Sickness Absence in the Social Care and Health Service

Report of the Scrutiny Working Group

Scrutiny Sub-Committee for Promoting Strong, Healthy and Safe Communities

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Section One - Foreword

The people who work for Durham County Council are our biggest resource. It is important that we do everything we can to ensure that the staff who deliver services in our local communities are well-trained, well-equipped, supported and motivated to provide excellent and reliable services.

All organisations, regardless of whether they are in the public or private sectors, experience staff absence due to sickness. The Department of Health Consultation Document "Choosing Health" (2004) highlighted that in 2001/2002 over 33 million days were lost due to work-related ill health alone. Proper management of absence is key to ensuring that high quality services continue to be delivered without interruption or inconvenience to clients.

This is particularly important in our Social Care and Health Service where clients and their carers rely upon us for support, either within their own homes, or in residential settings. If a home care worker is ill, the consequences for clients and their carers can be considerable and the costs of providing replacement cover can be significant. Sickness absence not only impacts on our clients and their families, it can also lead to added pressures upon those members of staff who have to manage increased workloads when colleagues are absent.

Although the focus of this scrutiny investigation has been on sickness absence in the Social Care and Health Service, sickness absence across all Departments of the County Council is a matter of interest to all Councillors. There are a number of findings and recommendations that have come out of this investigation that Members of the Working Group believe should be applied across the whole organisation.

It has been pleasing to note that over the period of the scrutiny investigation, levels of sickness absence in Social Care and Health Service have begun to fall and the trends are still downwards. The latest data received by the Working Group is located towards the end of Section Four of the report. I very much hope that the initiatives already introduced to assist with this process will continue to be applied and further developed so as to reduce sickness absence levels still further.

I am grateful to all of those Officers and Members (including representatives from the Human Resources Committee) who participated in this project. I would also like to thank all of the witnesses who came along to give evidence to the Working Group.

Councillor Morris Nicholls
Chairman of the Working Group

Section Two – Project Terms of Reference

Background to the Project

2.1 The project was instituted by the Scrutiny Sub-Committee for Strong, Healthy and Safe Communities. This followed issues raised by members in the light of proposed savings of £500,000 from reductions in sickness absence, identified by the then Director of Social Services during the budget deliberations for 2003/2004.

2.2 The project commenced in May 2003, when it was agreed that the Working Group would adopt the following Terms of Reference.

Terms of Reference

2.3 The Terms of Reference of the Working Group were agreed as follows:

To review the nature and extent of sickness absence within Durham County Council's Social Services Department* and the actions being taken to address this issue with a view to making recommendations, where appropriate, for any improvements.

****Now "Social Care and Health Service"***

Section Three – Social Care and Health Service Structure

Overall Structure

3.1 Social Services Department (re-named Social Care and Health Service with effect from 29 March 2004) consists of five Branches as follows:

- **2 Commissioning branches:-**
  - Children and their Families
  - Adult Commissioning

- **2 Support Services branches:-**
  - Strategic Planning and Finance
  - Quality and Performance

- **1 In-house Provider branch:-**
  - County Durham Care

Children and their Families

3.2 Within the legal framework of the Children Act 1989 and other key legislation, this Branch identifies and meets the assessed needs of children and families through the direct provision of a range of family support services and by commissioning services from other agencies.

3.3 The Branch is organised into the following service areas:

- Children in Need Teams in each locality
- Fostering and Adoption
- Disabled Children
- Residential and Community Services
- Looking After Children and Aftercare
- Community Support Team
- STEPS Therapeutic Service
- Family Services Teams (North and South)
- Early Years Service
- Secure Services
- Copelaw Education
- Service Development

Adult Commissioning

3.4 The Adult Commissioning Branch operates within the legal framework of the NHS and Community Care Act 1990 and other key legislation. The Branch identifies social care needs and commissions services on behalf of individual adult service users and their carers. Practitioners within the Branch work with other professionals e.g. NHS Trusts and PCT staff in partnership with Service Users and their Carers, in assessing needs, agreeing and reviewing care plans and packages.

3.5 The Branch is organised into the following service areas:

- Promoting Independence Teams – Adults
- Joint Community Mental Health Teams – Adults
- Integrated Learning Disabilities Commissioning Teams - Adults

- Substance Misuse Team
- Social Care Direct
- Sensory Impairment Team
- Carers Team
- Review Team

Strategic Planning and Finance

3.6 The Strategic Planning and Finance Branch is responsible for providing a central reference point within Social Care and Health Service to co-ordinate the planning and monitoring of activities in order to ensure that Corporate and Departmental objectives are met in the most effective and efficient way.

3.7 The Branch comprises comprises four Divisions:

- Strategic Finance Children and Families
- Strategic Finance Adults
- Strategic Planning
- Business Support

Quality and Performance

3.8 The Quality and Performance Branch is responsible for recruiting, developing and retaining staff, providing high quality information and technology services to members of the public, colleagues within the Department, County Council and other partner agencies; and producing performance and quality management systems.

3.9 The Branch comprises three Divisions:

- Information and Communication
- Quality and Performance Monitoring
- Human Resources

County Durham Care

3.10 County Durham Care (CDC) Branch is one of the largest providers of a range of social care services in County Durham. The work of the Branch is focused on supporting the Social Care and Health Service to achieve its objectives required under various performance indicators by providing services which are aimed at promoting and maximising independence.

3.11 The Branch provides a range of services including:-

- Services to people in their own homes
- Day Centres
- Residential care

Staffing Data

3.12 Social Services currently employ approximately 3393 staff; a detailed breakdown is provided below. Priority Services NHS Health Trust colleagues working in integrated Mental Health and Learning Disability Teams are also identified separately.

Nature of Employment	Average Number of Employees 2003/04	
	Full Time	Part Time
CENTRAL SERVICES		
Quality & Performance	89	26
Strategic Planning & Finance	27	2
Business & Support	154	51
OPERATIONAL SERVICES		
Children & Families	377	87
Aycliffe Young Peoples Centre	207	65
Adult Commissioning:		
Learning Disability Trust staff in integrated learning disability teams	28 44	8 24
Community Mental Health Trust staff in integrated adult mental health teams	42 94	10 17
Promoting Independence	148	35
Intermediate Care	9	7
Sensory Support Team	11	5
Social Care Direct	16	5
Substance Misuse	4	1
Review Team	11	3
Management & Support	12	0
Supporting People	8	0
Carers Development	3	0
Service Development	16	0
IN-HOUSE PROVIDER		
County Durham Care	587	1211
CORPORATE SERVICES		
Investing In Children	7	1
Youth Offending Service	100	20
Total (SSD & Trust employees):	**1994**	**1578**

Section Four – Social Care and Health Service Sickness Absence Data

Introduction

4.1 At the inaugural meeting of the Working Group in May 2003, we were provided by Peter Appleton (Head of Quality and Performance, Social Care and Health Service), with both historical and contemporary data about the levels of sickness absence in Social Care and Health Service. Wherever possible in this report, sickness absence levels are expressed as days lost per employee, as opposed to percentage data. This is to accord with the Best Value Performance Indicator (BVPI) 12, which measures sickness absence in local authorities in terms of days lost per employee per annum. This method of calculation also permits easier comparison with performance in other local authorities. It should be noted that the sickness absence figures presented to Members of the Working Group include separate data for Aycliffe Centre.

Sickness Absence in Social Care and Health Service 2002/2003

4.2 The numbers of **days sickness absence lost per employee in the financial year 2002/2003** were as follows:

Branch	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Total Days 2002/03
County Durham Care	6.8	7.5	8.2	7.4	**29.9**
Children and Their Families	4.1	4.0	5.0	4.5	**17.6**
Aycliffe Centre	5.8	5.1	4.3	3.7	**18.9**
Adult Commissioning	4.5	3.5	4.8	3.0	**15.8**
Business Support	3.6	3.2	3.4	2.2	**12.4**
Quality and Performance	1.9	2.8	3.3	1.9	**9.9**
Strategic Planning and Finance	0.2	0.3	0.1	0.5	**1.1**

Average Sickness Absence in Social Care and Health Service since 2000

4.3 The numbers of days lost due to sickness absence per employee in Social Care and Health Service in the period 2000/2001 to 2002/2003 were:

- **2000/2001 18.7 days**
- **2001/2002 22.9 days**
- **2002/2003 22.7 days***

(*The 2002/2003 average is influenced by the large numbers of staff working in County Durham Care, with its relatively high absence rate).

Sickness Absence in all Departments of the County Council in 2002/2003

4.4 For comparative purposes, the rates of sickness absence (per employee) across the whole of the County Council in 2002/2003 were as follows:

Department	Total No. of Days Lost
Cultural Services	10.86
Corporate and Legal	6.32
Economic Development & Planning Department	8.78
Education	10.37
Environment & Technical Services Department	8.81
Service Direct	12.83
Treasurer's	6.56
Social Services	22.43*
Total	**12.58**
Best Value Performance Indicator Target for 2002/2003	**10.2**

*This figure differs from that of 22.7 days, provided by Social Care and Health Service officers to the Working Group because it included community support and youth offending team data, which reflects lower levels of sickness absence.

Causes of Sickness Absence in Social Care and Health Service 2002/2003

4.5 The percentage of sickness absence **days** lost by reason type in Social Care and Health Service in 2002/2003 is shown below

Cause	%
Musculo skeletal	33.9
Depression/stress	24.9
Viral Respiratory	7.4
Hospital/post operative	5.8
Digestive/gastric	5.5
Cardiovascular/stroke	4.5
Not specified	4.0
Ear/nose/eye/throat	3.0
Gynaecological	2.5
Various	2.4
Neurological	2.1
Urinary	1.3
Obstetric	1.2
Infection	0.7
Endocrine	0.4
Skin	0.3

4.6 The percentage of sickness absence **episodes** by reason type in the Social Care and Health Service in 2002/2003 is shown below.

Cause	%
Digestive/gastric	21.2
Viral/respiratory	20.6
Musculo skeletal	14.7
Depression/stress	9.4
Not specified	8.8
Ear/nose/eye/throat	7.0
Neurological	5.2
Hospital/post operative	3.2
Gynaecological	2.0
Various	1.8
Infection	1.7
Cardiovascular/stroke	1.3
Urinary	1.2
Obstetric	1.1
Skin	0.6
Endocrine	0.2

4.7 The percentage of sickness absence **days** lost by reason in the top three categories in those **Branches** of Social Care and Health Service with some of the highest levels of recorded sickness absence in 2002/2003 was:

Branch	Reason/ Percentage	Reason/ Percentage	Reason/ Percentage
County Durham Care	Musculo skeletal 38.3%	Depression/ stress 25.3%	Viral/respiratory 6.5%
Children & Their Families	Depression/ stress 30.2%	Musculo skeletal 20.3%	Viral/respiratory 9.5%
Adult Commissioning	Musculo skeletal 36.9%	Depression/ Stress 18.6%	Hospital/post Operative 9.8%

Long Term Sickness Absences (3 months+) in Social Care and Health Service 2001/2002 and 2002/2003

4.8 Long term sickness was identified as an issue in relation to sickness absence levels in Social Care and Health Service. In 2001/2002 and 2002/2003 long term sickness absence of 3 months duration or more in Social Care and Health Service was as follows:

Branch	2001/2002	2002/2003
County Durham Care	237	252
Children & Their Families	56	30
Adult Commissioning	21	29
Aycliffe Centre	20	10
Business Support	0	0
Quality & Performance	3	2
Strategic Planning & Finance	2	0
Total	339	332

Social Care and Health Service Employees with 7 or More Sickness Absences within Financial Years 2001/2002 and 2002/2003

4.9 The numbers of employees in Social Care and Health Service with 7 or more sickness absences in the financial years 2001/2002 and 2002/2003 were:

Branch	2001/2002	2002/2003
County Durham Care	27	40
Children & Their Families	6	7
Adult Commissioning	0	0
Aycliffe Centre	6	5
Business Support	5	5
Quality & Performance	1	1
Strategic Planning & Finance	0	0
Total	45	58

4.10 We heard that in January 2003 there were 785 outstanding sickness absence reviews. By May 2003 this had reduced to 506 following positive action taken to address the issues and by November 2003 had reduced to 203..

4.11 We also heard that:

- The number of capability hearings in Social Care and Health Service increased by 56% between 2001/2002 and 2002/2003 (18 to 41)
- The number of ill-health retirements decreased by 49% between 2001/2002 and 2002/2003 (41 to 21)
- The number of physiotherapy referrals for Social Care and Health Service employees has risen since the introduction of a new service level agreement in January 2003
- The referral process to Occupational Health Service has scope for improvement (i.e. in March 2003, 133 employees hit trigger points, but only 74 were referred that month).

Current Social Care and Health Service Sickness Absence Data

Sickness Absence in Social Care and Health Service 2003/2004

4.12 The numbers of days sickness absence lost per employee in the financial year 2003/2004 were as follows (the figures for 2002/2003 are also shown for comparative purposes in brackets in each quarter and in the final column for the full year):

Branch	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Total 2003/04	Total 2002/03
County Durham Care	6.8 (6.8)	6.6 (7.5)	6.4 (8.2)	5.7 (7.4)	**25.5**	**29.9**
Children and Their Families	3.6 (4.1)	4.4 (4.0)	3.4 (5.0)	3.7 (4.5)	**15.1**	**17.6**
Aycliffe Centre	4.3 (5.8)	4.6 (5.1)	3.3 (4.3)	3.4 (3.7)	**15.6**	**18.9**
Adult Commissioning	2.1 (4.5)	3.0 (3.5)	3.8 (4.8)	3.4 (3.0)	**12.3**	**15.8**
Business Support	0.9 (3.6)	1.5 (3.2)	2.8 (3.4)	3.1 (2.2)	**8.3**	**12.4**
Quality and Performance	1.8 (1.9)	1.6 (2.8)	1.9 (3.3)	2.7 (1.9)	**8.0**	**9.9**
Strategic Planning and Finance	1.6 (0.2)	1.0 (0.3)	0.5 (0.1)	0.8 (0.5)	**3.9**	**1.1**

4.13 As regards sickness absence data expressed in percentage terms, the rates for Social Care and Health in respect of 2002/2003 were 8.6%. In the rolling year ending April 2004, they had reduced to 7.4%. The latest figures, for April 2004, are 6.6%.

4.14 The Director of Social Care and Health is to be congratulated on these reductions, which have been achieved year on year. This will contribute towards improved performance in the County Council'[s BVPI and will help to meet the monetary savings identified by the Director during the last budget round. We understand that the savings of £500,000 have been substantially met. In only one division was there a rise in sickness and this was from already low levels. However, the drive to tackle sickness absence, particularly in County Durham Care needs to be maintained. If reductions in quarterly absence can be sustained over the coming year at the levels of the last two quarters of 2003/04, the reductions would be significant and there would be continued movement towards levels of sickness absence similar to those in our IPF Comparator Authorities.

4.15 The average number of days lost per employee across the whole of Social Care and Health Service has also reduced to 18.9 days per year in 2003/04 (compared with 22.7 days in 2002/03).

4.16 In relation to referrals to the Occupational Health Service, figures submitted to the Working Group in January 2004 showed that in November 2003, 128 cases had met the trigger point, of which 101 forms had been submitted for potential referral. This compared with 133 triggered and 74 referrals respectively in March 2003. The current process is now more sophisticated, with a review by managers of returned forms to determine whether Occupational Health needs to be involved. Of the 101 potential referrals in November 2003, only 26 were referred to Occupational Health for assessment.

Section Five – Sickness Absence Levels in other Authorities

Introduction

5.1 An important aspect of any scrutiny investigation is looking at how we compare with others. Peter Appleton (Head of Quality and Performance), Social Care and Health Service provided the following data.

Sickness Absence Rates amongst Comparator Social Care and Health Services (Institute of Public Finance)

5.2 Out of 15 Social Care and Health Services in the same "family grouping" Durham had the second highest percentage rates of sickness absence (8.8% in 2001/2002 and 9.1% forecast for 2002/2003). Only Somerset had higher levels (12.9% and 11.5% forecast respectively). The best performing authority was Norfolk (4.8% and 4.5% forecast respectively).

Sickness Absence Levels in Social Care and Health Services in the North East

5.3 Out of 11 North East region Social Care and Health Services, Durham had the third highest rates of sickness absence (8.8% in 2001/2002 and 9.1% forecast for 2002/2003). Only South Tyneside (13% and 18.4% projected respectively) and Gateshead (10.7% and 9.5% projected respectively) were higher. The best performing authority was Middlesbrough (5.8% and 4% projected respectively).

National Data

5.4 Towards the end of the project, the Head of Overview and Scrutiny provided us with data from the Employers Organisation about sickness absence in Social Care and Health Services in 2001/2002.

Employers' Organisation Survey 2001/02

5.5 The survey was conducted between January and April 2003 in 171 Social Care and Health Services and contained information for the financial year April 2001 to March 2002. 102 authorities provided usable data (60% of the total). The survey collected two measures of sickness absence – average number of days lost per employee (subject of the BVPI) and percentage of absence. The average number of days lost per employee was calculated by dividing the total number of days sickness absence by the total number of employees.

5.6 The table below sets out details of sickness absence by various categories of employee and by authority type contrasted with Durham County Council's Social Care and Health Service rate for 2001/2002 and the County Council's rate for all Departments in 2001/2002.

Median number of sickness absence days per employee per year in Social Services Departments, England and Wales, 2001/02

All Authorities	Sickness Absence days p.a.
All employees	**16.1**
- Men	13.9
- Women	17.0
- Full-time	16.3
- Part-time	17.4
Manuals	21.1
Non-Manuals	15.0
Authority Type	
Metropolitan Authorities	18.9
English Unitaries	15.9
London Boroughs	14.7
Counties	13.2
Durham County Council (Social Services Dept)	**22.9**
Durham County Council (all Departments)	**11.2**

It should be pointed out that the figures above are **averages**, and there will be a range of sickness absence levels across authorities and between employees.

Rates of Absence within Social Care and Health Service Branches/Divisions

5.7. Rates for home care staff and those working in community/residential homes are high nationally. The Employers Organisation survey for 2001/02 showed average rates of sickness absence across all authorities in England broken down within Social Care and Health Services as follows:

Branch	Days lost per Employee p.a.
Community homes	*20.1*
Domiciliary service staff	*19.6*
Homes for the elderly	*19.5*
Other homes	*16.3*
Field social workers	*14.1*
Day nursery staff	*11.9*
Strategic & central staff	*9.9*

5.8 No figures at Branch level for Durham County Council's Social Care and Health Service for 2001/2002 were provided to the Working Group, so it was not possible to make a direct comparison. However, the figures above are reflected by the position in County Durham Care, which has the highest levels of sickness absence amongst all of the Branches in Social Care and Health Service.

Section Six – Causes and Factors in Sickness Absence

Introduction

6.1 To begin to understand sickness absence, it is important to consider what relevant factors can influence attendance at, or absence from, work.

6.2 The Senior Scrutiny Support Officer drew our attention to a Research Paper "Absence Management in the Public Services: Recent Evidence from the UK" published in 2001 which outlined some of the factors impacting on sickness absence and explored how sickness absence was being managed within the public sector.

6.3 The Research Paper identified two main causal factors of absence from work:

- Those which affect the motivation of workers to attend work (salary, conditions, working environment, enjoyment of work)
- Those which impact on ability to attend (illness, family responsibilities and transportation difficulties)

6.4 The research paper outlined a number of issues drawn from surveys and interviews with local authorities, including two authorities, one of which had high sickness absence levels and another, which had low sickness absence levels.

6.5 The following issues were highlighted in the Research Paper:

- Line managers were identified as being key in managing sickness absence, but devolvement of sickness absence management could also result in work overload for line managers
- There were often inconsistencies, both within and between Departments over how individual line managers managed sickness absence. In one authority, of three members of staff interviewed on return to work after six month (or more) terms of sickness, one had never been contacted by their line manager, one had been contacted once, and another had only been contacted just before their return to work
- Effective training of line managers in managing sickness absence was an issue (with a need for refresher training)
- Sickness absence management didn't stop when employees returned to work – some employees had subsequently left after the stress incurred in the process of return
- In care homes it appeared that return to work interviews were not always carried out – this was often linked to the different shift patterns of line managers and employees
- In both Authorities participating in the study, sickness absence was seen as a key issue and actions were underway to address absence, with three issues seen as important to managing sickness absence:
    - Clarity in relation to sickness absence policies and procedures
    - The nature of absence data collected (in one authority this was said to be hampering effective health monitoring)
    - A lack of communication (manifested in one authority in tension between occupational health and line managers)
- Chief Officers and Corporate Personnel had a role to play in managing sickness absence

6.6 The **main findings** of the study were that:

- There needs to be a closer working relationship between personnel, occupational health, trade unions, health and safety and line managers to manage the return to work process
- There was an inherent tension between discipline and support and employees needed to be reassured that they were a valuable resource; the underlying aim was not to dismiss them, but return them to the workforce
- Line managers need to be trained in how to effectively manage absence and the return to work process and be provided with the necessary resources to do so. The development of best practice guidelines that focus on the return to work process would assist.

An Occupational Health Perspective

6.7 Dr Philip Wynn, the County Council's Senior Occupational Health Physician, told us that some research studies had identified as many as 33 factors influencing sickness absence rates and an individual's decision to attend or resume work. He divided these as follows:

- Geographical – Climate, region, age profile of population etc.
- Organisational – Size of unit, sick pay rates, working conditions
- Individual – Age, gender, life crises, personality

6.8 Biopsychosocial phenomena impacting on sickness absence are complex as they involve a whole range of biological, psychological and sociological influences.

6.9 Dr Wynn suggested that Social Care and Health Service might constitute a "special case" in terms of its sickness absence because of the following factors:

- Occupational:
    - It comprised disparate working groups with poor social support and difficult risk management
    - There was a greater proportion of lower grade employees (from lower socio-economic groups)
    - There were low objective and subjective health standards (employees who perceived themselves to be "sicker" than some other groups)
- Organisational:
    - Historical differences between Social Services and other County Council Departments
    - There was separate physiotherapy provision
    - There was separate provision of psychological support

The Health and Safety Unit Perspective

6.10 Maureen Ayre, Corporate Health and Safety Unit Manager told us that in relation to home carers and staff in residential establishments, one of the main problems was the nature of the job and the duties involved. There had previously been some issues about equipment, with some equipment not available for use by staff. However, assessments now took place on site prior to staff carrying out their duties. Clients might also have multiple needs, with specialist input now being a common part of the process. Health and Safety Unit contributed to the assessment process, with the emphasis on protecting staff. There were also issues around musculo-skeletal injuries and Maureen believed that, often, injuries not reported at an early stage might be subjected to cumulative damage, resulting in more severe or chronic musculo-skeletal illness. Staff should be encouraged to report such injuries at an early stage.

The Social Care and Health Service Perspective

6.11 Peter Appleton (Head of Quality and Performance), Social Care and Health Service outlined some of the possible causes of sickness absence in the Department as follows:

- The impact of change upon staff in County Durham Care resulting from the County Council's Investing in Modern Services for Older People Programme might be causing uncertainty and impacting upon the morale and motivation of staff
- Work-related illnesses, some of which might be caused by moving and handling clients, were a factor in County Durham Care sickness absence
- The work undertaken by Social Services employees was growing in complexity and there were higher expectations of and greater demands upon staff
- Social Care and Health Service had an ageing workforce
- High workloads, particularly in the Children & Their Families Branch, were expressed in high levels of stress and depression.
- There was need for better management of sickness absence within the Department
- Recording procedures had improved and been enhanced and this might be resulting in more accurate and realistic reporting of sickness absence levels
- 40% of contacts to the Departmental Staff Care Service related to stress and 90% of contacts quoted work as a contributory factor
- Some teams had high vacancy levels, adding to the pressures of staff in post
- Staff within Children Services were increasingly subjected to violence and aggression and staff working with the elderly were sometimes subjected to violence, resulting in some employees taking time off work suffering from stress.

6.12 We heard that the sickness absence management system in Social Care and Health Service was believed to be complicated and difficult to operate. Managers had felt there had been a lack of training and support when managing absences (although actions were now being taken to address this issue).

Section Seven – Management of Sickness Absence in Social Care and Health Service

Introduction

7.1 We heard evidence from Peter Appleton about how sickness absence was managed in Social Care and Health Service and some of the recent developments that were underway to address sickness absence. Because of the higher levels of absence in County Durham Care Branch, we also heard from Patricia Davidson (Home Care Manager, County Durham Care) about how sickness absence is managed within the Branch and some of the difficulties that exist. Additionally, we received a presentation from Jean Carr (Staff Care Officer) about the Staff Care Service in Social Care and Health Service.

Actions taken to Manage Sickness Absence

7.2 Peter Appleton outlined the following actions, which had been taken in Social Care and Health Service in an effort to reduce sickness absence:

- A Sickness Absence Management Group established which meets bi-monthly; includes representatives from all Branches, Personnel Services and the Occupational Health Service, and examines all aspects of sickness absence management
- Better communication with the Occupational Health Service
- New performance measures for sickness absence procedures
- Targeting specific absenteeism
- Training for managers (see later in this Section)
- Training staff in County Durham Care on moving and handling techniques (centrally) with moving and handling training as part of the induction programme for staff in Children & Their Families
- Improved physiotherapy services (using University Hospital, Durham)
- The Staff Care Service (see later in this Section)
- Identifying best practice in other authorities to determine whether it might be applied in County Durham
- A 'flu immunisation programme for front line staff introduced (although there has been poor take up of this)
- Setting targets for savings from sickness absence reduction (£500,000 in 2003/04)
- Looking at payment anomalies (the current costs of payment of overtime/shift working enhancements staff who are off sick)
- Appointment of two members of staff to progress absence reviews etc. in County Durham Care

Management of Sickness Absence in County Durham Care

7.3 Patricia Davidson outlined some of the following issues in relation to managing sickness absence in County Durham Care:

- There were some issues about the design of the review forms and how information was recorded on them

- There were sometimes delays in obtaining medical information or sick notes and on some occasions it had been necessary to write to individual GP's
- The Branch enjoyed a good and developing relationship with Occupational Health
- There was little consistency in relation to how return to work interviews were conducted and what records were kept
- The nature of work (shift working, or staff dispersed geographically and not working from a fixed base) meant that in some Units, staff were unable to make contact easily with their managers or vice-versa
- The dispersed working arrangements meant that often, managers had little or no personal knowledge of staff
- In some Units there was a culture in relation to sickness absence, with employees believing they were entitled to a full six months absence at full-pay and a further six-months at half-pay before they left the service on capability grounds or retired on ill-health
- There was little cohesion of staff due to the nature of the work and this made education or sharing issues difficult
- The lack of definition of long term and short term absence made it difficult for managers to manage
- All managers needed to adopt a consistent approach and planning in relation to Third Reviews and Capability Hearings
- When line managers were absent there was uncertainty and issues around who picked up their monitoring role

Social Care and Health Service Staff Care Service

7.4 The Staff Care Service in Social Care and Health Service has been in place since 1993 and forms part of the Human Resource Division. It is staffed with one full-time Staff Care officer post and 0.5 Administrative Assistant. Whilst all County Council employees have access to telephone counselling via Lancaster LifeAssist, Social Services is the only Department of the County Council that operates a face-to-face counseling facility.

7.5 The Staff Care Service provides listening and support for employees in Social Care and Health Service. It is confidential, personal, direct, impartial, accessible and freely available. It can act as a gateway to other types of support such as independent private counsellors and other outside agencies. The Service dealt with 179 referrals in the 2002/2003 financial year as follows:

Branch	No. of Referrals	% of Staff
County Durham Care	82	4.0
Adult Commissioning	39	10.8
Children & Their Families	27	6.1
Business Support	10	4.8
Quality & Performance, Community Support*, Strategic Planning & Finance, and Youth Offending Service*	21	7.5
TOTAL	17.9	5.4

* No longer part of Social Care and Health Service

7.6 A wide range of problems are dealt with by the Staff Care Service including:

- Work
- Personal/Domestic issues
- Stress
- Making decisions
- Coping with crisis or traumatic experiences
- Bereavement or loss
- Ill health
- Conflict/threatening behaviour or assault

7.7 The main reasons for referral in 2001/2002 and 2002/2003 were:

Reason	**% of referrals 2002/3**	**% of referrals 2001/2**
Stress	39%	36%
Personal Issues	34%	31%
Ill Health	15%	13%
Information	4%	6%
Bereavement	4%	6%
Alcohol	0%	1%
Suspension	1%	3%
Violence at Work	1%	4%
Grievance	1%	4%

7.8 Outcomes for users had been generally good, with the following results:

Deal better with stress, depression, anxiety	78%
Cope better with family/personal relationship	78%
Remain at work/return to work quicker	64%
Work more effectively	29%
Make positive decision about employment	53%
Cope better with health problem	31%
Cope better with difficulty in workplace	20%
Access helpful information	38%
Feel more valued by employer	37%

7.9 In addition to counselling provision, the Staff Care Service also undertook research, provided information, was involved in health promotion and advised on development of policies and procedures within the Department. The Service would continue to offer listening and support as a priority, but there were plans for working within a new joint team and with Health and Safety and an increased team input into preventative initiatives such as the Health and Work Award; a sponsored Health promotion Seminar and prevention of stress and stress awareness.

Training on Sickness Absence Management for Social Services Managers

7.10 Paul Forster told us about the training scheme which had been developed within Social Care and Health Service to assist managers to better manage sickness absence.

7.11 Social Services has a programme of sickness absence management training for newly appointed managers who have a responsibility for managing sickness absence within their teams. The Social Care and Health Service Workforce Support Manager, together with a Personnel Officer from Corporate Services, currently delivers the training. Courses are held approximately once per month.

7.12 The training provides managers with:

- A better understanding of the need for continuous management of sickness absences and outlines the extent of the problem within the Department
- An outline of the manager's own responsibilities when managing sickness absence
- An in-depth look at Sickness Absence Management procedures and how they should be applied
- An examination of the forms to be completed in connection with the sickness absence review process
- Examples of the types of scenario that might be encountered when managing sickness absence (using a training video)
- Details of the services that can be called upon to support managers in managing sickness absence (Occupational Health, Staff Support and so on)
- How to manage and encourage a return to work after a prolonged period of absence, i.e. phased return, workplace adjustments etc.

7.13 Managers are encouraged to share their experiences of managing sickness absence with the rest of the group – this has proved a very valuable aspect of the course.

7.14 Feedback from managers has been very positive, with feedback showing that they feel better equipped to manage ongoing and future absences.

Corporate Resources

The County Council's Telephone Counselling Service

7.15 The County Council has provided a telephone counselling service for all its

employees (and immediate families) since 1996. Geoff Hardy (Principal Personnel Services Officer) told us that the service is linked to the Council's aim of providing strong, healthy and safe communities. The service was also established for a number of reasons:

- To demonstrate the County Council's commitment towards supporting its employees and their families
- To seek to overcome any potential legal issues/actions linked to workplace stress issues
- To provide financial savings as a result of reduced levels of sickness absence

7.16 The service, which is provided by Lancaster LifeAssist Services, includes:

- 24 hour telephone counselling
- Management consultation service
- Bullying/harassment support service
- Freephone facility
- Eligibility for immediate family members
- Quarterly statistical reports
- End of year reports
- Publicity posters and newsletters for distribution to staff
- Connection to Lancaster's extranet
- Liaison with our Occupational Health Service

7.17 Usage of the service declined until comparatively recently, but there was a large increase in calls in the first half of the year. In 2002, emotional issues (depression, trauma, anger, stress, loneliness and loss of confidence) accounted for some 30% of all calls; marital Issues stood at about 23%; and employment issues (bullying/harassment, stress, workload etc.) were at 11%. Nearly 69% of calls were made during daytime (including weekends). 42% of calls were from men (who make up 30% of the County Council's workforce).

Section Eight - Sickness Absence: User/Carer and Employee Views

Introduction

8.1 When members of staff are absent through sickness, this can have consequences for:

- Clients to whom services are delivered by front line staff
- Other colleagues
- The Departmental budget, where additional services may have to be bought in, often at short notice

8.2. High sickness absence levels in any one Department can also impact adversely upon and potentially skew the County Council's corporate sickness absence performance figures in relation to BVPI 12.

The Impact upon Clients

8.3 Evidence was taken from users/carers about sickness absence levels in Social Care and Health Service at a County wide meeting of the Service User and Carer Forum for Participation in Community Care Services, held at Shotton Hall on 13 August 2003.

8.4 Following a brief presentation outlining the background and scope of the sickness absence scrutiny project, Forum members were posed the following questions:

"If you, or someone you care for, receive support from Social Services directly employed staff at home or in a residential setting:

- *Have there been any instances where staff absences have occurred due to sickness?*
- *Where absences did occur, what was the impact upon yourself/the person cared for?*
- *What could we do to lessen the impact when staff are absent due to sickness?*
- *Why do think sickness absence levels may be higher amongst care staff?*
- *Do you have any views on how we might reduce sickness absence levels of our staff?"*

Feedback

8.5 The main issues raised in response are set out below:

- Is the requirement for care staff to undertake qualifications (i.e. NVQ) placing additional pressures or burdens upon staff?
- Given the high levels of musculo-skeletal illness in County Durham Care, is there a proper screening at the recruitment stage (via medical questionnaires) of individuals who have previously suffered from, or may be prone to this type of illness?

- When care staff fail to turn up due to illness, there can be:
    - Uncertainty about who to contact
    - Lack of continuity of service
    - Implications for carers - Respite support may be needed subsequently
    - Lack of people to fill the gap with client needs going unmet
    - Consequences for relatives/carers left without support who have no option other than to get on with things (which may involve lifting and carrying)
- There needs to be greater flexibility on the part of County Durham Care staff – it was felt there may be too many constraints, with staff having to abide by the "rule book" and not listening to the needs of users/carers
- Careline Services (District based) are very good services with monthly checks on clients/carers

Views of Front line Staff

8.6 During discussions at a combined meeting for care workers in Spennymoor, the following were considered to be possible factors in sickness absence:

- Repetitive injuries – these might often go unreported because staff did not want to miss a shift, but eventually could lead to sickness absence
- Whilst provision had been made for services for staff who required physiotherapy, there was a year's waiting list
- Stress - was an aspect of the job, but could be exacerbated when colleagues were absent through sickness; and caused problems particularly for Team Leaders who were responsible for finding cover
- Not all staff always adhered to the training and guidance given in lifting and carrying - whether because it was perceived as "easier" not to use methods taught or equipment provided, or because of clients particular circumstances
- Use of hoisting equipment in clients' homes, where there were sometimes thick carpets and rugs on floors, meant that staff might encounter difficulties in moving the equipment, even for very short distances. Training in use of equipment, provided centrally for staff, tended to mirror hospital scenarios, being provided in locations where floors were smooth and which did not accurately reflect the position in many clients' homes
- The majority of staff working in the two "patches" were older and might be more susceptible to injuries/illness
- The nature of work was such that staff sometimes felt isolated or unable to share problems with colleagues or supervisors
- The nature of some working was such that staff may have up to 21 days on duty. If they were then asked to provide cover for absent staff, particularly on evenings or overnights, this caused additional pressures.

8.7 As regards improvements that might be made to reduce sickness absence, morale and the isolation of frontline employees were raised as issues that needed to be tackled. We heard that, following a previous meeting, a list of morale boosting ideas had been drawn up and submitted to senior managers, but this appeared not to have elicited any response. Promoting good health amongst staff was also mentioned. The possibility of discounted access to local leisure centres for staff was proposed as one way of encouraging

healthier lifestyles amongst staff. Team building initiatives were also mentioned as something that could help. The possibility of engaging "bank" staff for overnight work when County Durham Care staff were under considerable pressures was also advanced, although it was appreciated that there would be financial implications to this.

The Trade Union Perspective

8.8 We heard the views of Trade Unions about their members' perspective of sickness absence at a meeting involving representatives from Unison, GMB and T&G.

8.9 Derrick Little (GMB) reminded the Working Group that many of the benefits for employees that had been outlined by officers to members were required by Statute (such as leave entitlement and payment protection in respect of pregnancy). It was explained that whilst the Unions had agreed to the sickness absence scheme introduced in 1991, the trigger points contained in the current scheme (which was revised in 1995) had not been agreed by the Unions. His Union's view was that, if sickness absence had been managed in accordance with the existing procedures, absence would never have reached its current levels in Social Care and Health Service. The Union had concerns about proposals for a revised sickness absence scheme and felt that it might compel employees to return to work before they should. In the case of home care workers this might lead to vulnerable clients being put at risk. Home care workers also had particularly onerous conditions of service, with some workers on guaranteed minimum hours having to be available for work from 6.00 p.m. to 11.00. p.m. on some occasions.

8.10 Joy Thompson (GMB) told us that some members were still waiting too long to hear about ill-health retirement decisions, with 8-10 months in some cases before a final decision was taken. Our Personnel Services officers advised us that this was because of the need for an **external** medical practitioner to confirm the suitability of retirement on ill-health grounds. It was possible for an individual's employment to be terminated on capability grounds, without a pension and for the employee to then bring a case for ill-health retirement.

8.11 John Higgins (T&G) told us how useful the externalisation of physiotherapy services by Social Care and Health Service had been had been and asked whether the facility could be extended to other employees. The GMB representatives suggested that use of County Council facilities such as the hydrotherapy pool at The Oaks might be explored. We heard from Peter Appleton that all these pro-active measures were being explored.

8.12 Paul Thompson and Neville Hancock (Unison) emphasised the need for the County Council to develop, as part of its personnel policies, measures that would support employees and prevent them from developing illnesses in the first place. There had been moves several years previously to establish a working group looking at issues related to stress, but this had foundered. It was only in recent months that a stress policy had come near to completion. There was also a need to develop a more supportive culture, where people felt they could openly raise issues about stress. As a caring employer, the County Council should consider whether "well women" and well men" clinics could help to improve the overall health of its workforce and thus reduce

sickness absence. The Council should also look again at how it manages staff who have to cover, for absent colleagues, or where there are unfilled posts, and at the increased pressures and stress this can cause for individuals.

Section Nine – The County Council's Corporate Sickness Absence Management Policy and Private Sector Policies

Introduction

9.1 Geoff Hardy and Peter Crowther (Principal Personnel Services Officers) in Corporate Services provided evidence about the County Council's current and emerging sickness absence management policies and private sector policies.

The Council's Current Sickness Absence Policy

9.2 The County Council's current sickness absence management policy (enshrined in the document "Wish You Were Here") was last reviewed in 1995. The policy (which was not fully agreed with the Trade Unions) has three key principles:

- To improve attendance
- Concern for Welfare of staff
- To fulfil Health and Safety Legislation requirements

9.3 The current policy requires employees to:

- Advise their manager as soon as possible when they are unable to attend due to illness (different departments have their own systems)
- Submit a medical certificate after one week's absence
- Keep managers informed of progress and any likely date for return to work
- Complete a sickness declaration form on their return to work stating the specific reason for the absence
- Attend "return to work" interviews with managers (unless there are insurmountable difficulties for managers in conducting such interviews).
-

9.4 Active Sickness Absence Management is achieved by three main elements:

- **Trigger points** (for a review of an individual's absence) which are:
  - 10 or more days sickness absence in a rolling year, or
  - 2 separate absences or more in a 3 month period
- **3 Stage Review Process** with 4-6 weeks between each review comprising:
  - **First Review** – Between line manager and employee (a relative, friend or Union representative may attend) to discuss problems causing the absence, operational problems caused by absence and what can be done to help
  - **Second Review -** Between line manager and employee (a relative, friend or Union representative may attend) with similar discussions as at First Review
  - **Third Review** - Between line manager and employee (a relative, friend or Union representative may attend). Similar discussions as at First and Second Reviews. However, a representative of Senior Management and someone from Personnel Services will be also be present

- **Options** – Various options will be explored in Review meetings:
    - Return to work of employee
    - Adjustments to workplace to facilitate return
    - Alternative employment (redeployment) of the employee
    - Ill Health Retirement
    - Reference to a Capability Hearing

Problems with the Current Sickness Absence Policy

9.5 Geoff Hardy felt that there were difficulties with the current sickness absence policy:

- The policy did not appear to be working in Social Care and Health Service which had high levels of absence compared with other Departments of the County Council
- The policy was not specific to long/short term sickness absence
- Only long term sickness absence was currently targeted
- Sickness was not being effectively managed:
    - Trigger points were not adequately monitored or acted upon
    - Return to work interviews were not always carried out
    - SSID information system in Social Care and Health Service was not used effectively
    - There was an expectation on Occupational Health to be decision makers, rather than managers making decisions

Possible Improvements to Sickness Absence Procedures

9.6 We were presented with the following as possible areas for improvement to the existing procedures:

- Immediate return to work interviews to be <u>mandatory</u> for every absence
- Consideration of alternative employment/reasonable adjustments
- Limited and/or partial pay protection to facilitate alternative employment
- Dismissal on grounds of capability
- Specific guidance to be issued for persistent short term absence and long term sickness absence

9.7 In relation to better managing persistent short-term absence we were advised that a system could be developed which:

- Applied more rigorous trigger points than those presently
- Provided for attendance targets to be set following triggering
- Required the potential consequences of further absences to be clearly spelled out
- Made dismissal an option if attendance targets were not met.

9.8 As regards long-term sickness absence we were told that this could be better managed if:

- Managers consulted regularly with employees who were off sick
- Formal sickness absence interviews were convened regularly at appropriate intervals to:
    - Support the employee
    - Assess possible improvements in attendance

- Consider continuing absence issues and possible return to work
- Consider alternative employment/reasonable adjustments
- Consider dismissal on capability grounds at the end of a specified time period

9.9 Geoff Hardy told us that sickness absence could be tackled more effectively if:

- Departmental Performance Targets around BVPI 12 were established and monitored
- There was a "push" on managing persistent short-term absence
- Managing absence became a management priority
- A standard information system was established to serve line managers and strategic management
- The accountability of managers in making decisions about sickness absence issues was emphasised and supported
- The advisory and pro-active role of Occupational Health was promoted.

9.10 In conclusion:

- The County Council needed to strive to achieve upper quartile performance in respect of BVPI 12 (currently 8.2 days absence per employee per year), as opposed to current performance which was in the lowest quartile
- There was a need for better guidance for managers, including specific guidance for managing persistent short-term and long-term sickness absence
- Managers must be more pro-active in managing sickness absence
- Trigger points should be used positively to manage sickness absence
- The role of the Occupational Health Service should be better promoted

Sickness Absence Management in the Private Sector

Introduction

9.11 We looked briefly at sickness absence management procedures in the private sector as part of our deliberations. One the schemes we examined was that of Glaxo Smith Kline (GSK), and the identity of the remaining scheme was (at the request of the Company) anonymised. The GSK scheme was made available as a result of links made with Company by Members of a separate Scrutiny Working Group, which had investigated job losses from the GSK plant at Barnard Castle.

9.12 We heard from Peter Crowther (Principal Personnel Services Officer), that, in comparing local authority sickness absence schemes with private sector schemes, it was important to consider the two main types of sickness – short term (which can result from a wide variety of reasons) and long term (which tends to result from an underlying medical problem).

9.13 The most marked difference between the local authority and private sector schemes was in how local authorities dealt with long term sickness and provided a more supportive environment for those absent for longer periods of time, in full compliance with pay protection, equalities and disability legislation. The emphasis was very much on local authorities being seen as "good employers" - working with employees over long periods of time to support their return to work. Private sector schemes tended to deal with long

term sickness absences much more speedily, with dismissal on capability grounds at a much earlier stage. In the evidence we took from the local authority Trade Unions, diminished unionisation of the workforce in the private sector was advanced as a possible factor in this situation.

Section Ten – The Health and Well Being of County Council Employees

Introduction

10.1 A workforce which is healthy, feels valued and has high levels of morale is likely to have lower sickness absence levels, and be more likely to stay in post. The County Council's Occupational Health Service and the Health and Safety Unit both play key roles and are capable of undertaking an enhanced role in promoting good health, safer working practices and better management of sickness absence within the County Council.

Occupational Health

10.2 Dr Philip Wynn, the County Council's Senior Occupational Health Physician explained to us that Occupational Health was concerned with the effect of work on health and the effect of health on work. The Occupational Health Service:

- Had a role in identifying what causes or contributes to ill health in the workplace
- Advised management on actions required (risk assessment)
- Ensured those with health conditions were not unreasonably prevented from taking up job opportunities
- Advised on whether people were fit to perform their required task, with or without workplace adjustment
- Helped in rehabilitation

10.3 The Occupational Health Service provided a service to over 18,500 full-time and part-time County Council employees, 700 Fire and Rescue Service staff and 3,300 other staff (some District Councils etc.) There are 5.5 full-time equivalent medical staff in the Occupational Health Service (one of whom is a full time senior nursing officer providing support solely to Service Direct), plus administrative support. Two long outstanding vacancies had only recently been filled.

10.4 In evidence some of the following issues were highlighted:

- Long term absence linked to chronic health conditions is not always well served by the NHS
- Occupational Health advice is often not sought until a late stage (although it was appreciated there may be capacity issues here)
- There is limited therapeutic support available via Occupational Health – referrals are usually made to specialists for psychiatric and physiotherapy services
- There are often organisational barriers to rehabilitation in relation to issues such as service level requirements, insurance (which provides alternative cover in schools), and about perceptions illness – i.e. "if you're sick, then you're sick"
- Ambiguity about the role of Occupational Health in relation to long and short term sickness absence
- Need for better management training

- Capacity issues of Occupational Health and a need for a greater clarity of role
- The impact of an ageing workforce - as retirement ages increased and ill health retirement reduced – sickness absence levels were likely to rise.
- There may be a wide range of health problems which impacted on recurrent short-term absence and Disability Discrimination Act issues also had to be considered
- There was a need for self-referral mechanisms to be introduced for individuals with musculo skeletal or psychological problems
- More needed to be done to tackle long-term absence (20 days or more), which was only 4% of episodes but accounted for nearly 49% of time lost.
- An audit of long-term sickness absence referrals to Occupational Health from Social Care and Health Service over a six month period has shown the following:

Cause	Number of Employees	Work Related	Non-Work Related
Psychological	18	2	16
Musculo Skeletal	13	4	9
Other Physical (Stroke, Cardiac, Parkinson's, MS etc.)	10	0	10

How the Occupational Health Service can help with Sickness Absence Reduction

10.5 Dr Wynn advanced the following as possible areas where the County Council's Occupational Health Service could play an enhanced role in reducing sickness absence:

- Developing and assisting with primary and secondary prevention in the workplace by:
  - Targeting psychological and musculo-skeletal conditions
  - Closing the loop of risk assessment
  - Developing a mental health at work policy
- Effective disability management and return to work practices which:
  - Target psychological and musculo-skeletal conditions
  - Provide incentives to implement appropriate adjustments
  - Allow employer/employee negotiated solutions
  - Include better communication with general practitioners
- A revised Sickness Absence Policy which:
  - Better promotes the role of Occupational Health in relation to short-term and long-term absences
  - Emphasises the role of the workplace in rehabilitation
  - Provides for earlier interventions
  - Uses Occupational Health more for advice and manager training
- Development and use of audit

The Health and Safety Unit

10.6 The role of the Health and Safety Unit was outlined to us by Maureen Ayre, the Corporate Health and Safety Unit Manager.

10.7 The Health and Safety Unit has a key role to play in helping the County Council to manage and reduce sickness absence.

10.8 A number of **proactive** measures have been developed involving Health and Safety Unit to help reduce sickness absence:

- Development of a Health and Safety Strategy – A corporate strategy had been developed and Action Plans were now in place to deliver the strategy. Social Care and Health Service was taking a lead in this process

- Development of a Health and Safety Management System – All departments were working to implement this and County Durham Care had led on piloting the system

- Development of Policy and Codes of Practice – These had been prepared and issued to all Departments for use by Health and Safety Management Teams in each Department when implementing the Health and Safety Management System

- Development of Managers Health and Safety Manual – This had been prepared and a pilot scheme was to be implemented in County Durham Care

- Corporate Health and Safety Unit link officers – All departments now had a link officer who attended all Health and Safety Management Team meetings and assisted with implementation of the Health and Safety Management System

10.9 The following **reactive** measures had or were being introduced:

- Review all notifications – not all work related absence was notified and the quality of information was often variable.

- Investigation of injury/illness/near miss occurrences – Not all of these were notified. However, there was a need currently to be selective because of a lack of resources/systems. For period 2002/2003 there had been 316 reports for Social Care and Health Service (43.1% of the total), of which 51 were reportable

- Advice on control measures - ongoing use of 'Hot Topics' bulletins to share information and advice.

10.10 Further proactive work was being undertaken to improve systems as follows:

- Introduction of a corporate injury/ill health report form - to be introduced from 1/4/04
- Introduction of an agreed Corporate Reporting, Recording and Manager investigation procedure and system - to be introduced from 1/4/04
- Introduce a Corporate Injury/ill health database - details to be inputted at County Hall - to be introduced from 1/4/04
- Develop cause analysis systems to enable electronic identification of patterns and trends. - to be introduced from 1/4/04

10.11 It was recognised however, that further work was needed in the following areas:

- Regular information was needed from Occupational Health on work related ill health by type and cause. The Health and Safety Corporate Group had made a recommendation about the need for development of a database and there was the possibility that a system could be developed and piloted in Social Care and Health Service
- Occupational Health to develop Corporate policies on work related injury/ill health prevention, health monitoring and health surveillance
- Producing a database system whereby notification can be inputted at the work base.

10.12 The Government was also promoting an initiative aimed at Revitalising Health and Safety and was seeking to reduce the number of days lost through work related injury and ill-health by 20% by 2010.

Workplace Health Promotion

10.13 Following the conclusion of the evidence taking sessions of the Group, Peter Appleton (Social Care and Health), supplied details of two schemes that were under active consideration by the Service for staff. These were:

- Working for Health Award Scheme
- WISH for Health Programme

10.14 It was likely that Social Care and Health would make application for a Bronze Working for Health Award for its staff in 2004. An additional Team Leader would be appointed to the Health and Safety and Staff Care Team to assist with this. As regards the WISH for Health Programme, this was being currently implemented in County Durham Care and was another initiative to try and improve the health of the Service workforce. The County Council corporately was currently undertaking some initiatives that would qualify towards Award status

Working for Health Award Scheme

10.15 “Working for Health” is a local award scheme for County Durham and Darlington, established by local Primary Care Trusts, which encourages employers to protect and promote the health of their employees by creating a healthier workplace and organisation. All workplaces, whether private or public, large or small, can participate. It involves organisations:

- Making a commitment to a healthier workforce
- Providing information and having policies and practices which encourage employees to make healthy choices
- Recognising that organisations themselves can have an impact on individual’s health

10.16 The perceived benefits of “Working for Health” for organisations may include:

- Improvements in health
- Reduced costs

- Reduced absenteeism
- Reduced staff turnover
- Fewer workplace accidents
- Increased productivity
- Improved efficiency
- Increased employee morale
- Good management/employee relations
- A boost for the image of the organisation

10.17 There are three levels of Award - Gold, Silver and Bronze. At each level a workplace must meet certain criteria, which demonstrate that they are promoting workplace health for their employees. The Bronze Award requires:

- Provision of information on relevant health issues to employees on a regular basis
- Raising awareness of health issues through appropriate activity
- Establishment of a health promotion working group, representing staff from all levels of the organisation, **or** provide evidence that an existing group within the organisation, regularly includes health on its working agenda, **or** demonstrate that there is an appropriate means to address staff health needs
- Implement a stated policy on smoking that provides a smoke free environment and promotes smoking cessation support
- Meet the relevant legal obligations for health and safety at work

10.18 Progress towards the Silver and Gold Awards requires additional criteria to be fulfilled including seminars/training for staff on at least two health topics, development of longer term strategies and action plans and, for the Gold Award, demonstration of activities the promote health in:

- Smoking
- Alcohol/drugs
- Healthy eating
- Physical activity
- HIV/Aids and sexual health
- Stress/mental health
- Dental/oral health

10.19 WISH stands for **W**ell-being, **I**ndependence, **S**ocial Inclusion and **H**ealth. The WISH for Health Programme was designed around the Government's core issues in their strategies for Improving Modern Services for Older People, but equally embraces the principles of promoting positive well-being and health care for staff. The main objective of the Programme is to raise everyone's awareness of their health, what affects physical and mental well-being and how we can all simply change our habits to give ourselves healthier lifestyles.

10.20 The WISH for Health Programme will be delivered to users and staff of County Durham Care, based around monthly themes such as food, exercise, healthy hearts and so on, supported by fact sheets, activities and events delivered by the CREATE Team within Social Care and Health Service. It is hoped partnerships and sponsorship can be developed with various supermarkets, pharmaceutical and other companies who have a vested interest in promoting healthy lifestyles, as well as the Unions and the health economy. A series of incentives would be developed to motivate, support and maintain interest in the Programme.

10.21 Many of the criteria for the Gold Award in the Working for Health local Award Scheme mirror the Chief Medical Officer's Ten Tips for Better Health expressed in "Choosing Health?" published by the Department of Health in Spring 2004. This consultation was published against the background of the Wanless Report on health inequalities and seeks views on the role that individuals, the government (central/local), the NHS, the public sector, voluntary sector, industry and the media can play in improving people's health. The Ten Tips are:

- Don't smoke and don't breather others' tobacco smoke
- Eat at least 5 portions of fruit and vegetables each day and cut down on fat, salt and added sugar
- Be physically active for at least 30 minutes, 5 days a week
- Maintain, or aim for, a healthy weight (BMI* of 20-25)
- If you drink alcohol, have no more than 2-3 units a day (women) or 3-4 units a day (men)
- Protect yourself from the sun – cover up, keep in the shade, never burn and use factor 15 plus sunscreen. Take extra care to protect children
- Practice safer sex – use a condom
- Make the decision to go for cancer screening when invited
- On the roads, THINK safety
- Manage stress levels – talking things through, relaxation and physical activity can help

The Ten Tips could perhaps be publicised more widely amongst County Council employees.

10.22 We are conscious that the Council may be considering actions in relation to stress issues and would reinforce the need to do so. The County Council's Human Resources Strategy may need to reflect this and the issues above in relation to staff health and well being.

Section Eleven – Other Local Authority Approaches to Managing Sickness Absence and Promoting a Healthy Workplace

Introduction

11.1 We received evidence from Nothumbria University about various practices adopted in local authorities to reduce sickness absence levels. The Head of Overview and Scrutiny also produced information about how high levels of sickness absence in Lambeth Borough Council Social Services Department had been addressed. We also received information about sickness absence policies in Norfolk County Council and Middlesbrough Council, which had been identified as having low levels of sickness absence.

Northumberland County Council

11.2. Staff sickness levels in the County Council were relatively low (8.11 days) during the period 2001-02 and showed a consistent reduction over time. In comparison with other Shire counties, the County Council were the 'best' in the County top quartile, which reported a counties average of 9.38 days (NCC Best Value Services Review – Personnel Directorate 2002).

Levels of sickness within NCC over the last six years

1993-94	1994-95	1995-96	1996-97	1997-98	1998-99
4.5%	4.2%	4.1%	4.3%	4.1%	3.9%

Source: NCC Best Value Services Review – Personnel Directorate 2002

11.3. The County Council had undertaken a number of measures to ensure low levels of staff sickness, which had proved effective. The comprehensive Attendance Management Policy adopted by NCC operates to ensure an appropriate and consistent level of support to managers and employees. The Policy includes:

- Completion of the 'Staff Morale Index'
- Completion of the 'Staff Quality Index'
-

Currently, the NCC reported a 77% level of satisfaction among employees from the 'Staff Morale Index', which estimated an 85% target.

East Riding of Yorkshire

11.4. East Riding of Yorkshire Council had addressed and sought to improve sickness absence levels through the effective management of employees who were committed to serve their community. Sickness absence levels between 2001-02 were well below the projected target at 6.25 days per full time employee. The council set a target of (BV12) 10.9 days in line with the government's target set for 2004-05. The council believe that, with more rigorous and consistent monitoring and management training, the levels of sickness absence have improved.

Gateshead Metropolitan Borough Council

11.5. During 2001-02, an average of 10.66 days were lost per employee to sickness. The target set for the council was 14.0 days, an improvement on the 13.0 days lost per employee in 2000-01. The council implemented a number of initiatives that included:

- More flexible working hours;
- Flexi-time system for part-time employees.

This series of initiatives was undertaken in collaboration with the North East Regional Employers' Organisation (NEREO) as part of the 'Work Life Balance' project.

11.6. The council have set up a training scheme, 'Managing the Modern Gateshead Way', which will allow managers to focus on responsibility, managing people and building a strong team. The council's Health and Safety policy is central to this work, which aims to make health at work a part of the corporate culture. Areas covered in the policy will include: physical activity, healthy eating and work-life balance promotion.

Sunderland City Council

11.7. Sunderland City Council implemented their 'Attendance Management Policy' in 2002 to reduce sickness absence. The City Council reported an average of 11.6 days per full time employee lost due to sickness absence during 2001-02 compared to the estimated target of 10.75 days. The Council's performance against the national target set at 11.4 days for the period 2001-02 was accounted for in terms of what the Council viewed as a change in definition for sickness absence'. According to the Council, considerable changes to the definition affected performance for the current year.

11.8 Recently introduced initiatives, which form part of the 'Attendance Management Policy', include:

- Assessment of sickness – effective monitoring of records, identifying patterns, and assessing problems that may be exacerbated by work.
- Consultations with employees, GP's and occupational health professionals through return to work interviews or, in the case of long term absence, maintaining contact with the employee through home visits.
- Improvement plans – health promotion, job analysis and involvement of various health support groups or networks.

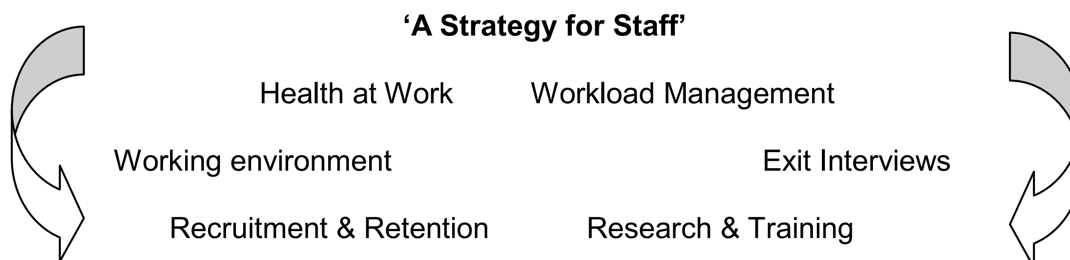
11.9 The City Council's half yearly figures for 2002-03 show an average of 5.16 days against the authority's target average of 10.5 days, and predicts the yearly figure to fall well within this yearly target.

Kent County Council

11.10 Kent County Council have recently adopted a holistic approach to reduce the level of sickness absence and support staff needs. Their 'Ten Point Plan', which aims to address the welfare of the whole individual and benefit all staff within the directorate, was implemented between 1999-2000 and includes number of initiatives that encourage healthy lifestyles. For example, a total of 85 days of health checks in 2000 were allocated to 699 members who took

part in 9 separate checks each lasting between 30-45 minutes. In addition, stress training seminars and health fairs are regularly organised, and discounted health club memberships and flu vaccinations are offered yearly.

Kent County Council's 'Strategy for Staff's Ten Point Plan'



11.11. The Council's 'Strategy for Staff' will be implemented fully over a period of five years and aims to reduce the proportion of days lost due to sickness absence to 4.0%. For the period between 2001-02 the County Council reported an average of 8.1 days lost due to sickness per full time employee equalling a 4.5% proportion.

Barnet Council - London

11.12 Barnet Council recently took part in a research project undertaken by the Employers' Organisation for local government (2002), and were generally reviewed as having relatively low levels of sickness absence per full time equivalent employees. In terms of performance, the council reported an estimated 8.3 days (2001-02) lost per full time employee due to sickness absence, against the BV12 indicator target of 9.8 days. Barnet Council introduced a number of measures and initiatives, which were implemented in management training courses. For example, workplace counselling by their line-manager on return to work, exit interviews and, more robust sickness monitoring methods. Barnet Council aims to reduce sickness absence levels to 7 days lost as set out in the Best Value Performance Plan 2002-03.

Sickness Absence Levels in Lambeth Borough Council Homecare Division

11.13 A study of sickness absence in Lambeth Borough Council Homecare Division of Social Services was undertaken in the late 1990's due to high levels of sickness absence within the Homecare Division. Initially, figures of over 30 days absence per person per year were reported, but later investigations showed over-reporting and in the period 2000-2001 the figures were revised downwards to 24 days absence per person per year.

11.14 An analysis of the absence statistics showed that nearly 50% of sickness amongst home-carers was back related. Over 66% of sickness was long term (one month or more).

11.15 Some of the actions undertaken within Lambeth Social Services to address the problems were as follows:

- Second and Third Tier Managers to discuss with managers all cases of high sickness to ensure prompt and effective action is being taken

- Reports to be produced centrally on all staff with over 15 days sickness absence, or three or more periods of sickness absence, in the previous year
- Publicity (“league tables”) within the Directorate/Divisions on notice-boards about sickness absence levels
- A sickness absence roadshow for managers to brief management teams on sickness procedure and best practice and to give practical assistance on individual cases
- Action to tackle long term sickness absence which was seen to be key to reduce overall levels of absence.

11.16 The high levels of back related problems were also investigated. The main factors were felt to be:

- Training in moving and lifting
- The disproportionate numbers of older home care workers.

11.17 Actions undertaken to prevent musculo-skeletal illness included:

- Training in manual handling as part of induction
- Yearly refresher training
- Training within service-user households
- Improved risk assessment processes (every three months for each client, instead of just at initial assessment)
- Externalisation of some aspects of home care that were seen as a factor in musculo-skeletal illness, such as shopping and housework, with the focus being on in-house provision of personal care

Sickness Absence Rates in Middlesbrough Council and Norfolk County Council

11.18 Members asked during the project if research could be undertaken to determine whether the rates of sickness absence in Social Services Departments within Middlesbrough Council and Norfolk County Council, (which are approximately 50% less than those in County Durham) could be investigated.

11.19 Neither of sickness absence schemes for these Authorities showed any significant differences to that of Durham County Council’s scheme. Telephone inquiries of each Council revealed the following:

Norfolk

11.20 Currently piloting a physiotherapy referral scheme which has physiotherapy services that are outsourced. Over 50 members of staff have been referred to date.

11.21. Home care staff undertake training on lifting and carrying, with refresher training from time to time.

11.22 Risk assessments are carried out in clients’ homes. It is up to carers to report any changes that might require an updated risk assessment.

11.23 Medical Screening prior to employment an intrinsic part of process.

Middlesbrough

11.24 Middlesbrough were tackling long term sickness absence and had produced a database and checklists for manager. They were robust in relation to referrals to occupational health and had rigorous pre-employment screening. The Health and Safety Executive would be conducting a stress audit pilot in the Authority in the coming months

Comments from Social Care and Health

11.25 Peter Appleton advised the Working Group that, whilst sickness absence rates were now falling in Social Care and Health Service in County Durham, latest data showed they had begun to rise in some of the authorities cited as examples of best practice.

Section Twelve – Conclusions

Introduction

12.1 The causes and consequences of sickness absence are many and varied. Whilst there are no easy answers to tackling sickness absence, evidence shows that a workforce which is motivated, feels valued and where health and well being are promoted, is less likely to spend time off work sick and is more likely to remain in post. There are number of initiatives ongoing (some of which have been personally endorsed by the Leader of the Council) and these provide a solid base on which to enhance support for health and well being promotion; however, more still needs to be done.

12.2 As the investigation progressed we found that, although there were a number of conclusions and recommendations that were specific to Social Care and Health Service, there were others that merit consideration across the whole of the County Council (including, of course, Social Care and Health).

Social Care and Health Specific Issues

12.3 We were presented with a considerable amount of evidence about the actions that were being taken within Social Care and Health Service to address high levels of sickness absence. Over the period of the scrutiny investigation the impact of this was evident, and we were pleased that the latest figures confirm that the trends are still downwards. Indeed, during the course of the investigation, we found some aspects of work going on within the Service that provide examples of best practice for the remainder of the Council. However, the levels of sickness absence in Social Care and Health in County Durham still need to reduce over time to achieve convergence with absence levels in other comparator authorities.

Lifting, Carrying and Assessment

12.4 One area that we feel needs further consideration is that of training in, and use of, equipment within client homes. We heard from Social Services Officers that training in use of equipment is provided at central locations for relevant staff and that there are staff who provide specific advice and instruction about use of equipment in clients' homes. However, home care staff told us that the training is not always relevant, as it is carried out in "artificial" hospital type situations with smooth floors and does not replicate the situation in clients' own homes where there may be thick carpets or rugs on the floors. This often requires care staff to have to pull or tug equipment, even for quite short distances. This needs to be addressed in both training and assessments of clients.

12.5 There may be issues which confront care staff on a daily basis about how to lift and carry users of services within their homes which are linked to training. We heard from home care staff that some employees on occasions may disregard what they have been taught because it is easier to do things a different way. We also heard from the Users and Carers group that they felt sometimes, home care staff might be too inflexible in how they deal with

clients. This makes it all the more important to ensure that the training which is given to staff is relevant; the benefits of the techniques are proven; and the use of the procedures is reinforced regularly. Likewise, clients need to be re-assured that the methods of care employed including lifting and carrying are there not only to ensure their own safety and comfort, but those of the staff caring for them. We heard in evidence from the Health and Safety Unit and from home care staff themselves, that some staff may not be reporting musculo skeletal injuries, but work through their injuries instead. Training and assessment and reporting procedures should reflect these matters and staff should be encouraged to discuss difficulties with supervisors where there are problems. When injuries are identified, staff should have speedy access to physiotherapy services. We heard from staff of some delays and waiting lists for help.

The Nature of the Work – Promoting Morale and Well Being

12.6 The rates of sickness absence in Social Care and Health are highest of all amongst County Durham Care staff. We heard various factors advanced for this during the course of the investigation, including an ageing workforce, the nature of the work and conditions of service. Home care staff work very much on the front line, often on their own, with some of the most vulnerable and dependent members of our communities, and frequently in difficult circumstances. We accept that the nature of the work, conditions of service and other factors outlined above may have an impact on sickness absence levels. This is borne out by the comparator data from the Employers' Organisation, which shows the highest levels of sickness absence in most other Social Services Authorities nationally to be in those Divisions or Branches which are similar to County Durham Care. However, given that the nature of the work and conditions are not dissimilar between authorities, the higher rates in County Durham are still difficult to explain. One factor which might be relevant, but about which we did not receive any direct evidence, is that of the health of the population generally in County Durham. In health terms we have some of the most deprived areas in the County and many home care staff are drawn from these communities. This makes it all the more important that, as employers, we promote health and well being amongst our staff. We did hear from some staff/supervisors in County Durham Care about the stress that some staff were subjected to when having to cover for absent colleagues and how this could have a "domino effect". We were told that this might be overcome in extreme cases by having access to "bank" or peripatetic staff to cover for absent colleagues. We make no specific recommendations in relation to this issue and understand that there are likely to be costs associated with such a proposal, it may merit consideration for extreme circumstances.

12.7 We heard from home care staff that, apart from "patch" meetings, they work very much on their own. County Durham Care managers explained that, often, the nature and demands of the job means that managers are not able to get to know all of their staff. More needs to be done to overcome these barriers, promote a sense of belonging and enhance morale. However, allied with this must be action to inform/educate Social Care and Health staff (and care staff particularly) about the impact and consequences of sickness absence upon clients and their carers.

Improving Sickness Absence Rates

12.8 Throughout the investigation we heard about improving figures for sickness absence and the various actions that were being taken to address this. This work needs to be sustained and intensified. Recommendations in relation to this issue will not only be made for Social Care and Health but across the whole of the County Council.

The Financial Costs of Sickness Absence

12.9 In circumstances where staff cover is arranged, those members of staff who are absent through sickness and who regularly undertake shift working as part of their duties, currently continue to receive their usual enhancements. Whilst there may be agreements, local or national which regulate this issue, we feel that Cabinet may wish to consider this matter further. Savings from non-payment of enhancements might be usefully directed to engagement of "bank" or peripatetic staff.

Corporate Recommendations

Management of Sickness Absence

12.10 Perhaps the most important aspect of sickness absence is how it is managed. During the course of the investigation we heard about the County Council's revised sickness absence policy, which is currently subject to consultation. Whilst the proposed policy has been revised and accords more closely with some of the sickness absence policies we examined in the private sector, it still reflects the County Council's wish to be a caring and supportive employer. However, policy apart, it is how sickness absence is managed on a day to day basis which is most important. Tackling sickness absence needs to assume a higher profile across the whole of the County Council, with Action Plans for reducing absence being pursued in Services. Staff in each Service need to be better informed about the costs of sickness absence and the impact it has on those we serve. Managers at all levels must address the issues and new training initiatives should be developed to support managers in this role.

The Sickness Absence Process

12.11 Whilst the current sickness absence policy ("Wish you we Here") applies equally across the whole of the Council, detailed arrangements for reporting and tracking sickness absence differ between some Services (i.e. following initial contact, Social Care and Health staff are required to contact line managers again after three days absence to provide an update; in some other Services, this is not required). There needs to be more consistency across the Authority in relation to the process (whilst still respecting any variation necessary to meet specific needs in different Services) and greater rigour in use of trigger points to ensure that necessary actions are taken by managers when trigger points are hit (even if this is simply a review without action). Personnel Division should play a greater co-ordinating role, but we recognise this may have resource implications.

12.12 Supporting people when they are absent through illness is part of a manager's role. The research evidence we received showed vast differences between some local authorities as to whether this was done. Keeping in

contact with absent staff is important. We feel that for longer term sickness absence (20 days or more) one possible way of monitoring this could be via the return to work declaration form. The procedures also need to allow for some variations in working between Services. Our preference would still be for face to face return to work interviews and every effort should be made to ensure this. However, there may be merit in some Services exploring whether return to work interviews can be conducted by telephone, where staff are often geographically remote.

"Gate keeping"

12.13 One of the issues raised with us in discussions with Users and Carers and which was also evident in the research undertaken about better performing local authorities, was that of screening of applicants for employment. The County Council clearly needs to comply fully with the requirements of the Disability Discrimination Act, but we believe scope exists for more rigorous scrutiny of previous sickness absence when assessing applicants for employment. This should not only apply to external candidates but also internal candidates for positions. Sickness absence should also form an important aspect of any assessment of performance at the completion of probationary periods of new staff. The Head of Personnel should produce further guidance on these issues

12.14 Whilst new employees receive information about sickness absence policies and procedures, this needs to be reinforced amongst longer serving members of staff.

A Healthier Workforce

12.15 There was evidence of much good practice amongst other local authorities and public sector organisations about promotion of health and well-being amongst staff. We heard from the County Council's Senior Occupational Health Physician about some of the actions that might be undertaken to develop the role of the service and do more to support staff. It appeared to us that the current arrangements, however, permitted little more than undertaking the day to day current responsibilities of the Service and until comparatively recently, there had been two vacancies which had only just been filled. We feel the roles of Occupational Health and possibly Health and Safety Unit need to be re-examined to explore what scope exists for delivery of some of the potential improvements identified in evidence, including campaigns to target musculo skeletal conditions, developing a mental health policy at work, and assisting more in return to work issues, as well as supporting enhanced health and well being initiatives for staff generally.

12.16 We were impressed with the work underway in Social Care and Health to do more to support its staff via the Working for Health Award and the WISH for Health Programme. The recent "Five a Week" initiative has also raised issues about increased exercise and healthier lifestyles. We are making recommendations about a whole range of options which Cabinet may wish to consider, including face-to-face counselling, access to health advice and leisure, staff morale surveys and the promotion of generally healthier lifestyles amongst all employees. We recognise, however, that the opportunities for front line staff working outside County Hall to access support are perhaps less than those who work in the Council's administrative Headquarters. In developing any programmes of action for support, we would suggest this issue must be taken into consideration and the necessary provision made.

Section Thirteen – Recommendations

13.1 Although the project looked particularly at sickness absence within Social Care and Health Services, many issues emerged which apply equally well across the whole of the County Council. Accordingly, our recommendations are grouped together under two broad headings – those specific to Social Care and Health Services and those which apply to the County Council corporately.

SOCIAL CARE AND HEALTH SERVICES RECOMMENDATIONS

13.2 The actions taken to address sickness absence levels in Social Care and Health Services and downward trends in absence levels are commendable, but this work needs to be sustained. Sickness absence levels in Social Care and Health Services, although now falling, are still high in comparison to most other Social Services Authorities nationally and adversely impact upon the County Council's Corporate BVPI. Our recommendations seek to build upon and sustain the work already underway on tackling this issue within the Service and are that:

Further and Improved Training

(a) Current training arrangements in Social Care and Health Service in relation to lifting, carrying and use of equipment should be reviewed. Wherever possible, lifting and carrying training should be delivered to Social Services staff, either within clients homes or in settings that more accurately represent clients' home situations.

(b) The appropriateness of existing hoisting and lifting equipment should be reviewed to ensure it can be moved easily in home settings where carpets or rugs are present.

(c) The current process of risk assessment for Social Care and Health Service clients should be reviewed. Whilst care staff are in the best position to report changes in client circumstances and needs and usually do so, there should be regular programmed re-assessments of client needs and the impact upon Social Service staff providing services to them.

More Inclusive

(d) The Director of Social Care and Health should give consideration to what actions can be taken in relation to staff (such as home care staff), within the Service who may be geographically isolated both from each other and their managers, to:

- Promote a greater sense of belonging and cohesiveness and build morale
- Provide greater opportunities for and give more encouragement to staff to raise health related issues with their managers
- Allow line managers to gain a greater understanding of the needs of their staff

- Highlight, on an ongoing basis, sickness absence as an important issue and the impact this has on clients
- Encourage reporting of injuries sustained at work; provide appropriate support (including recuperation and **speedy** access to services such as physiotherapy) where necessary; and publicise the availability of such therapies.

(e) The current focus on and actions taken within Social Care and Health to reduce sickness absence should be sustained and in particular, the actions taken ensure speedy referrals to Occupational Health and to process long term sickness absence cases through the review process.

(f) A review of the current arrangements, whereby staff in Social Care and Health Service who are absent due to illness continue to receive payment of shift allowances etc., where these are a regular constituent of wages, may be considered timely.

CORPORATE RECOMMENDATIONS

13.3 Whilst the main focus of our investigation was on sickness absence levels within the Social Care and Health Service, many of the recommendations apply equally well to all Service areas. We believe there is merit in considering the following recommendations for implementation corporately.

Management of Sickness Absence

13.4 A key factor in reducing sickness absence is _how it is managed_. This applies from senior management level down to individual line managers. We consider that:

(a) Where it does not already do so, ***Sickness Absence should be a regular item on all Service Management Team Meetings and Corporate Management Team Agendas.***

(b) Services, individually, should consider how sickness absence levels at both Branch and Team level can be reduced, and when necessary and where appropriate, develop Action Plans for so doing, indicating lead officers and timescales. Corporate Management Team would serve as the best mechanism for progressing this recommendation.

(c) Performance data on sickness absence at Team and Branch levels in each Service should be published at regular intervals to all employees, with an indication of the costs of absence to the Council, expressed in monetary terms.

(d) Managers should be better trained in how to manage sickness absence and we suggest **all** line managers should receive training, as appropriate, as a matter of course.

(e) Managers should be reminded of the need to conduct return to work interviews after each and every absence. However, the Working Group recognise that a balance needs to be struck between the informal nature of any such interviews and the need to note confidentially any key issues discussed.

The Sickness Absence Process

13.5 Whilst the existing County Council policy on sickness absence, “Wish You Were Here” provides a corporate framework, we found that the details of the sickness absence process sometimes differ between Services. There needs to be greater uniformity of the process itself across the County Council. Accordingly:

(a) Personnel Services should produce guidance for all Services to ensure that a more consistent approach is adopted across Services for return to work interviews.

(b) Whilst our preference is for face-to-face return to work interviews, in Services where it may be difficult for face-to-face return to work interviews to be held, options for alternative means of conducting interviews at the earliest possible opportunity on return (i.e. by telephone) should be explored.

(c) There should be greater overall consistency between Services about procedures for notification of sickness absence and tracking arrangements. Personnel Services should review existing procedures in Services and produce corporate guidance on the arrangements to be adopted.

(d) Individual Services should review their existing recording and tracking procedures for sickness absence to ensure that the necessary actions in terms of review (whether or not any action is taken) are undertaken by managers when trigger points are hit.

(e) Proper management of long term sickness absence (20 days or more) and the return to work process is essential. Mechanisms should be introduced to monitor and ensure that appropriate contacts between line managers and staff who are long term absent take place at appropriate times, in accordance with current policy. The return to work declaration form could potentially be used to gather such information - including comments from employees about their experience of the contact made.

(f) Personnel Services should play a stronger role in monitoring sickness absence corporately and drawing to the attention of members and officers issues which may arise that might require appropriate actions to be undertaken.

Recruitment/Promotion of Staff

13.6 Whilst there is a need to comply with Disability Discrimination Act requirements, the sickness absence history of applicants can provide an important indicator of potential difficulties when recruitment is undertaken. Wherever possible:

(a) More rigorous monitoring of the sickness absence history of potential employees at the application stage should be undertaken. This should apply equally to internal applicants for posts. The Head of Personnel Services should develop and issue guidance to Services on this issue.

(b) Sickness absence should form a major component in any assessment of individual employee performance at the completion of any probationary periods for new employees.

Publicity about Sickness Absence

13.7 All County Council employees should be reminded of the sickness absence procedures and the requirements to advise managers at the commencement of and during periods of sickness absence.

Staff Health and Well Being

13.8 The Council has already begun a process of developing and implementing policies to promote staff health and well being, most recently in relation to stress. However, more could be done (particularly in relation to staff working outside County Hall) and we recommend that the Head of Personnel should prepare a report for Cabinet about how this can be promoted. This could possibly include:

- development of face-to-face counselling and staff support in each Service area (we are aware this issue may be being actively considered)

- how access to health advice and clinics or health-related workshops/activities are promoted

- the opportunities for the Council to participate in and achieve the Working for Health Award or to promote the WISH for Health Programme

- development of staff surveys to assess employee health related concerns

- promotion of healthy lifestyles generally amongst all staff

- how Occupational Health can develop and assist with primary and secondary prevention in the workplace by targeting psychological and musculo-skeletal conditions, closing the loop of risk assessment and developing a mental health at work policy

- development of a database system for work related ill health by type and cause (preferably where notification can be inputted at the work base).

- The development of Corporate policies on work related injury/ill health prevention, health monitoring and health surveillance

- whether the existing structures in Occupational Health and/or Health and Safety Unit need to be reviewed in support of the above

- the implications, costs and benefits of pursuing the above recommendations

13.9 Cabinet may also wish to consider whether greater prominence should be given to staff health and well being issues within the Human Resources (People) Strategy.

Review

13.10 A Review of progress against the recommendation in this report should be undertaken six months after its consideration by Cabinet.

Section Fourteen – Membership of the Working Group

14.1 The following Councillors were Members of the Working Group:

Joe Armstrong
Dennis Coates (Human Resources Committee)
Jim Cordon
Sonny Douthwaite
Tom Forster
Edna Hunter
Morris Nicholls (Chairman)
John Priestley
Paul Stradling
Eric Watson (Human Resources Committee)
Anne Wright (Human Resources Committee)

14.2 Co-opted Member of the Working Group:

Ken Ibbitson (County Durham Service User and Carer Forum For Participation in Community Care Services)

Appendix One

Oral Evidence Taken

Date of Meeting	Organisation/Witnesses
9 May 2003	Peter Appleton (Operations Manager, Social Services Department) (Updates on progress with sickness absence reduction were also given at subsequent meetings)
11 September 2003	Trisha Davidson (Home Care Manager, County Durham Care)
23 October 2003	Geoff Hardy (Personnel Services Officer, Personnel Division, Corporate Services)
9 January 2004	Dr Philip Wynn (Senior Occupational Health Physician, Corporate Services), Jean /Carr (Staff Care Officer, Social Services Department)
30 January 2004	Peter Crowther (Personnel Services Officer, Personnel Division, Corporate Services), Derrick Little and Joy Thompson (GMB), Paul Thompson and Neville Hancock (Unison), John Higgins (T&G)
11 February 2004	Maureen Ayre (Principal Health and Safety Officer, Corporate Services), Paul Forster (Workforce Support Manager, Social Services Department)
20 April 2004	Participants in Combined Patch Meeting of Social Care and Health care staff at Derwent Court, Spennymoor

Appendix Two

Written Evidence Submitted

Date	Evidence (Reports of the Head of Overview and Scrutiny)
11 May 2003	Users/Carers Feedback on Sickness Absence
11 February 2004	Sickness Absence: Causes, Comparative Data and Best Practice in other Local Authorities