect how other staff and officers felt about the absence management culture of the organisation.

> *'We start from a premise that we would like to think that all absences are genuine, so it's then focussing down on those that we feel aren't and we manage those through the number of people we have on the trigger points. So if they've had a number of absences, we'll manage them that way. I think we have some people we could do with getting back earlier.'* (Manager)

> *'Getting the balance right between them knowing that if they're poorly they'll be looked after and them knowing that if people are off sick and shouldn't be off sick they're going to get managed is a really difficult balance to strike.'* (Chief Constable)

In some forces, it was felt that better data analysis might help to determine the scale of the problem and whether action was required in relation to non-health related absence. A related issue, however, was that whatever monitoring system was introduced, certain individuals would always be able to manipulate it if they wanted to. It should be stressed that an effective policy can play an important role here in tightening up any loopholes.

> *'I don't think we do enough to know whether it's genuine or not. I don't think our policy targets people who are persistently absent, so even if you're not genuine and you just have a day off every now and again, you don't ever hit any of the triggers on the policy, so in terms of how we manage it, we tend to focus on people who are genuine. If you're not genuine you probably get ignored. People know how to play it.'* (Manager)

8.3.2 Understanding and preventing mental ill health

How psychological rather than physical conditions were handled was a particularly concern. In a number of forces, those with mental health problems felt that their force's response was significantly less sympathetic than it might have been, had they had a physical injury, particularly if that injury had occurred on duty. As a result, there were a number of cases where individuals with experience of absence through mental illness felt that it was not dealt with satisfactorily.

There were a number of examples where employees felt that their force needed to take a more preventative approach to mental illness and that managers needed to be trained to intervene earlier to avoid an employee going off sick with a stress-related complaint.

'I've lost count of how many people in 15 years I've seen have nervous breakdowns in this job. Once they start down that slippery slope they're not picked out quick enough. The signs are there, then bang, once they've gone, they're off work. Supervisors need training, what to look for, signs and how to identify things.' (Police Officer)

'Until I became very unwell with stress, I was not put into contact with them (occupational health) … I was very severe and nearly at breaking point when my help came. I'm slightly resentful. If it had come before … I might not be in the state that I'm in now.' (Police Officer)

Where steps had been taken to change attitudes or policies regarding psychological issues (particularly in one force), there had been a change in attitudes and earlier reporting of mental health issues. In these forces there was no longer such a stigma attached to admitting stress or other mental health problems, which was seen to have had a preventive effect.

'There are even a number of people appealing to us who are stressed who haven't gone off work but who are looking for help, which I think is positive …. There is a bit of a sea change in terms of people understanding there's help here and seeking help before it becomes a crisis …. The culture within the police is changing, but that reflects the sea change in the culture in society. You are no longer seen as somebody who is weak if you admit to the fact that you're stressed about something.' (Occupational Health)

A lack of good data on the extent of mental health problems within forces was raised as another potential issue. Without effective monitoring information it was often difficult to fully understand the scale of the problem or to draw conclusions about the role of work in causing symptoms/illness.

'It turned out it was only about fifteen people, but they would go off with stress, they would return, something didn't quite go right or it didn't work out or it wasn't handled in the correct way. And they would then go off with depression. And it just seemed to be a vicious circle for them. And at no point, I think, had the underlying cause of that been identified.' (Manager)

8.3.3 Managing psychological illness

There was some evidence to show that how well long and short-term sickness absence was managed varied according to whether the absence was caused by physical or mental ill-health.

Generally, managers seemed to find dealing with the absence of individuals with mental illness was significantly more difficult than dealing with physical illness. This was fuelled by a lack of understanding amongst managers about mental ill-health. One manager, for example, contrasted dealing with the recovery of staff from mental illness with returning to work after surgery. He felt that mental health issues were less 'predictable' given that health professionals were often able to estimate with far more accuracy the time it would take the individual to return to work after surgery, and be more prescriptive about the adjustments to work which would make the return easier.

The difference between the experiences of those with physical and mental illness was even more pronounced if people felt that their condition was caused by work pressures, including pressures from the same line manager who was then required to help them back to work.

'I was being bullied at work. That wasn't investigated, which is what resulted in me going off. I then came back and was faced with the same bullies … I was very depressed and then, you're off with depression and they send an inspector round to give you a formal warning that you're off sick.' (Returnee from long-term absence)

The issue of stress could be particularly difficult for line managers to deal with. One reason for this was that police work is considered 'stressful' in itself. Therefore work 'stress' is often considered an occupational hazard, rather than something that can be managed. One Police Federation representative, for example, gave the view that it was unrealistic to expect that police work should be anything but stressful and that the recruitment procedures should make this clear. There is often, therefore, unwillingness for forces to take responsibility for stress, with the implication that individuals need to be able to 'cope' with the demands of police work.

> *'When I talk to one of my members and they say, 'I'm just stressed' … you go, 'I can't understand why you joined a job that's full of stress anyway', because you can't go to a road accident and expect to be a clean scene, there's going to be somebody killed or … blood and mess that's there and if a police officer didn't expect to deal with that, then you've started in the wrong job. And it goes back to very basics in the beginning really, you have to look at how we recruit and what recruits are expected to do; we should be clear about what we're doing, because that would take out an awful lot of this issue around stress.'* (Trade union representative)

Some of the cases where individuals had the most negative experiences of sickness absence management involved some form of dispute with their line manager or colleagues. There were a number of cases of this type encountered in the research, although it is difficult to tell whether there were any widespread problems, either within certain forces or across them. It is also important to note that this research was not able to link the views of line management with individuals regarding case management.

One police officer discussed his experiences, in terms of being victimised at work. He reported that the victimisation escalated and he eventually became too ill to work. He felt that he lacked support in the early stages of his absence, in particular in discussing his stressful situation at work. Eventually, he went off sick.

> *'There was nobody to talk to …. The people I did try and talk to like the unions, they were very adamant if you told them anything that was inappropriate, they were going straight to management, so I felt trapped, I had nobody to tell bar my wife.'* (Police Officer)

Threats of proceedings for unsatisfactory performance were made which added to his stress and prompted a premature return to work. However, he eventually needed to take a longer period of sickness. At this stage, he began to receive occupational health support. After this, he was offered a phased return to work on his own terms and given a rehabilitation plan, which he said was being partially followed. Discussing the situation after the event, he thought that confidentiality was a particular problem in his force because it was relatively small. He also thought he would have benefited from a service through which he could receive confidential advice on police work and from better line management arrangements.

> *'If we had had some confidential body or someone you could talk to even if the allegations were criminal, I think that would have relieved the stress and worry knowing someone could give you advice.'* (Police Officer)

> *'On a team you tend to have 3 or 4 sergeants and one inspector and each one will tell you to do something different every day …. If you have problems you need to be able to go to the same person so they have an understanding of your whole situation. If you keep going to different ones all the time they only get part of the picture and they can't form a full opinion. You need to have an individual sergeant. You do technically have one who is a reporting sergeant, who does your reports every year but you wouldn't necessarily go to the same sergeant with your problems or hassles.'* (Police Officer)

One theme that arose in many focus groups of long-term sickness absence returners was the fear of being watched and judged by colleagues when absent. There were many stories by people in the focus groups of 'well' staff who referred to seeing someone out who they felt did not look ill or who went on holiday even though they were meant to be ill. This was particularly the case with those absent due to mental health conditions, with these returnees feeling that they needed to be house-bound in case colleagues saw them out and about and wondered why, if they were well enough to be out, they weren't well enough to be back at work. Examples were given of people travelling long distances to go walking or shopping in order to avoid colleagues.

> *'I went to see the doctor and she said, what do you enjoy doing? I said I enjoy walking and cycling. She said, get out there and do it. I didn't. Because I knew for a fact that if I did, if somebody saw me, I'd immediately be criticised.'* (Returnee from long-term sickness absence)

8.3.4 Conflict with managers

If a particular individual, including a line manager, was the main cause of the problem leading to long-term sick leave, it is important that the situation be reviewed upon the return of the employee. In such cases, the fact that an employee was going back into the same situation following the absence was seen as a significant barrier to returning to work. This was the case across a number of forces, with some focus group participants stating that they had actually gone back to work, found the situation unchanged, and subsequently been forced to take another period of sick leave.

In contrast, one participant gave an example of a successful return to work, where their concerns had been addressed.

> *'I have had improvements from the head of personnel and assurances that things have changed and I know that they've changed. I feel more comfortable, my line manager's changed.'* (Police Staff)

8.3.5 Ability of occupational health to provide sufficient support

There was across a number of forces the view that the occupational health response to stress-related illness was inadequate. An officer described a situation where a person with stress or depression might be referred to a counsellor but will receive only a fixed number of counselling sessions rather than enough treatment to ensure that they have made suitable progress before counselling is terminated. It is not clear whether in-house or outsourced counselling services are more effective in this regard, but generally limiting the number of sessions with either type of counsellor was felt to have the potential to be counter productive.

> *'Somebody in this force with stress or depression will possibly be referred through Occupational Health to a counsellor. They will get a maximum of 5 to 6 sessions, then they will not fund it any more. The neighbouring force have 2 consultant psychiatrists, a psychotherapist, counsellor and an in-house nurse where you can use them indefinitely.'* (Police Officer)

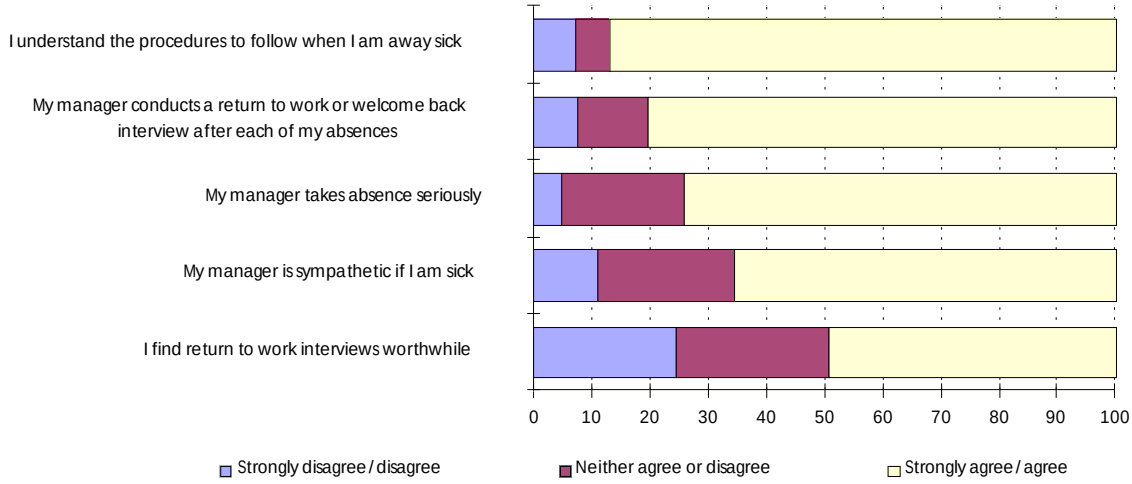
8.4 VIEWS ON PROCEDURES USED

In order to get a general overview of how individuals viewed the absence management procedures in place within their force, focus group participants completed a number of questions. Using a five point scale ranging from strongly disagree to strongly agree with a mid point of neither agree or disagree, respondents were asked to state how they felt about the

different components of absence management procedures that were used. The views of non managers and managers are presented separately in Figures 8.1 and 8.2.

Amongst non managers, overall, the balance of views was positive about absence management procedures. The vast majority of non managers, 87 per cent, either strongly agreed or agreed that they understood the procedures to follow when they were away sick. Four out of five reported that their managers conducted a return to work interview after every absence and 49 per cent of non managers felt that these interviews were worthwhile. However 24 per cent disagreed with this view. Managers were seen as taking absence seriously with 74 per cent of respondents agreeing with this statement, and managers were regarded as sympathetic in their approach by two thirds of non managers.

Figure 8.1 Non-manager views on absence management procedures (%)



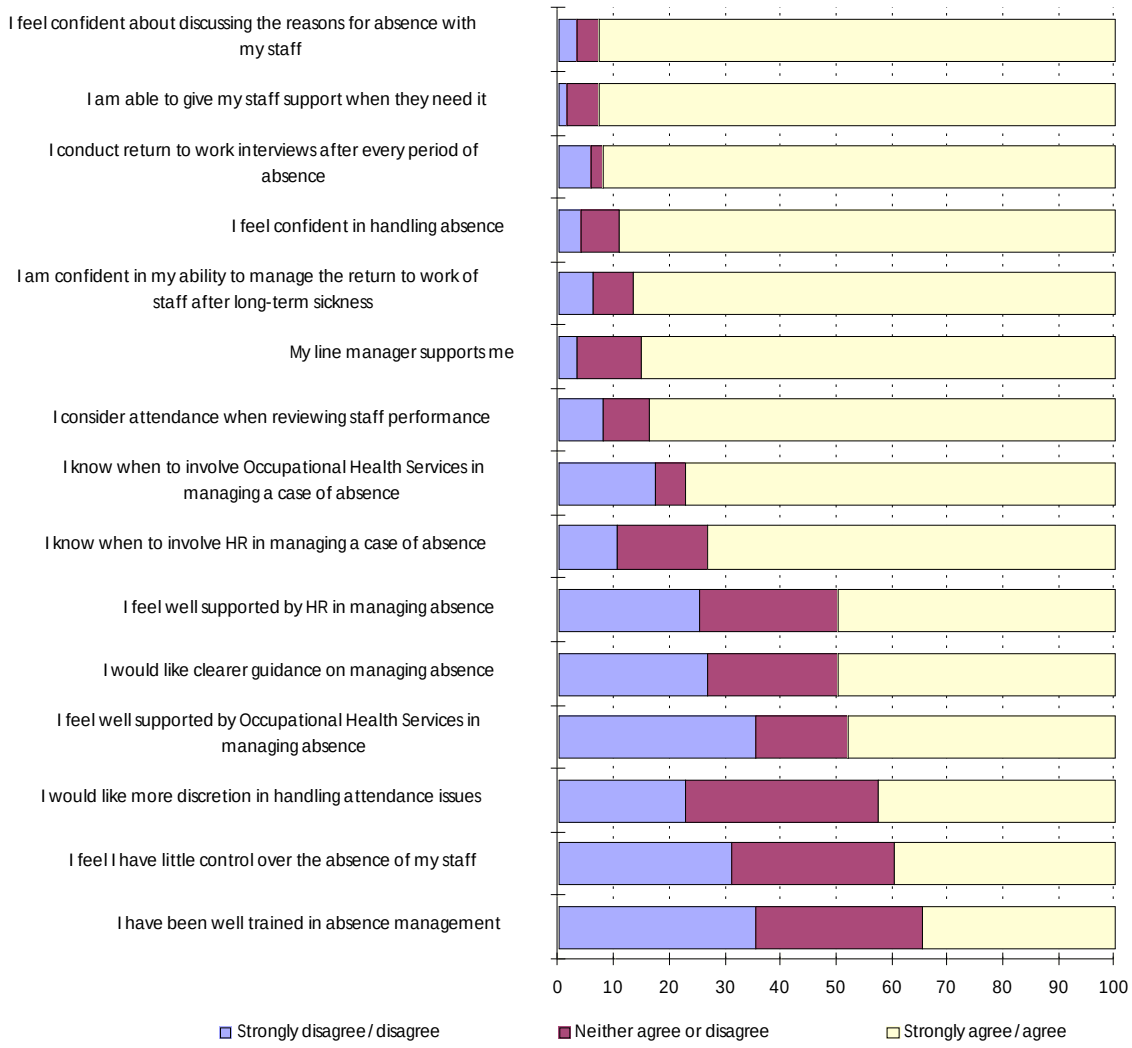
Source: IES Survey, 2007

Managers were asked a wider range of questions to probe their confidence in implementing absence procedures. Their responses are shown in Figure 8.2. It can be seen that they felt confident in handling absence and discussing the reasons for absence with their staff. Most claimed to be conducting return to work interviews after every absence and to be able to give their staff support when necessary. Seventy seven per cent thought they knew when to involve occupational health and 74 per cent understood when to refer to HR in managing an absence case.

Only half of respondents felt well supported by HR and a quarter disagreed with this statement. Similarly, just under half of managers, 48 per cent, thought they were well supported by occupational health but just over a third felt that they were not. Half also would like clearer guidance on managing absence and 35 per cent did not think that they had been well trained. Forty per cent felt that they had little control over the absence of their staff.

The responses present a slightly conflicting picture. Managers generally feel personally able to manage absence and, in fact, 43 per cent would like to use more discretion. However there is some feeling that the support given by occupational health and HR could be better and that more training would be beneficial.

Figure 8.2 Manager views of absence management procedures (%)



Source: IES Survey, 2007

8.4.1 Relative problems of short-term and long-term absence management

The view of senior managers on whether management of short-term and long-term absence was effective varied between forces, depending on the force's record for absence. Most could identify areas for improvement.

There was a view from line managers in many forces that short-term absence was more problematic to manage than long-term absence, due to the fact that it was usually unplanned and at very short notice. This may also be true for the beginning of a spell of long-term absence, although once it is clear that an individual will be off work for a longer time, plans for cover can be made. For many line managers, dealing with long-term absence was seen to be less problematic than managing short-term absence. There were fewer problems in covering rosters, for example, as changes could be planned more in advance. However, another side of this was that to deal with long-term absence, line managers needed to work successfully with other departments, such as occupational health, or absence management committees which often included HR. Further, the majority of managers thought that performance discussions, in line

with MTF recommendations, should include absence – 79 per cent agreed or strongly agreed that they should, while 11 per cent were neutral and ten per cent disagreed.

Unexpected absences caused difficulties for line managers and whole teams, particularly when they resulted in the cancellation of planned operational work, such as the supervision of football matches or attendance at neighbourhood watch meetings.

> *'It's the people who dip in and out that just take the odd day that actually create the bigger problem. The long-term you should be able to manage it: you should be able to deal with them; you should be able to offer them alternatives. The short term … is unpredictable … you can't cater for it.'* (Trade union representative)

There was also a view from focus groups that short-term absence puts even more pressure on operational officers – who often feel already overstretched – as they need to cover for absent colleagues. Linked to this, many officers and staff stated that they felt guilty about taking short-term absence, knowing that it had placed additional pressure on their colleagues.

> *'You feel so guilty because somebody's doing your work, trying to cover, and in the attendance policy it reiterates that you should let that person know.'* (Staff)

Overall, there was considerable variation in the way that those who had experienced a period of short and long-term absence viewed the support they had received from line managers. Individual approaches and relationships could be incredibly supportive, or cause a major problem. Therefore it was important that those away sick had access to others, apart from their line manager, to ensure a positive experience.

Finally, there was a view from some individuals that whilst absence management was becoming an increasing priority for senior staff, this was only related to their need to meet their own targets rather than a real concern about staff health.

8.5 SUMMARY

The management of both short-term and long-term absence is central to any force's absence policy and practice. Overall, questionnaire data suggests that individuals and managers are fairly positive about the procedures in place within their force for managing absence and their ability to understand and follow them. However, whilst there is a general acceptance of the need to effectively manage absence, in trying to reduce the amount of sick leave taken, it can be difficult to introduce policies which staff recognise as fair.

In returning to work after a period of absence, the role of line managers and colleagues was key. If managers and team mates were sceptical about the reason for an individual's absence this could make their return to work difficult. Line managers also have a role to play in promoting a supportive atmosphere and in building a motivated team to promote attendance.

There are often high expectations about the role of line managers in the process, but it is important for them to have appropriate training, the support of HR and occupational health, a clear understanding of force policies and the ability to use aspects of policy flexibly to suit the individual case in question.

Occupational health was often seen to be under-funded, with the result that their response could be slow or inadequate (particularly in the case of outsourced counselling). However, individuals were generally very supportive of the role played by occupational health, particularly in cases where line management relationships or work factors contributed to the health issue. Having a third party to represent the interests of the absentee was seen as very important in some cases.

Maintaining appropriate contact with individuals whilst they are off sick can be challenging for managers. What is right for some individuals in terms of frequency and type of contact does not work for others. Finding a balance between intrusion and support can be difficult, particularly where the individual representing the force is part of the problem from the perspective of the absentee. The reaction of colleagues to individuals on sick leave can also be problematic, particularly in cases of mental ill-health where absentees may fear being seen outside of their home by work mates whilst 'looking well'.

The use of pre-specified 'trigger points' or points at which the level of sick leave results in management action being taken differed to some extent across forces. In the two forces using Bradford scores there was a widespread view that it was overly punitive and rigid.

Withholding special payments for officers was felt to be a useful motivator, but needed to be sensitively handled in cases of work-related injury. The removal of increments for staff, however, was criticised in that rather than being a 'bonus', this affected actual levels of salary and could impact on wages for more than just the year where the absence occurred. Limiting promotion activities was another measure used within forces, but in cases where an individual demonstrated good performance and their absence was felt to be genuine, this could have negative consequences. This was true for both the individual and the force, which could lose the skills of valuable staff through the imposition of this rule.

The use of incentives in some form was also common, but there was little evidence of any particular form of incentive being more effective. Differential payments could prove divisive, as could the allocation of additional leave days to those with good sickness records. However, not offering any incentive at all was also viewed as counterproductive.

Managing a successful return to work raised further challenges. Ensuring that the timing of the return is appropriate for the individual is a major contributor to how individuals feel about coming back to work. It is important that they are neither pushed too hard to return nor held back inappropriately due to procedures (eg blockages in the system as caused by occupational health constraints or difficulties in implementing timely adjustments) when they are clearly ready. In addition, being seen to offer flexibility in how individuals return to work, and making appropriate adjustments for them were key factors in effective re-entry to jobs. However, such adjustments do need to be brought in with the support of colleagues and line managers or it can be difficult for returning individuals to operate successfully. Ensuring that individuals are involved in the decision about when to return to work and how to do so is one way of facilitating successful returns.

The experiences of those returning from sickness absence suggest that it is vital that managers communicate clearly about what is expected from individuals on their return, setting targets where appropriate and conducting regular reviews of progress. This allows the return to work arrangements to be adjusted where necessary in a timely manner. In addition, it was suggested that forces should not only focus on the individual returning to a role, but also the role itself and ask whether the nature of the post in question is part of the problem. By accepting some responsibility where appropriate, the force not only helps the individual in question but can also help to prevent future absence by others in a similar role.

Forces all offered recuperative duties as methods of helping individuals return to work swiftly. However, such roles need to be tightly managed to ensure that colleagues do not see individuals performing them as 'getting off easy'. Again this can be more of a problem in cases without an obvious physical injury. Ensuring that individuals feel they are getting back to normal duties as quickly as possible is important. Where individuals recounted difficulties in their return this was often due to how they perceived the reception they had received from colleagues and managers, particularly how the role they had been given was viewed. Where individuals were experiencing

fatigue or side effects from medication, they could also find it difficult to adjust to being back at work.

There was some confusion around the perception of restrictive duties, with some research participants viewing this as a stage on the way to getting back to full duties. However, the purpose of restrictive duties is to allow individuals who can no longer perform their individual role to remain in the force, rather than retiring on grounds of ill-health, by performing a changed role or changed job content on a permanent basis.

Managing psychological illness was often more problematic for managers and forces than managing physical conditions. This was due to a range of factors including a lack of understanding about mental ill-health, difficulties in planning a return to work without clear timescales (contrasted with better information regarding physical conditions) and in some forces a lack of ownership of the problem – working for the police is seen as 'stressful' so individuals ought to be able to 'cope' as part of their job.

The management of long-term absence is generally seen as less difficult than short-term absence as managers are better able to provide cover for those off sick. However, there are a number of specific factors in successfully managing long-term absence. Line managers and occupational health in particular have key roles in the process, and it is important that the two parties work closely together, and with the support of senior staff.

9 PREVENTION OF ABSENCE AND WELL-BEING AT WORK INITIATIVES

This chapter looks at issues surrounding the prevention of absence and accidents, and the types of well-being at work initiatives implemented. Most of the forces in the sample had some initiatives to prevent sickness absence occurring and initiatives were also in place to prevent absence from being counted as sickness when it was due to other reasons, such family problems or other non-work problems.

9.1.1 Special leave

Whether officers and staff could obtain time off to care for sick relatives or to deal with family-related problems, such as a breakdown in childcare arrangements, often depended on individual line managers. The research found that some line managers were supportive, while others put more pressure on officers and staff to attend.

One force had a policy of granting leave of up to five days for family emergencies but from the focus groups, it was clear that knowledge of this policy was not widespread. In another force, where absence levels had improved significantly, the Chief Constable noted that the force had put a range of measures into place that had been successful in reducing absence levels. One of these was a policy that allowed people to be honest about taking time off for family-related events rather than calling in sick.

> *'By that I mean people going sick because they had a major family issue to deal with. There is no other way of dealing with them having to take the kids to the dentist, they go on sick. Yes there is. Go to the dentist but don't put in sick for it. We now have an arrangement where for family reasons, fairly wide, or put it another way, you need to be at home today, you do it, we want to know you've done it and don't take the mickey. And there's a maximum of 5 days. Some people use it, some don't. Booking yourself off sick to do it, a) damages the sickness rate; b) is a lie and c) can cause all sorts of consequences.'* (Chief Constable)

The view was very much that each case needed to be looked at on its own merits in another force and a package of measures was available to encourage a return to work tailored to particular individual situations.

In the case of special leave arrangements, one view expressed was that if the procedures surrounding special leave were too complicated and it becomes too difficult for individuals to access it, then it might be more convenient for them to take sick leave instead.

The same could apply if individuals feel that their managers are not supportive of those who use special leave days, or that in some way it affects views of their performance. Therefore again, as with many interventions, simply having arrangements in place is not enough – they must be sensibly implemented and have the commitment of management. Two contrasting examples were encountered in the research.

> *'… it makes you feel really guilty for being off, when I've done everything that I could possibly do to come into work and … I had no choice but to look after him myself, and it's not a regular thing, but you have to put this report in and explain it fully. Your life story to go through to the Chief Super to say, 'Yes, you can have it; no, you can't'. I didn't know until a couple of weeks after whether or not I'd been granted that. You feel so guilty for that. It would be so easy to just ring in sick. Yes. I could have just rung in sick.'* (Police Staff)

'I've found that one of the team … put in leave to cover his getting over the death of a close family member and it sounds as if the reason he did it is because he didn't want it to be discussed going through various managers, supervisors, HR; he just wanted to stay away from work until he could cope with himself and then come back. And because he didn't think that would happen he chose not to highlight it and just take leave. So when it came out what had happened, I called him in and spoke to him and I gave him back his leave, which I can do because it's at my discretion. He said, 'Oh, right'. I said, 'And to prove how discreet the service can be … do you realise you're not the only one on the corridor in exactly the same position'. He said, 'I've no idea'. And it changed from then on. He was suddenly a lot more open. Whenever there's a problem now he comes to me and describes the problem and discuss what we can do, whereas before he decided he was going to manage it himself.' (Manager, Staff)

Some managers said that they allowed their staff to take annual holiday leave instead of sick leave, while others did not. Other line managers said that they were more likely to prohibit their staff from doing this when their resources were under pressure. They felt that this was likely to reflect poorly on their management and lead to criticism that they were allowing their staff time off when they were under-resourced.

9.1.2 Flexible working

Measures that were found to be effective in preventing sickness absence included flexible working and in particular allowing employees with young families a greater amount of flexibility in terms of working hours and start times and changes to duties. The introduction of flexible working was seen as a successful tool to address short-term absence in some forces, although its use often depended on the discretion of the individual line manager. In preventative terms, some forces were successfully putting into place a working system that allowed employees to balance work-life commitments without recourse to sickness absence. In one force, flexible working was being piloted among the staff and the view from the focus group was that it was working well and allowing people more flexibility to set their working times, thus reducing potential sickness absence.

'It hasn't radically changed people's working patterns, but, one of two of the younger ones who don't like to get up particularly early, but they're quite happy to work until 7. So, you know. Somebody was feeling a bit down one day so she didn't turn up until nearly 11 o'clock. She had a lie-in and she felt better for it. She was quite happy to work until 7.' (Line manager)

According to the survey of focus group attendees, a significant proportion of managers agreed that flexible working has helped to reduce absence, almost half, 49 per cent, agreed or strongly agreed that it had, although 42 per cent held a neutral view with nine per cent disagreeing or strongly disagreeing.

The positive impact of flexible working on work life balance was recognised by many participants in the research. The feedback from staff focus groups was positive, with participants stating that flexible working had contributed greatly to a better work-life balance and a reduction in stress levels.

'Individuals feel a little bit freer now … because they haven't got to have their lunch between 12 and 2, providing they work within the health and safety and not work more than five hours without lunch. What they could do is come back that bit later and work that bit later, so they might want to come in at 11 and not have to ask if they can have a morning off, because they come in at 11 and they can work till seven. Providing they get their hours in. That's given that bit more freedom. And I know is that there does seem to

be a bit more of a relaxed attitude, that tension's gone. Also as well as promoting the actual work life balance policy of working different hours so, working the hours, compounding the hours so an individual can have one day off in a fortnight. People have started doing that and that's helped tremendously and you can almost feel that relaxed attitude. It's not a come day go attitude, but it's again, it's the individual managing the work life balance so that they've got a life as well as work but they're getting the work done.' (HR business partner)

9.2 ACCIDENT PREVENTION

Accident prevention was a key area of activity for the majority of the forces examined, and an issue that links into the physical illness and work environment issues raised in the chapter dealing with the reasons for absence (see Chapter 7). One force had a three-year plan in place to reduce accidents and any types of incidents, including psychological, that might result in employees needing time off.

'We have a 3-year plan on health and safety and we have objectives in there to reduce certain types of accidents that result in time off work, slips, trips and falls, manual handling, psychological. All those are backed by advice and training from the health and safety section and we'll be dip sampling. They've already dip sampled stress risk assessment but they will be dip sampling throughout the year things like maintenance inspections for ladders to try and prevent. A lot of their work is on accident prevention.' (Senior manager)

In another force, the force doctor was keen to reduce the number and severity of accidents and injuries in police patrol cars, maintaining that interventions such as warm-up exercises and the correct adjustment of headrests could reduce accident and injury rates.

Doing warming up exercises in the morning before they get in their car or whatever … would be quite a good thing. If you could make people slow down for instance and just adjust the seats in their cars before they get in the patrol car just to see that they've got the right headrest height, little things like that to a large extent. Because I've seen a couple of people now who had whiplash injuries, tall guys, small cars and they have hyper extended their neck when they have gone into a shunt. If we can actually encourage people to look at things like headrests and things like that we might just be able to reduce [injuries].' (Force doctor)

9.3 HEALTH AT WORK INITIATIVES

Most of the forces in the study had initiatives in place to prevent sickness absence occurring. However, these were rarely evaluated for their effectiveness. A number of general initiatives were discussed, including the following:

- Mobile health checks, which were judged by occupational health departments or those organising them to have been successful, due to the high numbers of staff attending.
- The offer of 'flu vaccinations. The force offering this wanted to use its sickness absence database to see whether this has led to lower sickness absence levels, although was finding it difficult to find the data to support this.
- Discounts from local gyms, which occupational health departments reported had led to higher than normal sign-up and use levels.
- Nicotine replacement therapy
- The offer of fruit baskets to officers and staff at the workplace
- Complementary therapy and massage to officers and staff.

9.3.1 Home Office-funded initiatives

In addition to the general initiatives mentioned above, Home Office funding was available to police forces in England and Wales to help reduce sickness absence and improve the health of police officers and staff during 2002 to 2006. The Home Office aimed to reduce sickness absence levels, using a range of measures introduced by the Strategy for Healthy Police. Under this, funding was available to police forces to implement measures and evaluate their outcomes. The Home Office initiative stopped in 2006 and it is now being taken forward by ACPO to 2010 but no further funding is available.

A range of specific initiatives that used the Home Office funding were identified by the participants in the research. Most detail was given about schemes to provide access to private medical treatment and the funding of additional occupational health staff.

Providing Access to Private Medical Care

Some forces used funding for private scans or operations which they thought would shorten sickness absence periods. A number of managers recounted individual cases of an employee being offered private medical treatment and returning to work more quickly. For example:

> *'We had a whiplash injury and the guy's GP was sending him off for physiotherapy and his sessions came to an end and he was still [seeing] no improvement, and when [the force doctor] saw him, he referred him to a clinic in [a nearby town] and within a matter of 2 weeks sorted this injury out. That was fast tracked and the force paid for that. You can see the logic. If it costs say £200, it was a saving of £200 against a month's salary.'* (HR Manager)

Evaluation reports on the effectiveness of these measures had been provided to the Home Office, showing the waiting time saved by providing access to private medical care and enabling employees to return to work more quickly.

> *'We've provided evaluation reports to the Home Office … I think we saved 19 police years in waiting time over a 12 month period by paying for surgery. You would have had to have waited longer to get your treatment. We treated you earlier which means you can go back to work earlier.'* (Absence data manager)

In another force, funding private medical treatment was an issue for debate, with some managers expressing frustration this was not used more, as they thought it would save a force a considerable amount of money in sick pay.

> *'What I am frustrated by … is when people have a diagnosed illness or a need for a sort of surgical procedure and they are then put on a waiting list and sometimes that means that they are not allowed to come into work until that procedure takes place and the frustration is that the force just haven't got any funding available to … say, once this procedure is done, that person would be back at work within a set period of time …. They don't seem to think that this is money that we are wasting at the moment … sometimes it is a considerable amount of money being paid in sick pay but they don't look at the wider picture by saying we have an amount of money set aside to fast track that small surgical procedure, we could get that person back to work and obviously the money that we pay for that person being off on sick … they would actually be working and earning that money.'* (Line manager)

There was some acknowledgement by focus group participants in this force, however, that 'fast-tracking' police officers through the NHS may not be acceptable to the wider public as it might appear that the police force was receiving special treatment.

Additional health staff

Many forces used Home Office funding to provide posts within the occupational health department, usually on a temporary basis.

In one force, a temporary Attendance Manager post, an additional Welfare Officer and an extra Health and Safety Officer were funded through the Strategy for Healthy Police. Other Home Office-funded initiatives mentioned in the research included physiotherapy and rehabilitation equipment, and stress and working life policy audits.

9.3.2 Reducing stress

The research found evidence of a variety of initiatives aimed at promoting healthy lifestyles and reducing stress. One of the most substantial of these encountered in the review was in one force which operated a 'Healthy Minds at Work' initiative, based on an external partnership.

This initiative was composed of a number of elements, including a self-referral scheme, where people who felt that they were under stress or had work-related issues can talk on the phone with trained staff. It also contained self-diagnosis software to enable employees to find out whether they were under stress or in danger of becoming over-stressed. Two members of the occupational health department were partly funded through this initiative and the local authority provided a further member of staff to help them. There is also a network of trained wellness advisers in the force. Staff, officers and line managers expressed support for this initiative, as had the Chief Constable, who noted that, in contrast to many initiatives, this focussed on mental well-being rather than physical health.

> *'The Healthy Minds at Work thing is about a two- or three-year programme to do it in the area where we haven't been covering, which is the mind. As important as the body. They're inextricably linked'.* (Chief Constable)

Another force successfully ran a stress e-learning course, designed to guide managers through the protocols of what to do with officers in the event of a work-related stress problem. The initiative was piloted and judged to be successful and was at the time of the research being rolled out across the force.

9.3.3 Healthy eating

One force had run a healthy eating and no smoking campaign in its canteen, aided by external advisers and other departments within the force. This event was judged to have been successful, based on criteria such as the number of people who attended the event. The only form of assessment took place in a debrief meeting after the event.

> *'What we tend to do is put ourselves fairly close to the rest areas – canteen areas. We did a health promotion about four weeks ago in the canteen on diet and smoking. We were side by side. We had somebody from an external organisation come in, we had the force doctors and nurses down there, and we did healthy eating in the canteen, so we got the contractors service provider to put on a healthy eating day so they basically designed a wok style menu with vegetables and things and it went down very well. So, we'll do things like that and we'll consider extending that to other divisions where we can do that.'* (Health and safety adviser)

9.3.4 Evaluation of initiatives

There was not a great deal of evidence of systematic and rigorous evaluation of well-being and health initiatives. Evaluations often centred on the numbers of people that had attended rather than attempting to track any resulting health improvements. For example, in one force, evaluation of in-house initiatives was carried out in debrief meetings after the event.

> *'Following the actual day itself, we had a local debrief between all the disciplines. It was agreed that it was successful. We did see sufficient people come through the doors.'* (Health and safety officer)

The difficulties of evaluating initiatives were highlighted by an Assistant Chief Constable, who stressed that in many cases, initiatives are long-term and therefore not easily evaluated. There was also the problem of being able to access or find the data on which to make the assessment.

9.3.5 Obstacles to the implementation of initiatives

The research did not uncover many examples of initiatives that have not worked. However, there were a number of issues around sustaining existing initiatives or facilities that were seen as promoting well-being at work and preventing absence.

The lack of resources to enable forces to introduce or sustain consistent and long-term initiatives was highlighted by some research participants. In one force, the Chief Constable expressed concern about the fact that shortage of funds had meant that the force has been less active than he felt it should have been in terms of promoting health and well-being:

> *'It is something we have done in the past and because of some financial pressures I've had to spend less effort on this. We used to have a health promotion officer post within Occupational Health which is a nurse post. That has gone now. We used to have a mobile occupational health unit which we still have but don't use. We used to visit various locations doing the kind of basic health checks like blood pressure to try to spot things and give advice about diet and exercise. We've tried a number or initiatives around exercise. We do run campaigns from time to time on looking after your back, drinking, smoking, those kinds of general health issues. We are not doing a massive amount. That's basically been a resources issue. I just don't have the resource to be able to do it any more.'* (Chief Constable)

However, resources were not always the reason for withdrawing or not introducing prevention strategies. In one force, a number of HSE Quality of Working Life audits had been conducted. Workplace stress was identified as an area of particular vulnerability for this force, but recommendations based on the audits were not followed through as the District Commander was unwilling to implement them. This was because he did not want attention drawn to the problems in his district.

In another force, there was a view that the problem was the lack of a coordinated strategy and therefore the activities and resources available for health initiatives were not focussed on the actual problem.

> *'Do we either throw more funds at this to the Occupational Health and Welfare Departments or do we say they're not working because absence is bad, so we'll farm them out to a national body which is … so we all know that doesn't work and yet somebody will come up with that idea that it does. That will be the sticking plaster again and it's fundamentally an organisational problem. This is not about the people that provide the services. They fail to look at the real fundamental problems and issues that*

are going on … is it absence or inefficiency? It's about the organisation preventing some of this happening in the first place.' (Welfare officer)

Frustration was sometimes expressed at the fact that initiatives would be introduced for a short period of time and then be taken away again. In one case study, for example, several well-being initiatives had been introduced, all for limited periods. These included provision of water bottles (to patrol staff), installation of a water cooler, fresh fruit, one month's gym membership, 'roadshow' health checks from an occupational health nurse, and flu vaccinations. These initiatives were all largely welcomed. However, it was felt that their long-term effectiveness depended on them remaining in place and when they were removed owing to lack of funding this resulted in considerable dissatisfaction.

'They pay lip service. They'll install the water fountain and a bit of fruit. They'll do that for a week or two weeks then take it back off you.' (Officer)

Closure of canteens

One view that was expressed across all forces was major discontent with the fact that canteens had been closed or that services had been reduced (see also above under Section 7.4.1). Many officers complained that as a consequence it was almost impossible to obtain any hot food when on shift work.

'The trouble with the staff canteen in the kitchen downstairs, all we've got is a microwave. We haven't got a cooker or hob. You're supposed to keep yourself healthy and fit in the police force and they're taking away all the opportunities to do that. You end up 24/7 eating takeaways.' (Officer)

This view was echoed by research participants in another force, who recounted that access to healthy food was impossible unless it was prepared at home. They stated that vending machines were installed in place of canteens, and were stocked with unhealthy processed food such as crisps and chocolate. When working long hours, especially at night, officers said they were forced to eat junk food because that was all there was available.

Keeping adequately hydrated was also an issue in some forces, where interviewees lamented the lack of water dispensers.

'You can probably see from this room if we wanted a drink of water, there is no water facility. There's no hot food facility and that is an issue. It's important that the officers I represent eat healthily and they can't always do that and it's a facility that was always offered. Now we can't even get water.' (Trade union representative)

Closure of gyms

Similar discontent was expressed at the closure of force gyms and fitness centres. In one force, a number of interviewees regretted the removal of gyms and thought that their potential was under-valued. It was commented that having readily-available gyms helped staff to stay fit and strong enough to reduce the risk of injury on duty. Further, gyms were seen as a useful aid to cope with the stress of police work, some respondents having used them as places to 'let off steam'. The removal of gyms was thus considered to have also been detrimental to staff morale.

The HR manager in this force noted that the gyms had been removed due to the potential of accidents resulting in litigation.

'There was litigation against the force in terms of injuries …. On the one hand it would be helpful, particularly for our front-line officers … but on the other hand there is this issue [that] they're unsupervised, you don't know who's using them, you don't know the quality of the pre-work that's been done to make sure that they can use them safely and appropriately and all those sorts of things. And it turned into something that was quite difficult to manage.' (HR Manager)

However, it was not accepted by officers and staff that the force did not have adequate resources to fund supervision of gyms, if that was what was required to reduce the risk of litigation from accidents.

'It was a simple thing, a little room where there were weights, exercise bike, treadmill. People went in there and blew off a bit of steam at the end of their tour of duties sometimes during the day, sometimes before in the morning …. They took it away and people just feel bad about it. There is always talk in the background of how people should be maintaining their fitness and … people are still members of gyms anyway but now they begrudge being a member of a gym.' (Police Officer)

This interviewee further argued that because the police demands so much flexibility from its staff, it is crucial to give them a sense that there is some 'give and take'. Thus, although the perk of the gym may have seemed a relatively minor aspect of the job:

'The amount of damage that has been done to morale by taking that away you just can't measure … it builds up resentment where it feels like there is a lot more take than give … I mean weren't anything really, it was a room, it didn't cost anything but it was just that little bit of give, … a feel good factor.' (Police Officer)

He thought that this could affect absence levels because commitment would fall and '*people will be more likely in the end to stand up for what they are entitled to*' rather than strive to do their best.

These views on the closing of gyms and canteens were echoed elsewhere.

'I think getting rid of gyms in the workplace was a big mistake. At [our station] we've got just one left for the four police stations which is at [another station]. They all had them at one time. Why did they go? Canteens– they had two massive offices at [one station] and they say we're short of space so the gyms going to possibly go but why and it didn't just get used by staff [in those locations], it was used by people who live over that way who work anywhere in the force. You've got to try and keep fit. We're not getting exercise and then you've got to try and pinch a sausage roll or just not bother having anything, it's not the best of situations.' (Police Officer)

9.4 VIEWS ON WELL-BEING INITIATIVES AND HEALTH PROMOTION FROM STAFF AND MANAGERS

Focus group participants in all forces could cite initiatives that had been undertaken to promote health and well-being, although views varied on how effective they had been. The initiatives included health fairs, healthy eating initiatives, anti-smoking campaigns, advice on nutrition and fitness and sharing of individual experiences of illness and how to help prevent and/or treat them.

Overall, there was general support for well-being initiatives and health promotion, although some focus group participants expressed some scepticism.

In one force, there was strong support for these initiatives and what the force was trying to achieve through them.

> *'If you're promoting fitness, then ultimately you're going to have to cut down on your absence. If you're physically fit, you're able to cope better with your shift patterns and you're not going to be picking up bugs and sniffles'.* (Officer)

In terms of the view of senior management, the Chief Constable of this force noted that well-being at work was more important than attendance management, as if people are well, sickness absence will not be a problem.

> *'The right approach. If you start from the moment you join, being healthy, being well, being fit, far more important than attendance management, because if you get those right, attendance management shouldn't be an issue. I think it's a better approach. You've got the positive approach. It's about, the moment you join, the emphasis is on your health, at home, your well-being at work, we can help at home but not overly.'* (Chief Constable)

The Assistant Chief Constable in one force maintained that the key to successful prevention and absence management is communicating effectively, making sure initiatives and procedures are properly understood and then acted upon, and ultimately in creating a more communicative and engaged culture.

> *'We've been trying over the last three or four years, as a separate issue, not to do with health per se to try to change the culture in the organisation to a more engaged and communicative approach to managing staff rather than a traditional command and control and that is not easy but longer term it does potentially pay dividends, particularly around some of the psychological issues. Less so with the physical stuff, a lot of that is about equipment, training and shift patterns. A lot of work on shift patterns and trying to produce shift patterns which minimise the damage to people in terms of sleep patterns and that kind of thing. There is a lot of stuff you can do that is more pro-active and just getting people to understand some of the things that are going on and why they are going on. Some of that is about communication, it's not difficult to do. Generally there is so much health promotion out there, you only have to turn on the TV and there are constant health programmes about obesity and exercise so do we need to do this as well? You can walk into your GP any time and get a free blood pressure check so you wonder if you are in danger of replicating something already available.'* (Assistant Chief Constable)

The general view from occupational health departments was that health promotion initiatives do have an impact on sickness absence levels. However, in one force, the occupational health department said that it had run initiatives in the past, but that it no longer had the financial or personnel resources to run the level of initiatives that they once did, and that this had had a negative impact on sickness levels.

> *'One of the things we noticed, is that since we stopped running health promotion activities for this extra funding, and it may just be coincidental, sickness levels have gradually been creeping up.'* (Occupational health manager)

9.5 SUMMARY

A range of initiatives aimed at increasing well-being, promoting a healthy lifestyle and preventing accidents were described as having been successful by the participants in the research. These tended to fall into three categories: special leave, flexible working and work-life

balance initiatives; accident prevention; and health at work initiatives. Overall, the measures on offer included:

- work-life balance initiatives
- the introduction of special leave and flexible working
- initiatives aimed at reducing stress
- a range of accident prevention initiatives, including those centred around patrol cars
- healthy eating initiatives
- mobile health checks
- the offer of 'flu vaccinations
- discounts from local gyms
- nicotine replacement therapy.

There was no description of any kind of formal evaluation of these initiatives. The organisers often described meeting after the activity and deciding whether or not it had been a success, using factors such as attendance rates. There was also a view that it was difficult to evaluate initiatives as they are often targeting long-term changes in health.

Many forces pointed to the benefits of having some type of special leave, flexible working or work-life balance policy in place, in order to ensure that absence that is not related to sickness is not recorded as sickness absence.

A number of interviewees pointed to some general frustrations and difficulties surrounding health and well-being initiatives. These included the fact that some initiatives were short-term and therefore not seen by staff and officers as a serious attempt to improve health and well-being on a long-term basis. Further, one force pointed to a lack of resources, which meant that it was difficult to carry out any sustained campaign of health and well-being initiatives.

One of the main issues to arise was dissatisfaction with the closure of canteens and gyms. Interviewees stated that officers on shifts found it extremely difficult to find hot food and either had to survive on junk food or no food at all. Further, some interviewees stated that there was a risk of dehydration due to the disappearance of water coolers.

The disappearance of gyms was seen as having a negative impact on well-being by most interviewees. The closures were justified by the fact that there was a danger of litigation from unsupervised gyms. However, this was rejected by officers and staff, who believed that gyms played a vital role in keeping officers and staff physically and mentally fit. Further, both canteens and gyms were seen as places where officers and staff could let off steam, either by working out or simply talking to colleagues, therefore lowering their stress levels.

A range of Home Office-funded initiatives to improve health and well-being were in place in the forces interviewed for the research. These included:

- physiotherapy and rehabilitation equipment
- stress audits, safety and working life audits
- the use of private medical care for people needing scans or operations
- the funding of temporary additional occupational health posts.

Some forces had evaluated these measures – particularly the access to private medical care measures – in terms of the police hours they had saved, the reduction in waiting times and the

reduction in absence rates. One force had submitted evaluation reports to the Home Office. Accessing private medical care was generally seen as a successful way of managing sickness absence. In one force, there was frustration that it was not used more often, as the benefits, in terms of cost, appeared to be considerable.

In terms of the general views of well-being initiatives and health promotion, there was overall support, although some focus group participants expressed some scepticism, particularly where initiatives had been short-lived.

10 SUMMARY AND CONCLUSIONS

This report has considered in depth the management of sickness absence in seven police forces in England and Wales. The study has involved a wide range of techniques to consider absence in the forces from all possible viewpoints and has created a wealth of information. The forces selected had varying absences levels, policies and practices but clear themes and issues have emerged and will now be discussed under the key report headings.

10.1 ABSENCE POLICIES

For any force to manage absence it is essential that they have a well documented policy available to all staff either on paper or the intranet. This needs to establish the processes to be used and who should be responsible for their initiation and delivery. The allocation of clear roles to the individual who is sick, the line manager, occupational health, HR and any other support services is essential. All the policies from the forces met these requirements.

The approaches of the policies were varied, from one that took a very punitive stance, to others which stressed their duty of care towards staff. The most effective policies were those that accepted that ill health was unavoidable, recognised the importance of a culture where individuals felt valued, and where suitable measures were in place to encourage and support returning to work.

The absence policies of the forces included many widely-accepted effective measures. They clearly placed the responsibility for managing absence on line managers with defined assistance from occupational health and HR. However, greater emphasis on the commitment of senior management to absence in the policies would be beneficial and the inclusion of an estimate of the annual cost of absence to the force would strengthen their impact. The greater use of process flowcharts would also improve understanding of the procedures and timelines.

In line with the MTF's recommendation, the consideration of the unit's attendance levels should form part of the line manager's PDR. This was a feature neglected in some of the forces. Working conditions could also be more widely required to be considered as a cause of individual absence. Allowing managers some discretion on when an attendance review is necessary would also ensure that policies are not applied as rigid processes which can undermine effectiveness.

10.2 MONITORING ABSENCE

A successfully managed absence policy is based on the knowledge of the actual number of days lost to sickness for each individual. Managers in the study felt that they could have been better informed about basic absence statistics for their own teams and other parts of the force. The accuracy and usefulness of such information depends on a number of factors. The line managers themselves were responsible for recording notifications of absence and return to work details and there were some difficulties with them recording both accurate and timely data. This was due to other pressures on their time and the fact that it was not a priority task for them.

The use of the Dorset 12 general sickness categories as required by the Home Office, unless augmented by sub categories of conditions, led to a serious loss of detail about the individual's illness which made understanding the causes of absence difficult. Home Office guidance in 2004/05 also recommended that disability-related absence should be identified in any recording systems but it was apparent that this was the least well monitored form of absence. The forces were generally unable to separate it from other forms of absence.

A major factor in the quality and usefulness of the data was the software used. Most of the forces used the National Strategy for Police Information System (NSPIS) which holds individual demographic and absence data. However, this was rarely linked to payroll where the number of days lost was held. This seriously limits the amount of potentially useful cross analyses that can be made.

The requirement of the Home Office that absence is reported in hours led to a number of approaches being employed to convert days to hours, unless forces had a Duty Management System (DMS) in place to record the actual number of hours staff work. This source of inconsistency means that it is unlikely that absence figures across the forces are comparable. The forces seemed confused as to whether the request to report absence in hours had come from the Home Office or Her Majesty's Inspectorate (HMI). This has implications for knowing where to find appropriate guidance.

The reporting of absence statistics requires production of reports that are easy for the senior and line managers to comprehend. The forces had differing levels of ability to achieve this. This was limited, in some cases, by the capacity of the force's systems to perform complex analyses across datasets.

The actual presentation of the data was determined by those processing it, and the reports made available to the forces showed a range of sophistication from Excel spreadsheets to user-friendly reports, with commentaries, summary tables and graphs. The producers of the reports frequently just reacted to requests and did not proactively seek the views of the users. Greater customer awareness among those processing data would prevent managers from having current unmet demands for improvements in the usefulness, reliability and detail in their absence reports.

10.3 CAUSES OF ABSENCE

To manage absence with targeted solutions, it is necessary to appreciate the reasons why people are taking sick leave. All the forces recognised that the vast majority of absence was health related with just certain individuals having attendance problems. In the case of short-term absence the most common causes were seen as colds, 'flu and stomach upsets. The impact of domestic and caring responsibilities was also acknowledged as a potential hidden reason for absence. In contrast, long-term sickness was more likely to be caused by psychological problems (such as stress, depression and anxiety), musculoskeletal disorders and serious or fatal illnesses.

Work was perceived to be a contributory factor to both short and long-term sickness. This occurred where individuals felt they were under pressure due to lack of resources or bureaucratic demands, especially when this was against a background of organisational change. Those affected felt that they just had to take time off or did so to register a protest about their situation or management decisions. Work factors also resulted in long-term sickness if individuals felt that they had little or no support from the force, or negative work situations persisted for a length of time.

10.4 MANAGMENT OF ABSENCE

The successful management of both short-term and long-term absence is vital for any absence policy. Overall the respondents were positive about the procedures in their forces and thought that they understood them. However, it was seen as difficult to introduce policies which staff recognised as fair.

Line managers had the majority of the responsibility for managing absence. Their ability to do this depended upon a good understanding of policy and confidence to use discretion to ensure

individual circumstances were handled appropriately. Their skills in maintaining useful contact with those away sick was important. They also needed to understand the issues around the sickness, which they found particularly difficult in cases of psychological illness and where the individual's problem was work related. A requirement for managers to be well trained in absence management and supported with interpersonal skills was identified.

Occupational health was a key part of managing long-term absence but was little used in the short term despite managers wanting them to be more involved here. Under-funding was often a problem leading to slow or inadequate responses and creating barriers to staff returning to work. There was also some confusion about what occupational health was able to provide, which added to pressure on the service through unsuitable referrals. Individuals, however, were generally very supportive of the roles played by occupational health.

Appropriate solutions for managers to address absence due to domestic responsibilities is part of an well balanced absence policy. Flexible working and the use of special leave were commonly used to help staff manage their lives. These were welcomed by staff, but to work effectively the processes need to be simple, able to be applied at relatively short notice and managers to be aware of their discretionary powers.

The use of pre-specified 'trigger points' or points at which the level of sick leave results in management action being taken differed to some extent across forces. In the two forces using Bradford scores there was a widespread view that it was overly punitive and rigid.

A range of sanctions were used to manage absence based on pay and access to promotion and training. The reaction to these approaches from staff was that they were unfair if individuals were injured or genuinely ill. The true impact of these measures is not clear.

There were many instances in the research discussions of individuals taking annual rather than sick leave. This was a result of the imposition of sanctions or the desire to keep a 'clean' sickness record. Individuals felt it was better to take annual leave rather than struggling into work when not feeling well. Whilst this helps to reduce absence rates overall, it could have negative impacts in the longer term for the individual's health and well-being.

Incentives, such as extra leave, special payments or certificates for good attendance, formed part of most forces' policies. Again, there were mixed views on their efficacy and how they worked in practice was perceived as variable. However, not offering any incentive was also seen as counter productive.

Managing a successful and maintained return to work raised challenges. Ensuring the timing is right for the individual is a major contributor to how they feel about their return. It is important that they are neither pushed too hard, nor held back by occupational health constraints or delays in making timely adjustments. This is particularly difficult in the case of mental ill-health where timescales are unclear. Consideration of flexibility in how and where returnees work is essential and needs support from both colleagues and line managers. Those returning from sick leave have suggested that it is vital that managers communicate what is expected from individuals on their return, set targets and hold regular reviews of progress.

Recuperative duties were used in all forces. These needed to be well designed and used for a limited time so that individuals get back to normal duties as soon as possible. Where difficulties were reported in returning, this was due to the reception from colleagues and how individuals felt their new duties were regarded.

There was misunderstanding around restrictive duties, possibly due to the word 'restrictive', implying that the constraints could be lifted. These roles were often seen as a means of getting back to full duties, ie recuperative duties, rather than as a means of retaining officers in the force

who would otherwise be retired on ill health grounds. Previously such duties had been regarded as a privilege for officers in their final years of service, whereas now their increased usage led some to feel that younger officers were being 'carried'. There was also some evidence of resentment of those on restrictive duties as they reduced the number of active officers that could be deployed.

10.5 WELL-BEING INITIATIVES

There was overall support for the well-being initiatives and health promotion activities undertaken in the forces. A wide range was identified, including initiatives to reduce stress, promote healthy eating and work-life balance, mobile health checks and 'flu vaccinations. Formal evaluations of their effectiveness was unusual. Attendance at events was frequently taken as the only indicator of success, which did not take into account any of the more relevant long-term effects.

Some general frustrations and difficulties surrounding health and well-being initiatives were apparent. These centred on the fact that some were short-term and not seen by staff and officers as serious attempts to improve health and well-being. These measures gave rise to dissatisfaction when they were removed, following the exhaustion of funding. The issue of the basic lack of resources, which meant that it was difficult to carry out any sustained campaign of health and well-being initiatives was also raised.

The closure of canteens has widely occurred in the forces owing to pressure on office space. This has had a negative impact on the availability and quality of food for both officers and staff. Similarly there had also been a widespread removal of force gyms owing to the fear of litigation from injuries sustained. The gyms were seen as having a vital role in keeping officers and staff physically and mentally fit. Further, both canteens and gyms were seen as places where officers and staff could relax and reduce their stress levels.

A limited number of Home Office-funded initiatives were encountered in the research. The most significant of these were the funding of temporary occupational health posts and the fast tracking of individuals needing hospital treatment. The evaluation of providing access to private medical care had shown that it was a cost effective approach to managing long-term absence for some.

10.6 SUMMARY

The report has shown that the management of absence in the case study police forces is complex and dependent upon a mix of approaches to support those who are sick and to deter the small minority whose absence is non-health related. A good clear policy which is well communicated and understood by both staff and managers is necessary but not sufficient. The policies also need to be supported by data that is reliably collected and then attractively presented.

However, managing absence in police forces is about wider issues than policies and data collection. The causes of individual absence have to be fully appreciated to provide appropriate solutions. Work is often perceived to be a contributory factor to absence where staff feel that they have little support and are under pressure. Line managers also need to be assisted in their role by effective occupational health departments, HR and senior managers committed to absence management. Attention should also be paid to the converse issue of promoting attendance to ensure that staff are motivated to come to work. The decision to take a day's sick leave critically depends on how an individual feels about the force and how it values their contribution. The key player in both managing attendance and encouraging attendance is the line manager. To perform their demanding role it is vital that managers are well trained and capable of using their discretion when applying the management tools of an absence policy.