

## Job Retention and Rehabilitation Pilot: Employers' management of long-term sickness absence

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The study explored how employers view and deal with sickness absence. It was commissioned by the Department for Work and Pensions to inform work undertaken through the Government's Job Retention and Rehabilitation Pilot (JRRP), which is trialling ways of helping people on sick leave to return to work. In-depth interviews were carried out with 53 representatives with differing roles in 22 public, private and voluntary sectors organisations in four of the six pilot areas. The main aims were to understand how sickness absence policies translate into practice and to investigate any needs for extra help or information to manage sickness absence.

### *Employers' attitudes to sickness absence*

Sickness absence was seen as a problem because of difficulties in providing cover, stress and overload on the workforce, costs, effects on productivity, profitability or competitiveness, and repercussions for customer service.

Among managers there was some lack of sympathy towards days off for 'minor' complaints, suspicions that short-term absences were not always 'genuine' and suggestions that the seven-day self-certification period encouraged illegitimate days off and longer spells than warranted. There were some tensions between human resources staff, who wanted to avoid an overly punitive approach, and managers who wanted to pursue a disciplinary route. Organisations that saw themselves as caring and supportive were keen to identify underlying problems at work and make changes to pre-empt further absences.

There was a widespread desire to retain staff absent with long-term sickness in order to keep specialist skills, maximise investment in training, avoid costs of recruiting and training new staff, circumvent the shortage of new recruits and to give the wider message to staff and job applicants that they are valued.

It was easier to plan work if absence periods and lengths were known in advance, and uncertainty about absences related to mental ill health made work planning harder to manage. There was little evidence of unsympathetic attitudes towards long-term absence, though some scepticism among managers about stress-related illnesses, and some tendencies to see retirement on health grounds as inevitable where redeployment opportunities were restricted.

Policies for long-term absence were generally thought to be supportive of the individual, except where a disciplinary tone was taken at an early stage.

Apart from in small companies, performance in terms of days or percentages of time lost was generally commented on. Targets appeared to be a spur to improve absence rates, especially where the performances of different parts of the organisation were regularly compared, and reducing long-term absences could have an important affect on ability to meet targets.

### *Documenting and communicating policies and procedures*

According to accounts from study participants, documentation appeared to concentrate on procedures absent employees had to follow

and, in unionised organisations, to emphasise formal investigation and grievance procedures. Written guidance on how to apply procedures varied in depth and prescriptiveness. There were examples in large companies of intranet-based information on supports to help people back to work. Some documents stated the rationales for policies; here language and tone was intended to convey values underpinning the approach.

A strong impression emerged of policies and procedures evolving rapidly: being formalised for the first time, re-written or tightened. Human resources staff brought their professional experiences to policy development, as well as advice from specialist organisations. Policies also had been informed by asking other employers, and there were mentions of emulating 'good practice' employers. Often part of the process were consultations with unions or elected staff representatives and human resources staff. Occupational health staff were sometimes marginal here, and ordinary staff were not necessarily asked.

A noticeable development was changes to short-time absence policies to allow more scope for disciplining staff perceived to take advantage of lax procedures.

Where policies and procedures were kept under review, human resources staff used guidance on employment practice, and the Disability Discrimination Act 1995 was often an impetus to review policies.

Efforts to ensure that policy and procedures were fully understood appeared to be directed more at managers charged with implementing them than at employees subject to them. There was a view that an approach that outlines what the organisation can do for the employee is more helpful than rules on what to do.

### ***Managing short-term absences***

The approach to managing short-term absence was typically non-interventionist. While it was widespread practice for the employee to make contact on the first day of absence, only one employer in the study was proactive at this point in that they offered occupational health advice for selected conditions. There was rather little evidence of active management of sickness absence in the first two to three weeks following self-certificated absence, though some large

organisations asked employees about whom they had concerns to see the occupational health service for help. Stress, depression, upper limb disorders and recurring illnesses such as asthma were mentioned here. Referral to occupational health typically depended on managers understanding conditions. Exceptionally, occupational health staff monitored medical certificates and applied their expertise in deciding which absent employees to contact.

Return to work interviews, or less formal discussions, were almost universal, but sometimes cursory. The thrust and tone ranged from suspicion of unwarranted absences to demonstrating that the organisation cares. There were beliefs that return to work interviews deterred unwarranted days off, and sometimes those employees about whom managers had suspicions received the most attention. Work pressures meant it could be hard for managers to make time, and systems for checking that return to work interviews were sometimes acknowledged to be inadequate. Sometimes interviews were taken seriously as opportunities to explore work-related causes or hidden problems, and occasionally were thought to have been successful.

Although it was sometimes recognised that repeated short spells of absence, like occasional days off, could be the precursor to prolonged sickness absence, there was a tendency for them to be seen as suspect. In larger organisations with systems to log repeated absences, attendance review meetings could be the first step on a disciplinary route with the requirement imposed to improve attendance. But there were also organisations that investigated and tried to address underlying problems.

### ***Managing long-term absences***

Respondents in almost all organisations stated a defined number of days or weeks at which continued absence became regarded as long-term, usually four or three weeks. The earliest thresholds, from ten days, had been chosen as the most appropriate at which to intervene with rehabilitation efforts. Managers tended to be less certain than human resources staff about when activities related to long-term absent employees should begin. Monitoring systems were not always robust, and it was possible for long-term absent employees to be forgotten.

In the period before a continued absence became long-term, the line manager was typically the main actor. In terms of responsibilities for the management of long-term absence, there were five models:

- prime responsibility with departmental or line managers, common in public sector organisations;
- shared between managers and human resources managers;
- led by human resources managers;
- led by the occupational health department, in one organisation;
- shared by human resources, occupational health nurse and line managers.

Some problems were associated with leaving responsibility to managers: other pressures on their time, limited knowledge or skills, and inconsistent treatment. Back up from human resources included more proactive advice giving, and, in large companies, central telephone-based help teams. Managers welcomed directive advice from central or regional human resources staff, and 'hands-on' involvement of locally-based human resources staff. Where human resources took the lead there was scope for consistent practice across the organisation. A 'triangle' of human resources, occupational health nurse and line manager had clearly defined roles.

There was variation in how organisations kept in touch with long-term absent employees, and sometimes differing understandings within an organisation of what should happen and when. Home visits were at regular intervals or discretionary. Human resources staff, and managers themselves, reported some reluctance on the part of line managers to undertake home visits, in part because of wishes to avoid pressuring the person back to work. Staff who made home visits believed they were appreciated, however. Where the employee was invited to see an occupational health professional and line manager regularly, home visits were unusual.

Formal meetings to review prospects for or to plan return to work were carried out at the workplace, and sometimes involved case conferences with the interested parties and action planning

Occupational sick pay provisions were thought to be a disincentive to early return to work and to hinder employer's efforts to facilitate return to work. It is possible that an untrusting approach to managing short-term absence reduces confidence in the organisation's commitment to them on the part of long-term absent employees.

### *Rehabilitation resources*

Use of services for rehabilitation was not strongly evident. Counselling and medical assessments or interventions were the main services purchased on a contractual basis or provided internally to assist a return to work. Counselling services were aimed at assisting both employees and managers, but their effectiveness was often unknown due to confidentiality requirements. Advice on specific issues and health conditions was sought from external sources as the need arose. Services such as physiotherapy, MRI scans and sessions with chiropractors were purchased as individual need arose. Employers reported the value of using public services such as the Jobcentre Plus Disability Services, appreciating their specialist knowledge and expertise, but there were also some frustrations in using them.

### *Use of occupational health services*

Among large organisation, occupational health advice was drawn from in-house occupational physicians and nurses or from contracted providers. Long-term absent staff variously were referred automatically to occupational health at trigger points, strongly encouraged to make contact, referred selectively or referred as a last resort. Managers valued occupational health advice if it indicated a likely return date or added to understanding of the condition and its impact on work. Criticisms included the perceived impracticality of advisers' suggestions, views that occupational health intervention held back speedy return to work, and delays in receiving reports. Human resources staff approved of occupational health advisers who were found to be supportive of the individual. Some human resources staff felt they played an important role in managing tensions with between occupational health and managerial staff's priorities.

## **Adjustments and adaptations on return to work**

In general, employers were willing to consider and make adjustments or adaptations to employees' working conditions and the workplace. A wide variety of modifications were reported including phased returns, altering or reducing hours worked and tasks undertaken, adapting equipment and the place of work, and temporary or permanent redeployment.

The focus was primarily on the employee so that employers were guided by their circumstances and needs as far as possible. The ability to be flexible and imaginative about what could be offered and agreed with an employee was seen as important. Despite a willingness to do what they could to help employees back to work employers faced a number of barriers. The employer's capacity to make modifications was dependent on their size, resources, type of work undertaken and variety of jobs offered. The employee's circumstances could also prove to be an obstacle, such that nothing that the employer could offer or do would facilitate their return to work.

## **Needs for further support**

Employers were asked about their awareness of external services to support return to work other than those they had used. Awareness was greater among dedicated human resources staff and less among staff at smaller private organisations who were not human resources specialists. Specialist employment services, advice bureaux, charities and professional bodies in the medical field were mentioned, as was one private company offering a return to work service. Some felt they did not need to use external support because the services on offer were not suitable for the work environment, their internal resources were sufficient and valued, or a specific need had not arisen.

Although informants were not questioned directly about the JRRP, larger organisations in particular recalled it as an external service they were aware of and sometimes had experience of. Some had been in contact with JRRP providers on a purely introductory level; some had built on the introduction by collaborating with them for the benefit of an absent employee; others had first-hand experience of working alongside JRRP providers without prior briefings. There were

some mixed views about the service, but positive reflections included the ability to be proactive and provide a seamless service. Learning from the pilot included being introduced to making return to work plans.

The idea of best practice guidance was welcome for some: as a source of advice on making adjustments and accessing grants, as a form of moral support, or as a tool for measuring themselves against other organisations. Those whose sickness absence procedures were being updated or were newly installed were particularly keen to access good practice guidance. Otherwise there were doubts among human resources specialists that it could add anything to their own personal experience and organisational resources. While some operational and line managers felt they might benefit, for example from guides to managing stress, they said they lacked time to read them.

Respondents often spoke of the need for changes to existing arrangements, such as long National Health Service waiting lists, certification practices and GP medical reports. People spoke about key elements that they would like to see in service provision such as better communication, faster access and responsiveness to needs. There were some calls for information on what is available to help employers support people back to work. Some respondents could not identify any specific needs but said they would not refuse offers of further assistance and information.

The full report of these research findings is published for the Department for Work and Pensions by Corporate Document Services (ISBN 1 84123 757 4. Research Report 227. November 2004).

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