MANAGEMENT OF SICKNESS ABSENCE WITHIN THE
NATIONAL HEALTH SERVICE —
STUDY OF THE CEREDIGION AND MID WALES NHS TRUST

by

Laura Jane Sowden
Bachelor of Business Administration, Simon Fraser University, 2003

PROJECT SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF BUSINESS ADMINISTRATION

In the
Faculty of Business Administration

© Laura Jane Sowden 2004

SIMON FRASER UNIVERSITY

July 2004

All rights reserved. This work may not be reproduced in whole or in part, by photocopy
or other means, without permission of the author.
Ceredigion and Mid Wales NHS Trust: Sickness Absenteeism

Approval

Name: Laura J. Sowden
Degree: Master of Business Administration

Title of Project: Management of Sickness Absence within the National Health Service - Study of Ceredigion and Mid Wales NHS Trust

Supervisory Committee:

Dr. First Committee Member
(Assistant Professor/ Associate Professor / Professor)
Senior Supervisor
Faculty of Business Administration

Dr. Bert Schoner
Professor Emeritus
Faculty of Business Administration

Date Approved: August 12th, 2004
Abstract

In assessing the best sickness absence strategy at Ceredigion and Mid Wales NHS Trust numerous interviews were completed, with line/directorate managers and Directors as well as an overview of the industry and the company itself.

This information along with sickness absence theory was used to establish four criteria with which to assess the alternatives. Specifically: (1) the alternative must be realistic & relatively inexpensive; (2) the alternative must not rely on harsh disciplinary procedures (retaining trust and satisfaction); (3) the alternative must be consistent with current system and ERS implementation and; (4) the alternative must not be difficult to implementation or disrupt service.

Three alternatives were weighed against this criterion. (1) The implementation of Internet based tracking system to improve recording, (2) Focus on bottlenecks in culture and policy by managing the change initiative, and (3) Simplify the current absence policy/increase satisfaction and trust. After assessing each of the alternatives it appeared that option two, to focus on bottlenecks in culture and policy by managing the change initiative, was the best alternative at this time.

Option two includes addressing the sickness absence culture and policy by focusing on the systematic implementation of current changes. Not changing the current systems structure, but focus on building a powerful and effective change structure within the organization. The implementation of this change structure itself would include the introduction of a steering committee, new statistical reporting system, rewards by directorate, introduction of new networks and an associated communication plan. In essence, these could be used to fast track the implementation of the ERS system once it arrives.
Acknowledgements

Thank you to those who have supported and encouraged me throughout the last year. In particular, I would like to thank Dr. David Hannah, Dr. Michael Parent, Dr. Chris Zatzick and Dr. Gervase Bushe for making my trip to Wales and, hence, this project possible. Thank you for all your guidance, inspiration and support.
Table of Contents

Approval .............................................................................................................................. ii
Abstract ............................................................................................................................... iii
Acknowledgements ........................................................................................................... iv
Table of Contents .............................................................................................................. v
List of Tables ...................................................................................................................... vii

Section One: Description of Report .................................................................................. 1
  Purpose .............................................................................................................................. 1
  Background ...................................................................................................................... 2
  Scope ................................................................................................................................ 4
  Methodology .................................................................................................................... 5

Section Two: Feedback Report for the Ceredigion and Mid Wales NHS Trust ............ 6
  Recording .......................................................................................................................... 7
  Time in Queue and Transit ............................................................................................... 8
  Gaps between Payroll and HR ......................................................................................... 9
  Statistics ........................................................................................................................... 11
  Self Certification Forms ................................................................................................ 12
  Return to Work Talk ....................................................................................................... 17
  Medical Certification ....................................................................................................... 18
  Management Interventions in Response to Frequent/Long Term Sickness Absence ... 19
    Cost of sickness Absence ............................................................................................. 22
    Causes of Sickness Absence ....................................................................................... 23
    Compliance ................................................................................................................... 30
    Human Resources ........................................................................................................ 31
    Change Leadership ....................................................................................................... 32
    Criteria and Alternatives ............................................................................................. 33
    Recommendations ....................................................................................................... 35

Section Three: Relevant Professional and Research Literatures .................................. 41

Section Four: Reflection and Analysis of Project Process .............................................. 55
  Consulting Samples, Templates and Outlines ................................................................ 55
  Professionalism .............................................................................................................. 56
  A Multistage Approach ................................................................................................. 58
  The Team ....................................................................................................................... 59
  Utilization of Time ......................................................................................................... 59

Bibliography ...................................................................................................................... 62
  Literature ......................................................................................................................... 62
  Interviews ....................................................................................................................... 64
  Company Specific Information ....................................................................................... 64

Appendix A ......................................................................................................................... 66
Appendix B ......................................................................................................................... 67
List of Tables

Table 1: Self certification form completion ............................................. 13
Table 2: Absence cost figures ................................................................. 23
Section One: Description of Report

Purpose

In fulfillment of course requirements for Business 999, I, an MBA student from Simon Fraser University, traveled to the Ceredigion and Mid Wales NHS Trust and proposed a project that would advise the management team on how to proceed with a pending change. Dawn Thomas, the Deputy Director of Human Resources, mentioned that the Trust was currently struggling with how to effectively manage sickness absenteeism. After discussions with Jo Davies, the Director of Human Resources, it was established that the main problem the Trust is facing is how to encourage directorate/line managers to manage absenteeism and therefore reduce percentage absenteeism of contracted hours from 5.5% to 4.2% whilst facilitating implementation of the national ERS system scheduled to arrive in 2005/06. This report includes both the current analysis and recommendations that have been established utilizing a customized version of the NHS Assembly’s format to approaching absenteeism. These recommendations will essentially “free-up” capital within the Ceredigion and Mid Wales NHS Trust which can later be reallocated to other programs (i.e. updating equipment, opening beds, shortening waiting lists, etc.) as well as improve working conditions within each directorate. The proposed recommendations will hopefully resolve the above stated problem which will concurrently meet the organizations objectives and minimize the directorate/ward manager’s resistance to the impending change.
Background

The 15 Wales NHS Trusts still remain true to principles upon which they were founded in 1948. These are listed below:

- To provide comprehensive care
- To provide this care to everyone in the UK (they have the right to use it)
- To provide care on the basis of people’s clinical need – not on their ability to pay

(http://www.wales.nhs.uk).

Recently, however costs have increased enough to threaten fundamental principals and require Assembly Department intervention. Between 2003 and 2004, for instance, the NHS website indicates that Wales spent approximately £3.8 billion. Of this £3.8 billion, as Wales’ largest employer (with over 81,000 staff), a substantial amount was spent on sickness absences among employees. An audit conducted in 2003 by the Auditor General for Wales and presented to the National Assembly in 2004, indicated that sickness absence, on average, accounted for 6% of contracted hours in comparison to the 4.7% of the NHS trusts in England (National Assembly, 2004). Upon closer examination of absence records held by NHS trusts, the auditor general increased this figure claiming that current levels have been understated due to errors in recording. If this finding is indeed correct, this would adjust the level of sickness absence to at least 6.3% of contracted hours in 2002-2003, an increase in absence that would not only affect the quality of patient care that the NHS trusts are able to provide but also “exacerbate the service delivery problem caused by staff shortages and vacancies” (National Assembly, 2004). This discrepancy has been noted to cost NHS trusts in Wales an additional £400,000 per annum in sick pay on top of the recorded £66 million (in 2002-2003) of
staff time lost and £14 million in replacement bank, agency and locum staff (National Assembly, 2004), not including cost associated with general management and termination/hiring.

As one of the 15 NHS Trusts in Wales, the Ceredigion and Mid Wales NHS Trust must heed the recommendations of the Assembly’s NHS Wales Department to “address the overall quality and consistency of sickness absence management through improvements to existing procedures” (National Assembly, 2004). More specifically, develop a standard definition of sickness absence, review sickness absence recording systems, train managers, calculate accurate cost data, improve and maintain awareness among employees, develop an implementation plan and targets with deadlines, monitor the reasons/develop categories for sickness absences and establish minimum headline levels in each department. Additionally, the Ceredigion and Mid Wales NHS Trust must also address a significant “gap” in reporting sickness absence between its HR and payroll departments. As a result the HR department has chosen to take a proactive approach. Having already produced a ten page attendance policy and associated communication plan, the Ceredigion and Mid Wales NHS trust plans to look into factors that are presently inhibiting its change efforts and those that may in the future. As stated, the trust aims to reduce sickness absence in 2004 further by approximately 5.5% of contracted hours to a target of 4.2% set for the end of 2006. Such a reduction would not only decrease costs and increase effectiveness of care delivery but also assist the Trust in achieving the Assembly’s Corporate Standard “Gold” Assessment.
Ceredigion and Mid Wales NHS Trust: Sickness Absenteeism

Scope

This report presents a summary of key findings from my, Laura J. Sowden, examination of the sickness absence reporting, recording and management within Ceredigion and Mid Wales NHS Trust in June/July of 2004. The visit and findings from it will be utilized by management to pull all previous data, audits, surveys, etc. together into one current and comprehensive paper for decision making purposes. Note that while most surveys & audits to-date have looked at specific parts of the problem (the process or the employee awareness) this paper will take a comprehensive perspective introducing new data were data is needed and updating the information currently provided through informal interviews with HR staff and directorate/line managers. I hope to uncover bottlenecks in the change process today that may be inhibiting effectiveness of newly implemented reporting systems, forms, attendance records and time sheets, communication packages, policies, etc. Ideally, I want to identify the current state of the Ceredigion and Mid Wales NHS Trust and propose recommendations based on these findings.

The main aims of my study were to examine:

- The policies and procedures in place for managing sickness absence and the extent to which these appeared to be implemented
- The processes in place for the reporting and recording of sickness absence and the accuracy of the information held
- The casual data and statistics surrounding sickness absence
Ceredigion and Mid Wales NHS Trust: Sickness Absenteeism

- The factors inhibiting the change process presented now or that may present themselves in the future

Methodology

I attempted to capture all pre-existing data relevant to this change process for the following analysis. This data included attendance documents, self certifications forms, medical certificates, preexisting audits and surveys, the National Assembly’s Report for Wales, absenteeism communications, policies and procedures, absenteeism best practice documentation held by other trusts and absenteeism statistics/records. These were incorporated together with (1) casual/compliance data collected from self certification forms & medical certificates, (2) procedural, cost & managerial information gathered through various in-person meetings conducted during a visit to the Ceredigion and Mid Wales NHS Trust Managerial Head Office and, finally, (3) semi structured interviews with twelve directorate/line managers.

Since the introduction of the casual data form on April 1st of 2004, casual data was gathered but not yet analyzed. The casual section is a representation of the casual data I entered and analyzed for the trust. Data is interpreted in percentages and as statistics by cause as well as by directorate. The excel template I created and utilized was provided to Dawn Thomas and Jo Davies for future research and analysis.

Strategic, procedural and general systems knowledge interviews were conducted with human resource/managerial staff including Jo Davies, Dawn Thomas, Marie Lamb,
Ceredigion and Mid Wales NHS Trust: Sickness Absenteeism

Cath Ruff and Carwen Jarman in June of 2004. These interviews defined the problem and thus formed the foundation for all sickness absence data gathered in this analysis.

Twelve semi-structured informal interviews were conducted with line/directorate managers in July between the 1st and 6th of this year. Line managers were selected randomly and as such are believed to be representative of the population as a whole. However, it is important to note that while this sample seemed to contain a balanced demographic, it does not necessarily express views of all directorate/line managers within the Ceredigion and Mid Wales NHS Trust, and therefore, is not mutually exclusive or collectively exhaustive. This information should only be used as a general guideline facilitating decision making concerning sickness absence management.

**Section Two: Feedback Report for the Ceredigion and Mid Wales NHS Trust**

The flowchart taken from the 2002 National Audit (Refer to appendix A) depicts the notification and recording of sickness absence and the generation of sickness absence statistics. However, it is important to note that since 2002 many improvements to the system have been introduced. New forms have been implemented and casual data has been submitted since April 1st of this year. The following is an assessment of the current situation given various changes made throughout the past year. At the request of department heads, this information on sickness absence is written in a format similar to that of the 2002 National Assembly’s Audit for consistency.
Ceredigion and Mid Wales NHS Trust: Sickness Absenteeism

Recording

The current trust sickness absence policy, states that accurate attendance records must be maintained by departments showing the duration of all absences, and the reason for each absence. Studies suggest that keeping accurate and up-to-date attendance records is vital to accurate absence management and an area of noted concern since the 2002 National Audit within the Trust. In particular, the 2002 National Audit found that the existence of an attendance record did not imply that these are used to record all sickness absence periods. Where used, attendance records held evidence of 80% of all absence episodes identified in our sample (National Audit, 2002). Recent interviews conducted with directorate managers in July of 2004 indicated similar results. 58% of managers interviewed indicated that “almost”, “nearly”, or “most” absences get recorded. They indicated that time pressure, their own absence and having to work on the ward themselves often meant that attendance records did not get updated immediately. It is possible that in and “ad hoc” situation that staff reported themselves fit to work earlier than their official return to work date. Either way, the possibility of inaccurate or incomplete attendance records lead to the risk of inaccurate verification of payroll returns and impacts the manager’s ability to appropriately review staff sickness records and intervene accordingly.

Variation in response was also noted between departments. First, while some managers sent forms to HR and payroll, other indicated their forms were sent to payroll or HR but not both. This indicates confusion within the directorates. Second, in 2002 the National Audit office examination of records on personal files revealed considerable variety in the
nature of the record keeping systems employed. These varied from computerized spreadsheets to individual calendar sheets or more general department off duty books. Other departments reported that they did not use separate attendance records and relied merely on recording onto timesheets and keeping the duplicate copies. Today, the survey revealed that all managers used the “weekly sickness and absence return” implemented in April of this year but that it is not completely integrated within each system. In truth, most managers indicated that they still utilize traditional methods of recording absence and then transfer data onto the new form. This would explain why complaints of “too much paperwork”, “too much redundancy” & “unfriendly forms” have currently been noted. It is because these forms are not directly compatible with existing forms that managers are resisting the change. In this case, the “appearance of compliance” or “superficial compliance” itself is increasing the risk of error in data transfer. It has been indicated that new forms are left aside to complete at a later date “only to satisfy human resource requirements” (interviews, 2004).

Time in Queue and Transit

It was indicated that attendance records spend a considerable time between payroll, human resources and managers each month, potentially increasing the risk of absences being unrecorded. In our survey, of ward/directorate managers surveyed all agreed that “time lags” existed between the recognition of sickness and submission of forms confirming an occurrence and its duration. Of these cases, the majority indicated that they did not note any serious problems arising from this queue in their department. In fact, managers claimed that they start the form when an absence occurs and then leave it
Ceredigion and Mid Wales NHS Trust: Sickness Absenteeism

until they are able to finish it. Often and in the case of their absence, annual leave, holiday or backlog within their department, forms have been indicated to sit for up to three weeks (40% of all cases) prior to submission. This not only creates inaccuracies in human resource statistics and increases the risk of absence going unrecorded at payroll but also could be responsible for employees not taking new policies seriously. For instance, if employees perceive that management does not place emphasis of sickness absence (weeks pass before completion of documentation or interviews occur and complaints are voiced) they themselves will not place emphasis on sickness absence.

Gaps between Payroll and HR.

Calculation of sickness absence is “percentage of available hours lost to sickness for directly contracted staff” as per the Assembly’s memo dated April 1st, 2004.

\[
100\% \times \frac{\text{Total hours lost}}{\text{Contracted hours of employee}} = 5.5\%
\]

The reported sickness rate in 2001/02 was 4.9% in 2003 approximately 5.5%. However, after taking into account non-recording or under recording of sickness onto timesheets, it can be estimated that the actual 2001/02 sickness rate, based on recorded data across all sources, was 5.1% (National Audit, 2002) and hypothesize that the adjusted sickness absence rate in 2003 was actually 5.9%. This demonstrates a slight rise in sickness absence between 2002 and 2003 and between 2003 and 2004. However, it also suggests that rates are increasing at a diminishing rate. Basically, as sickness absence rates become
more accurate, the reported sickness rate will actually increase before experiencing plateau and eventually decline.

In 2002, the National Audit revealed a total of 135 sickness absence episodes across their sample. It suggested that only 84% of actual absences are recorded onto the payroll system. That more specifically, the 22 episodes they found missing from the payroll system were all under seven days in length and comprised a total of 50 calendar days, with 12 being single day absences. Inclusion of these 50 days on the payroll system would have added 4.43% of the 1128 days logged (National Audit, 2002). They estimate that as a net result of these cases, up to 31 calendars days of sickness may therefore have gone unrecorded on the payroll system. This presented a risk of over payment where staff may not be entitled to sick pay or alternatively, the exclusion of the particular cases may mean the move from full to half pay entitlement, or half to nil entitlement. (National Audit, 2002)

“Gaps” can be attributed to late submission, unreported absences, incomplete/missing self certification forms, inconsistencies in procedures and gaps between self certification and medical certification forms. In fact, the 2002 National Audit claimed that the requirement to send all self certification sheets and medical certificates to the payroll department provides a double protection against the risk of absences going unrecorded on timesheets. Even currently, staff in payroll indicated that absences would often be noted on the system prior to confirmation with a timesheet. It is therefore worth noting that payrolls receipt of self certification and medical certificates prevents further sickness
absence from being unrecorded on payroll systems. Perhaps, a system that “double checks” itself or works with payroll to account for errors by directorate would help human resources to alleviate some discrepancy. A breakdown as such, will set actionable targets for each directorate or ward manager to champion.

Statistics

The sickness absence statistics, used to report progress to the Assembly are compiled from sickness forms submitted from each directorate and received by the Human Resource Office on an intermittent basis. Currently, there is one employee responsible for data entry into both the personnel database and excel spreadsheets. Upon receiving weekly attendance updates, she enters data (note that casual and new “weekly sickness and absent forms” as of early June were not yet entered) and files forms in sectional binders. Self certification forms and medical certificates are then matched to these sheets in the binders once they are received.

Our survey of managers indicated that sickness statistics for the trust are no longer calculated by departmental managers. Those 41% who did originally compile departmental statistics now rely on the human resources department to compile statistics and communicate these statistics to them.

The human resource department does compile statistics for each department and for the organization as a whole. Yet, statistics appear to be missing pertinent data. Time periods appear to differ slightly and statistics do not appear to take into account the number of
employees associated with each department. Small departments, for instance, appear to have smaller sickness absence statistics. Therefore, comparison between departments and longitudinal comparison (due to slightly different time periods and late submission) is limited. That said, long term, short term and total sickness statistics are available for each department, noting increases decreases and total hours lost per quarter. Total contracted hours and total absence statistics are also noted for each department, leading us to believe that by utilizing an average hourly wage, cost figures could also be developed for each department. Time permitting many changes could be made in this area. For example, statistical sickness reviews could be conducted when increases appear, duplication of data entry could be rectified via software training and figures could generally become more accurate. In addition, human resource staff and payroll could work together to ensure accurate representation of data and communicate a new figure to each directorate, called “reporting error”. This would entail comparing numbers and enquire about differences before preparation of quarterly statistic. Basically, reporting the percentage of error or “gap” experienced between the payroll and human resource department but broken down by department. Errors rates could then be compared across departments and inconsistencies in process addressed in departments with higher rates.

Self Certification Forms

Self certification forms were often incomplete and lacked key details such as the return to work date, the last working day lost, the cause of the absence or in many cases the managers signature. Interviews with HR staff and with line managers also confirmed this problem. In my sample, 92 Sickness absence self certification forms were collected.
Within these 92 forms, a troubling 44.56% were found to be incomplete in some way.

The following table indicates numbers and percentages of missing data by section.

Table 1

<table>
<thead>
<tr>
<th>Section or question</th>
<th>Number of forms Missing this section</th>
<th>Percentage of forms missing this section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Casual info/reason</td>
<td>3</td>
<td>3.26%</td>
</tr>
<tr>
<td>Staff number</td>
<td>9</td>
<td>9.78%</td>
</tr>
<tr>
<td>Boxes (work related &amp; 3rd party)</td>
<td>18</td>
<td>19.57%</td>
</tr>
<tr>
<td>Department</td>
<td>2</td>
<td>2.17%</td>
</tr>
<tr>
<td>All dates</td>
<td>1</td>
<td>1.09%</td>
</tr>
<tr>
<td>Date began absence</td>
<td>1</td>
<td>1.09%</td>
</tr>
<tr>
<td>Date ended absence</td>
<td>4</td>
<td>4.35%</td>
</tr>
<tr>
<td>Expected Date of return</td>
<td>8</td>
<td>8.70%</td>
</tr>
<tr>
<td>Signature of employee</td>
<td>1</td>
<td>1.09%</td>
</tr>
<tr>
<td>Entire managerial section</td>
<td>9</td>
<td>9.78%</td>
</tr>
<tr>
<td>Date received</td>
<td>17</td>
<td>18.48%</td>
</tr>
<tr>
<td>Compliance question</td>
<td>15</td>
<td>16.30%</td>
</tr>
<tr>
<td>Condition attributable to work</td>
<td>18</td>
<td>19.57%</td>
</tr>
<tr>
<td>Date signed</td>
<td>14</td>
<td>15.22%</td>
</tr>
<tr>
<td>Position</td>
<td>15</td>
<td>16.30%</td>
</tr>
<tr>
<td>Signature</td>
<td>12</td>
<td>13.04%</td>
</tr>
</tbody>
</table>

The chart pinpoints three main problem areas. One being the industrial injury, work related and third party claim boxes, the second been the end dates of sickness and expected dates of return and the third been the completion of the form by management.

**Industrial Injury, work related absence, work related condition and third party claim boxes.** Since the National Audit in 2002 and the questionnaire distributed in 2002/2003 a few things have changed. For instance, the audit hypothesized that there may be some confusion as to the requirement for the self-certification where medical certificates have been provided. They noted that of the 25 absences that were medically certificated, in only four cases was there evidence of
self-certification on either the payroll or personal files (16%), contrasting with self-certificates being found for 38% of the absence cases that did not have medical certification. Interviews suggest that since 2002 this figure has decreased dramatically. That while employees are aware that they must complete self-certification forms that they are not necessarily clear on all facets of the form. In fact, self certificates taken between April 1\textsuperscript{st}, 2004 and June 1\textsuperscript{st}, 2004 indicate that the section on industrial injury, work related injury and third party liability was left incomplete 19.57\% of time. A trend could also be noticed when accessing this section. It seemed that if there was any doubt about work place accident, injury or third party liability the box would be left unmarked. In many instances, these were cases that involved viral illnesses & diarrhea were it can only be hypothesized that the employee did not want to limit his/her options or was unfamiliar with the policy surrounding the option. It would be interesting see if educational intervention upon managerial signoff would increase the completion percentages associated with this section.

\textit{End dates and expected dates of return.} In several cases the end date of sickness (4.35\%) and expected date of return (8.70\%) were missing from the self-certification forms. This creates difficulty for not only personnel but also for payroll and those preparing statistics for managerial decision making. Furthermore, it is a sign of inaccuracy within the system itself. Line managers should not only verify return dates of absence but also not sign a form that is missing pertinent information.
Moreover, the National Audit 2002 assessed personal files held by payroll and identified evidence of self-certification for only 46 of the 135 absence cases across their sample (34%). Of all the self certificates identified, there was a 76% likelihood that these could be found on the payroll files and a 71% likelihood of finding them on the personal files held by managers. Overall they found evidence of self certification on both the payroll and personal files for only 15% of all absence cases. While this statistic has dramatically increased today, interviews with key personnel and details on the self certification forms themselves indicate this discrepancy still exists for several reasons. Firstly, dates of submission. The submission of self certification and medical forms seems to vary between directorate and each individual situation. It would be interesting to look at an accurate timeline. Perhaps if employees were proactively provided with forms prior to sickness absence and a deadline was provided, time in transit could be minimized. Secondly, it has been indicated that there is a discrepancy as to self certification form’s destination and purpose. It was noted that in our sample of data that some forms were copies while others appeared original. This was also noted in various interviews. Some self certification forms were sent to payroll directly and copied to HR, some to HR and copied to payroll and others to one or the other.

*Completion of the form by management.* Managerial signoff is a requirement on Self Certification forms. Managers must approve an absence, analyze patterns
and meet with employees upon return incase intervention is required. That said on approximately 20% of all forms analyzed, some aspect of the managerial section was incomplete. In some instances, the managerial section was left completely blank (10%) or the form was not signed (13%). This indicates that some line managers may not be accurately tracking and assessing absence patterns. HR, personnel and payroll staff who wish to rectify this situation are left individually returning their copy to the manager. This not only increases time in transit but also redundancy (as multiple copies may be returned to the same department). Furthermore, an interesting 18.48% of the forms excluded the date received when they included dates of absence and dates signed. In this situation, it can only be hypothesized that there may be gaps between dates received, dates signed, date of sickness and finally submission. In one case, for instance, an employee was terminated April 26th following an absence on the 14th, returning to work of the 15th. The manager noted that the form could not be signed do to termination and signed it officially on April 24th. Whether or not this does suggest tardiness is debatable. However, it is important absences are addressed promptly as recently determines effectiveness on intervention.

Furthermore, there seemed to be confusion in several cases. This was demonstrated by inconsistencies in response and lack of answer clarity. For instance, many forms stipulated multiple causes for each absence. It was not just headache, for instance, but a headache, sweats, nausea, diarrhea and stomach ache. These are difficult to transpose in a casual analysis. In other cases, dates of expected return and end of sickness appeared to
Ceredigion and Mid Wales NHS Trust: Sickness Absenteeism
differ. It seemed that employees were confused about the definitions of, for example, “end date” and “expected date of return” (some indicating end date as the day after and some the last day... it a one day scenario it was difficult to decipher one from two).
Confusion could also be noted in drastically different definitions of “non-compliance”, one manager claiming non-compliance with the notification feature was having a wife call in” and another was having the employee “show up and then be sent home”. This was also seen in the case of “address”. About half the sample indicated the location of the workplace while the other half posted their personal home address. It is possibly that definitions attached to each form that are specific may help clear up such discrepancies.

Return to Work Talk
Return to work talks are required to be carried out for all absence cases. However, interviews conducted with directorate/line mangers established that 98% of all managers interviewed conducted back to work talks on a regular basis. However, when asked to estimate the percentage of short-term absences they conducted such talks with, figures ranged from anywhere between 70 to 100 percent of the time, completing on average about 80% of interviews following absence. This means approximately 20% of absences went without a back to work talk. While this still indicates potential for improvement, it is a far cry for the result of the 2002 National Audit’s survey distributed to a random sample of staff at the Ceredigion and Mid Wales NHS Trust. It indicated that in 2002/2003, 86% of employees did not have a return to work interview with their manager, 97% of employers did not visit the employees surveyed during the absence and 75% said that they were not even telephoned. Therefore, while line managers in many
departments’ claim they are struggling and do not necessarily always use the prepared form, statistics demonstrate a significant improvement in this area.

Of the directorate/line managers surveyed 92% used the back to work talk form when they did conduct back to work talks. These forms were completed signed and filed within the employee’s personal file. During interviews questions arose regarding the forms confidentiality, why it was copied so many times and if questions regarding medication, Dr.’s names and further medical treatment left managers should even be posed. In fact, some managers claimed that they or their assistants outright refuse to conduct the interviews based on this premise. For example, to prevent against drug reactions managers claim they ask “what drugs have been prescribed over the course of the absence”. Managers with little knowledge of these drugs worry that their lack of knowledge once such information is disclosed opens them up to liability issues. Possibly a meeting that addresses such concerns should be considered.

Medical Certification

Medical Certificates must be submitted for sickness absences of longer than seven days to payroll departments, human resources and copied to the personal files. In my sample, while I did not look directly at Medical Certification, I noted that of the 92 cases of absence recorded (April 1st and June 1st, 2004) only 7 exceeded the 7 day period and hence required Medical Certification. Of these 7 absences indicated, 2 lacked a Medical Certificate and 1 Medical certificate did not fully cover periods of absence. Furthermore, not all Medical Certificates were matched up to the appropriate self certification form or
even the correct department. It seemed many more; over 49 forms were submitted during this same period. Either way, it can be hypothesized that absences are underestimated, multiple forms were submitted for the same person or same case and medical certification forms are arriving late or not all self certification forms have yet being received.

In the case examined there appeared to be a gap immediately after the first seven days of absence. Interviews with human resource staff also alluded to concerns regarding gaps between coverage when Medical Certification is required. It was indicated that because medical certification cannot be backdated, gaps do occur. In 2002 National Audit estimated that absences past the seventh day of and not supported by medical certification (2.3% in 2002) accounted for up to 19,142 pounds of sick pay been recorded without appropriate cover by medical certification.

Management Interventions in Response to Frequent/Long Term Sickness Absence
The sickness absence policy states that: “The manager will be responsible for carrying out a review of all attendance records on a monthly basis”. The policy encourages intervention by managers in response to a range of different trigger points. Currently, these triggers consist of three separate spells of absence of at least one day in the eight week period, intermittent absence equaling or exceeding seven days of their working pattern in the previous twelve months, employees absent for at least three continuous weeks and occupational health referral for absences of over eight weeks. In the sample surveyed (2004), 90% had at least one case within the last 3 months which they have had
to review or refer to occupational health. Of these cases, 67% stated that they did or would require human resource advice or attendance.

**Triggers.** Whilst recognizing that sickness policy guidelines are discretionary rather than mandatory, the extent of intervention by managers appeared extremely limited. For instance, the 2002/03 National Audit found that overall 21 staff had breached at least one of the triggers for a sickness review and yet no evidence of a sickness review taking place could be found. My study pinpointed a similar predicament. Out of those interviewed when asked if cases had recently breached triggers, 56% needed to be reminded what the triggers were and 34% explicitly stated that they did not understand the trigger points.

**Pattern recognition.** When asked how managers sought out patterns in data, 70% of those interviewed claimed they had no formal consistent system to recognize patterns in data and approximately 20% of this 70% claimed that they did not look for patterns at all anymore. One manager in particular, indicated needing advice in this area. In the 2002/03 National Audits Associations survey, 90% of those surveyed claimed that they had no formal training when it came to return to work interviews and counseling interviews, 60% claimed they had training dealing with regular/long periods of absenteeism, 60% claimed they had either formal or informal training for sickness/general record keeping and 80% claimed they had informal training in the use of occupational health services and referrals. In my sample it was indicated that current pattern detection consists of a system of
mental notes against a calendar of weekends, holidays and shift summaries.

Aside from lack of process knowledge, managers assert that due to time constraints, pattern detection and monthly review has recently taken a back seat. It is possible then that managers of larger departments are missing patterns or are biased by recency (evaluating based on most recent experience). Problems have also been noted in the case of managerial absence or when they take annual leave. In this case, an assistant or “S grade nurse” may handle the attendance but not necessarily the back to work interviews or pattern analysis. In fact, in some instances both weekly attendance reports and back to work talks were left completely, creating a backlog.

**Scheduling.** Of those managers surveyed only 35% indicated using a scheduling system that incorporates a percentage for sickness absence. Of this 35%, managers could not communicate the exact percentage or procedure used in their calculations. This suggests that knowledge of scheduling processes could be improved. Perhaps, sickness absence could be reduced through improvements in the scheduling process itself. In 2002/03 employees pinpointed “reducing staff workload” as the number one issue management could address when spending money to reduce sickness absence. That been said of the managers surveyed in 2004, 65% claimed scheduling was “ad hoc” only involving minimum set levels. Sickness absence was dealt with on the day of the occurrence, requiring managers to drop all duties and step in, call employees on days off, or by requesting overtime. Managers admit that sometimes absenteeism leaves wards understaffed.
For managers and well as shift workers, this creates a cyclic problem. Not only does the ward not run at maximum capacity but the nature of the job requires over exertion. Work builds up and those who start subsequent shifts also feel the burden.

**Communications.** In 2004 managers indicated that they have open communication with employees but do not intentionally introduce the topic of sickness absence on a regular basis. Over 90% claimed that while they do hold weekly or monthly staff meeting, absenteeism is not discussed. Similarly, managers assert that they do not have time to conduct all back to work talks with employees, yet alone sit down to proactively review policies and procedures with staff. All considered, the 2002/03 statistics claiming that only 66% of the cases had policies and procedures explained by a department/line manager has only increased slightly. This statistic will have to increase substantially before the introduction of new policies and the ERS system in 2005.

**Cost of sickness Absence**

Whilst the trust does not itself monitor the salary costs of sickness. The 2002 National Audit produced the following estimates based on the staffing costs data submitted in response to their questionnaire. They used data derived from other trusts to complete these estimates. The 2004 comparison, is taken from total sick hours in the “year to date” section of the April 1st Ceredigion and Mid Wales NHS Trust Staffing Report.
Note that these estimates are calculated using the gross and direct staffing costs for the trust and then adjusted downward by 88%. This adjustment allows for the fact that these calculations will generally over inflate the true sickness salary costs as sickness rates tend to be higher among lower paid staff groups. The 88% adjustment was derived from the average trend across seven other NHS Wales Trusts.

<table>
<thead>
<tr>
<th>Year</th>
<th>Lost productivity costs</th>
<th>Actually salary cost</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(accounting for 11% of sickness at half pay and 5.66% at nil pay)</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>£936,825</td>
<td>£832,275</td>
<td></td>
</tr>
<tr>
<td>Direct Sickness Salary Costs</td>
<td>£1,058,596</td>
<td>£940,457</td>
<td></td>
</tr>
<tr>
<td>Gross Sickness Salary Costs (NI/pension, etc.)</td>
<td>2004 (as of April 1st)</td>
<td>£902,866.08</td>
<td>£801,745.08</td>
</tr>
<tr>
<td></td>
<td>Actual Salary Cost Calculation:</td>
<td>£905,926.64</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>£902,866.08</td>
<td>£801,745.08</td>
<td></td>
</tr>
<tr>
<td>Direct Sickness Salary Costs</td>
<td>£1,020,031.91</td>
<td>£905,926.64</td>
<td></td>
</tr>
<tr>
<td>Gross Sickness Salary Costs (NI/pension, etc.)</td>
<td>Average Salary Calculation:</td>
<td>£1,020,031.91</td>
<td>£905,926.64</td>
</tr>
<tr>
<td></td>
<td>£28836729/1020.97 (full time equivalents) = £28,244.44 average salary per full time equivalent/ 53 weeks per year/37.5 hours per week =</td>
<td>£801,745.08 actual salary estimate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>£14.21 hourly average wage</td>
<td>Note: to use specific salary figures depends of both compensation broad band and pay scales as well as replacement cost schedules... For this purpose (an overall view) utilizing an average hourly figure and average percentages provides the most comprehensive and comparable view.</td>
<td></td>
</tr>
<tr>
<td>Causes of Sickness Absence</td>
<td>From the 92 sickness absence entries recorded between April 1, 2004 and June 1, 2004 the majority of causes were noted to be upset stomach (27.17%), headaches (8.70%),</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
coughs and colds (13.04%) and ears, nose and throat problems (10.87%). Muscular and respiratory problems were shown to cause sickness in only 7.61% of cases. In every other category occurrence ranged from nil to 3 cases in 92 absences.

**Upset stomach.** Stomach upset occurred in a total of 27% of forms gathered. Of this 27%, 60% indicated diarrhea while the remaining 40% indicated a combination of vomiting and ache. Of these instances several statistics were gathered. The mean length of absence was 2.32 days. The standard error of the sample was .028, median or middle was 2 days and mode or most common length of absence was also 2 days. The range or lengths of absence for this particular group lay between 1 and 5 days. The total amount of days absent do to stomach upset was 58 days in 25 cases. This was the most common illness responsible for short term absence in the Trust within this time period.

**Headaches.** Headaches occurred in a total of 9% of forms gathered. Of this 9%, 62% of cases indicated headache, sickness or fever and 38% complained of migraines. However, there did not appear to be a significant distinction between lengths of absence for migraines as opposed to lengths of absence for headaches. I would hypothesize that a distinction may appear in employee patterns over time, rather than length of absence. Of these instances several statistics were gathered. The mean length of absence for the headache was 1.85 days. The standard error of the sample was .52, median or middle was 1 day and mode or most common length of absence was also 1 day. The range or lengths of absence for this
particular group lay between 1 and 5 days. The total amount of days absent do to headache was 15 days in 8 cases. However, statistics also revealed trends across high stress occupations. For instance, the Theatre, a senior IT manager and nursing in general accounted for 75% of all cases. Consequently, evidence suggests that the headache may be a result of stress or pressure within the department. If this is the case, management may want to consider amalgamating the “headache” and “stress” categories for statistical purposes.

*Coughs and colds.* Coughs and colds occurred in a total of 13% of forms gathered. Of this 13%, 100% consisted of the common cold. However, a variety of terms were used to describe the same illness; “heavy cold”, “head cold”, “cough and cold” or “temperature”. Of these instances several statistics were gathered. The mean length of absence was 2.41 days. The standard error of the sample was .36, median or middle was 2.5 days and mode or most common length of absence was 1 days. The range or lengths of absence for this particular group lay between 1 and 4 days. The total amount of days absent do to cough and cold was 29 days in 12 cases.

*Ears, nose and throat problems.* Ears, nose and throat problems occurred in a total of 11% of forms gathered. Of this 10%, 80% consisted of a throat related condition (laryngitis, sore throat, etc.) with remaining cases of tonsillitis and one tooth infection. Of these instances several statistics were gathered. The mean length of absence was 3.6 days. The standard error of the sample was .76, median
or middle was 2.5 days and mode or most common length of absence was 2 days. The range or lengths of absence for this particular group lay between 1 and 7 days. The total amount of days absent due to ears, nose and throat problems was 36 days in 10 cases. It is interesting that within this sample the mean is higher than the median. This suggests that there may be several cases that should be “red flagged” within the sample as they may be unique cases that are skewing the average.

Respiratory problems. Respiratory problems occurred in a total of 7.6% of forms gathered. Of this 7.6%, 86% consisted of a chest or upper/lower respiratory track condition. Of these instances several statistics were gathered. The mean length of absence was 4.42 days. The standard error of the sample was .81, median or middle was 4 days and mode or most common length of absence was also 4 days. The range or lengths of absence for this particular group lay between 1 and 7 days. The total amount of days absent due to respiratory problems was 31 days in 7 cases. Therefore, while respiratory problems account for less of total absence altogether, they account for a longer length of absence in each situation.

Musculoskeletal problems. Musculoskeletal problems occurred in a total of 7.6% of forms gathered. Of this 7.6%, 57% consisted of backaches while the remaining cases contained a mixture of shoulder injuries, knee injuries and arthritis. Of these instances several statistics were gathered. The mean length of absence was 2.29 days. The standard error of the sample was .52, median or middle was 2 days and
mode or most common length of absence was 1 day. The range or lengths of absence for this particular group lay between 1 and 4 days. The total amount of days absent due to respiratory problems was 16 days in 7 cases.

An analysis of days absent within the 92 entry sample indicated a total of 267 days absent. The minimum being 1 day and maximum been 14 between April 1st and June 1st of this year. The mode or most common number of days absent was one day. However, statistics show that the mean or average amount of time absent per entry was 2.9 or 3 days with a standard error of .247 and median or middle range of 2 days. When comparing this data to the 2002/03 statistics gathered by the National Audit Survey we note that (after adjusting for the differences in duration of the study) sickness absence appears to have actually decreased since 2002/03.

Within this time period several divisions or departments came up frequently in absenteeism statistics. The following is a summary of frequently appearing departmental statistics. In each case the mean, median mode and range were assessed. Casual data was interpreted in each individual case for patterns. These are noted as follows:

**Outpatients.** Of the data gathered the outpatients department accounted for 8 cases and over 21 absence days. The mean of these cases was indicated to be 2.63 days with a median of 2 and mode of 1. Within this department no specific pattern could be found.
Radiology. Of the data gathered the radiology department accounted for 7 cases and over 29 absence days. The mean of these cases was indicated to be 4.14 days with a median of 4 and mode of 4. 29% of these were due to cold, 43% respiratory infections with a dislocated back joint and skin rash.

Cardigan. Of the data gathered the Cardigan division accounted for 7 cases and over 17 absence days. The mean of these cases was indicated to be 2.24 days with a median of 2 and mode of 2. In this division subjects were all nurses complaining of 43% diarrhea & vomiting, 28% unspecified, one case of a painful shoulder and one case of laryngitis.

Iowerth. Of the data gathered the Iowerth division accounted for 17 cases and over 43 absence days. The mean of these cases was indicated to be 2.52 days with a median of 2 and mode of 1. In this division subjects were all nurses complaining of 29% stomach upset, 18% colds and 12% headache.

Theatre. Of the data gathered the Theatre department accounted for 14 cases and over 28 absence days. The mean of these cases was indicated to be 2 days with a median of 2 and mode of 1. 36% of these were due to stomach upset, 21% migraines and 14% cold.

OG. Of the data gathered the OG department accounted for 5 cases and over 19 absence days. The mean of these cases was indicated to be 3.8 days with a
median or middle length of 4. Of these 40% were reported as colds, 40% diarrhea with one case of chest infection.

Work related conditions were only indicated in 3.26% of all cases. Two of the three cases were nurses and the other a switchboard operator. The complaints indicated were backache, muscle stain and a chest infection. Interestingly, many employees intentionally or unintentionally left this section of the form incomplete and similar conditions (backache and chest infection) were found to be prevalent within the sample. It is possible that further work related conditions or injuries may yet be uncovered.

Some problems were noted while calculating statistics from this data. First, there were at least two different types of forms used containing different types of information. To amalgamate all casual information into a program for analysis, data must be consistently obtained across the sample. Given that there are both medical certificates and self certification forms this is difficult to do. For the purpose of data analysis, our sample contained only info retrieved from self certification forms given that they had data required and were consistent across the sample. Furthermore, without shift information it is difficult to tell which employees were full-time as opposed to part-time and how much overtime they worked in any given period.

Sickness definition also appeared to be inconsistently represented on many of the forms. Employees often indicated multiple sickness classifications or illnesses that were not listed in the assembly’s casual categories. Perhaps, categories should be displayed with
boxes clearly on each form requesting the employee to tick only one and elaborate. This would further reduce errors when recording data as well as preserve confidentiality.

Compliance

Interviews conducted indicated that managers feel employees are not resistant when it comes to new absenteeism polices and procedures. They indicated that any resistant that did arise was associated with fear surrounding the confidentiality of their medical information. Of those managers surveyed, 97% felt employees understood the process, indicating that 100% understood the self certification process, 100% understood medical certification process, 83% understood back to work talks and 83% understood referrals to occupational health. This is up from the 2002/03 statistics that claimed 85% of employees had not been made aware of the policies and procedures and 91%, 68% who were completely clear on the self certificate process, 75% were completely clear on the medical certificate, 32% were clear as to when a return to work interview would take place and 49% clear as to the circumstances they would be referred to occupational health. However, it must be noted that the interviews conducted in 2002/03 contained mostly employees rather than line managers. In actual fact, these figures are probably overstated, indicating that while awareness of sickness absence has improved, further communication initiatives must still be introduced. The compliance question on the self certification form illustrates a similar situation. Only a mere 5.62% of employees were found to be non-compliant, suggesting that approximately 94.38% of employees are willing to comply with the process.
Human Resources

The 2002/03 survey indicated that only 7% of cases had the policies and procedures explained by Human Resource/ Personnel Staff (that 93% did not). In my 2004 survey, managers indicated that human resource representation and visibility has increased dramatically within the Trust. That, 80% of managers interviewed had contact with a human resource representative in one way or another. From sickness reviews to PowerPoint sickness absence presentations, managers have received help dealing with red flag cases and general communication. However while approval rates rise, accountability among managers and employees alike remains to be an issue. For instance, the National Audit in 2002/03 indicated that 87% feel that they have no responsibility for managing staff sickness absence. My survey indicated that 100% of managers do not develop their own sickness absence statistics and 30% indicated that they do not always keep paperwork of file (claiming there is too much paper). Off hand, 79% were individually not aware of current/recent sickness absence rates for their departments and 74% were not aware of statistics for the organization as a whole (only having some vague idea). Perhaps, this relates each manager’s limited vision of the organization as a whole. In my sample, the majority or over 70% of those managers surveyed claimed they were not entirely aware of the impact of sickness absence on the organization, claiming that sickness absence costs money but not knowing precisely how much. In several cases, absence was referred to as “administrative”, claiming that for the most part their cases were legitimate and, therefore, require no intervention. When asked whether human resources could do anything to help manage sickness absence, managers
responded with “the reduction of paperwork”, “more PowerPoint presentations”, “leaflets accompanying the introductions of new policies or forms” and “increase wages”.

**Change Leadership**

Currently the sponsor of this project is Jo Davies, the Director of Human Resources, and the coordinator of this project in Dawn Thomas, the Deputy Director of Human Resources. The Human Resource “absenteeism team” also includes change advocates such as Cath Ruffe and Marie Lamb, both of which interview “targets” and design/implement systems chosen by Jo Davies and Dawn Thomas. The targets of this change are the ward/line managers who manage and have the ability to influence employees on a day-to-day basis. Decisions are made by Jo Davies and Dawn Thomas, policy is written by Dawn Thomas (however must be approved by the board and Union heads prior to implementation), communications plans (PPT and pamphlets) are written and introduced by Dawn Thomas, compliance relating to form submission/completion is regulated by Marie Lamb while Marie, Cath and Dawn all conduct interviews with ward/line managers.

When looking a *change leadership* both Jo Davies and Dawn Thomas lead this change. Their level of resilience and personality type must be strong enough to ensure the change it instilled from the top to bottom of the organization. It is their vision, which will create the vision of others. Therefore, their goals for reducing absenteeism must be clear and must be transferable to each department (clear directorate/ward/ department goals). Furthermore, as leaders Jo and Dawn must be able to create the “need for urgency” that
and understand how to minimize the resistance experienced among employees and managers. Perhaps, a matrix and action plan could be developed to deal with specific form of resistance as it arises. Secondly, both Dawn and Jo must indicate understand and have the power to fund this change process with resources needed and have the power to authorize such a change within the organizational structure. They must have the ability and willingness to demonstrate public support and commitment as well as to meet privately with groups or individuals to convey their strong personal support. Perhaps, those managers who support initiatives should be rewarded (targets for return to work talks and meeting submission dates should be acknowledged). Monitoring procedures should be established to monitor progress that may occur. Perhaps a team could be recruited for just this purpose. All in all, Jo and Dawn must champion this project individually while clearly defining roles and responsibilities of team members engaging in this change initiative.

Criteria and Alternatives

Several alternatives are available for the Ceredigion and Mid Wales NHS Trust.

The first alternative would be to implement an internet based system for tracking employee absenteeism and managing absence. This would automatically compile information on a secured site following the daily entry of absence figures onto customized data entry form. This site need not be connected by LAN of WAN; however, each directorate/station must have internet access coupled with computer hardware and software able to support the application.
The second alternative would be to focus on the “absence culture” and “policies” by micro managing the change initiative. This would not include a dramatic change but rather the facilitation and focused diffusion of current changes into the system. Smaller more viable updates would be initiated where current bottlenecks have been identified.

The third alternative would be to simplify the current absence policy and increase employee “trust” and “job satisfaction” within the Trust. Many studies on absenteeism today reveal that low morale, poor working conditions and job dissatisfaction increase absenteeism. The underlying premise is that experts claim casual data collection, back to work interviews, probing questions, etc. actually undermine trust and promote absence within the organization. However, it must be noted that the Ceredigion and Mid Wales NHS Trust is a small Trust with only evidence to the contrary.

After running these alternatives against the following four criteria: (1) the alternative must be realistic & relatively inexpensive; (2) the alternative must not rely on harsh disciplinary procedures (retaining trust and satisfaction); (3) the alternative must be consistent with current system and ERS implementation and; (4) the alternative must not be difficult to implementation or disrupt service... alternative two, focusing on culture and policy by managing the change initiative was chosen as the best alternative at this time. Taking into consideration disruption of service, compatibility with the 2005/06 Electronic Resources Staffing system and complexity of implementation, option one was discarded. Option three was also discarded, seeing that it did not closely align with the organization’s structure & size as well current regulations placed on the Trust by the National Assembly.
Recommendations

While the implementation of a fully automated computer system allowing managers to enter data onto a secure network of templates would be the best alternative, I realize that it is not the most feasible. With the introduction of the NHS’s ERS system on the horizon, an interim strategy that addresses the sickness absence culture and policy would be most beneficial. More specifically, the Ceredigion and Mid Wales NHS Trust must concentrate on the systematic implementation of current changes. Not changing the current systems structure, but focus on building a powerful and effective change structure within the organization. The implementation of this change structure itself must be viewed as step one in the implementation of the future ERS system. That said the same structure (procedures, networks of authority and networks of communication, etc.) could be used to fast track the implementation of the ERS system once it arrives. The key is, integrating change from top to bottom of the organization consistently and comprehensively, eliminating gossip and surfacing resistance within directorates.

*Change process*. Two leaders from one department cannot do it alone. A steering committee must be formed that includes representation from each particular area. Perhaps, an IT representative, representatives from the directorates (or a representative of directorate managers), a representative from payroll, a front line employee, etc. should be included. Basically, all categories mentioned in the above analysis should be covered. From scheduling to reporting, experts or “the best in the area” will have a chance to voice their opinion and “champion the system” within their own area of expertise. One initial
meeting should be set and projects assigned. Communication thereafter could be
determined as needed or be broken into smaller more convenient groupings.

Statistics. If I could choose one area in particular to focus attention on it would be
statistics and their generation. Recently, this has become even more of an issue as
managers indicate that they are no longer generating their own statistics. Of course, this
can also be seen as an opportunity for the human resource department. More specifically,
it is an opportunity to measure effectiveness of line management and intervene
accordingly. It is an opportunity to develop a new statistical system that reports
directorate rates on a monthly basis. I say “rates” and not “absence statistics” because
these statistics should communicate to managers actionable targets which they as
managers have direct control over. An example of this, although it may be difficult to
initially set up, a measure of “reporting error” by department could be introduced. By
that I mean, developing a figure that holds the managers accountable for missed dates,
late forms, inaccuracies, etc. by department or directorate. Error rates could then be
compared across departments and inconsistencies in process addressed in departments
with higher rates. All in all, a meeting must be held to determine what statistics would
best hold managers accountable for their actions. These statistics should be provided on
a monthly basis, holding supervisors responsible for the management of sickness and not
sickness itself. That said, I recommend that the Ceredigion and Mid Wales NHS Trust
focus more personnel in the area temporarily. They could train all managers; however,
training just a few employees how to manage and develop a system that holds all
managers accountable for their actions is a worthy investment that can accomplish the
same effect. Especially, considering training invested in this area does not take medical service providers off the floor. Finally, a statistic that measures management by directorate will identify those who have high absenteeism themselves, are resistant, untrained or whom create an atmosphere that actually increases absenteeism rates. As a result, training could be provided on a case by case basis.

**Accountability.** Rewards should not be given to the individual employee or to the department for “reducing absenteeism”. It is my belief that the truly sick employee should remain at home and not be encouraged to return to work before they are fully recovered and rewards should not be provided for attendance that is already expected. However, rewards could be provided to the department or directorate for reducing errors in recording, for submitting forms in a timely manner and for completing back to work talks as required. This would provide incentives, not only for the manager but for the department as a “team”. That said, the manager would not be just “disciplining employees” or performing “general administrative duties” but be working for the benefit of the department as a whole.

**Networks.** Several absenteeism networks must also be introduced. An *authority network* would outline to whom each manager would be accountable to. At present, it has been indicated that some Clinical Director collect absenteeism data, while others do not. Perhaps the Clinical Directors could hold managers accountable for errors in recording, pattern analysis, figures and timely form submission. Second, a *knowledge network* could be set up among managers. This would include names and contacts of those who
Ceredigion and Mid Wales NHS Trust: Sickness Absenteeism

champion a particular area of absent management. Whether it is back to work talks or pattern detection, this network would be informal and welcoming, fostering communication amongst all managers. A wall hanging listing names of “the expert manager in each area” and the associated contact number could be provided to the manager of each department. This would increase both communication and consistency among directorates. Finally, a contingency network should be introduced within each directorate. When the manager is not working or absent a list of capable replacements must be contacted within the ward to step-in to take over all required duties. The creation and administration of this list would be the line manager’s duty to maintain. However, human resources should have a copy of this network and be informed of lengthy absence so as to provide assistance and avoid backlog. For employees, a buddy system could be introduced. A model employee could be assigned to a newer employee. In essence, this would open communication up between parties and create a greater sense of a “team atmosphere”. Ideally, this model employee would become a mentor to the newer employee, reestablishing an open atmosphere in departments that may be struggling. In the case of absence, buddies may provide needed warning to schedulers unaware that a sickness is about to occur.

**Scheduling.** The key to utilizing any group of staff effectively is the ability to schedule them. Particularly, strategic scheduling based on percentages and mathematical equations has been found to reduce shortages and hence mandatory overtime, burnout, etc. For shift workers, nurses and occupations were work builds-up in the case of absence, strategic scheduling is essential. Therefore, managerial training and expert
Advice in this area should be considered and a more proactive rather than "ad hoc" approach should be taken. Perhaps, it is possible to use means, median and modes associated with casual data to schedule shifts once the absence is reported. For instance, if the employee complains of a cough or cold prior to sickness, we note that the mean length of absence for cough and cold was 2.41 days, median was 2.5 days and mode was 1 day. The range or lengths of absence for this particular sickness lay between 1 and 4 days. Given this information, it can be hypothesized that there is a 99% chance that the employee will be over his/her sickness in 4 days. Therefore, replacements should be arranged for in advance to minimize work load and disruption.

**Policy.** Policies should be adhered to on a consistent basis. Therefore, I recommend that line managers have access to the attendance records of every agent in the trust so they can make appropriate decisions or, perhaps, human resources can communicate similar cases that form *precedents* for evaluative purposes. Furthermore, the policy itself could be updated to promote an environment of "zero tolerance". This is especially important in the case of new staff members. For instance, during orientation new staff members late or absent for the job offer session, orientation, training, etc. could have the job offer revoked. Also, trigger points could be slightly broadened to provide a greater number of breaches requiring review. The 2002 National Audit noted that the three episodes in eight weeks scenario is one of the shortest periods that they had come across for this sort of frequent absence trigger. They claimed that other trusts were using broad triggers such as three episodes in six months or four in 12 months and are therefore likely to identify greater numbers of breaches of their frequent absence trigger points. Other options could
also be investigated or tested on a smaller employee group. For instance, less generous paid sick leave, allowing for accumulation of sick leave, allowing compensation for employees who have earned sick leave and not used it if they quit or retire, incorporate a “waiting day policy” to discourage one day absences or tie other benefits to actual hours worked so that employees with more absenteeism would receive proportionately less vacation, retirement, etc. or allow employees to make up lost time. (Dalton & Enz, 1986, pg 84) Of course, it is realized that policy changes must be approved by the board and union representations before implementation. The goal is to balance business needs and the employee’s personal needs within the Trust. Thus, this is not an immediate solution.

**Communicating zero tolerance strategy.** The final step to developing a change strategy would be to develop and vision and communicate this vision to each and every department. This could be in the form of a two or three hour seminar that runs on rotating shift for a period of one week so all line managers are able to attend once. During this seminar, success stories, allegories, and case studies could be posed. Managers could rotate from one department to the next choosing from training in a variety of absent management areas (pattern analysis, listening/interview techniques, trigger & policy, approaching the employee, etc) as well as talking about overall goals and results of absenteeism management within the Trust as a whole. This rotational pattern would allow managers to focus on areas they feel require the most attention. At this point the new change structure could be introduced. This would include introduction of the steering committee, networks, etc. At the end of the seminar, line manager could state explicitly what goals they have upon return and how these goals may in turn affect their
Ceredigion and Mid Wales NHS Trust: Sickness Absenteeism

department. Each manager would take back to their directorate clearly defined roles and responsibilities, lists of changes, handouts for employees, know to whom and what they report, how often and how their skills will be assessed.

The Ceredigion and Mid Wales NHS Trust's primary purpose is the distribution of Health Care Services to the citizen's of Wales. It is recognized that for the most part managers are also service providers working hands-on within each directorate. The recommendations and analysis provided in this paper are to be utilized as a guideline by the human resource department to reduce absenteeism within the Trust. Future studies may want to look at the correlation between absence and stress within the directorates as well as a regression equation and corresponding beta values identifying factors that contribute to sickness absence overall. Finally, for evaluation of future change processes it should be noted that similar if not identical studies to those conducted here and in the past should be performed for consistency.

Section Three: Relevant Professional and Research Literatures

For the purpose of this project sickness absence refers to “time an employee is not on the job during scheduled work hours, except for a granted leave of absence, holiday and vacation time” (Levine, 1999, pg 66). Absence by this definition can be intentional or unintentional, certified or uncertified and have both indirect and direct costs. That said, the annual direct cost of absenteeism from the workplace in the United Kingdom “has been estimated at over 1% of the GDP” (Chatterji and Tilley, 2002, pg. 669) been “a major cost of lost productivity and cost to the British economy” (Murray, 2003, pg. 9). It
is estimated that up to “200 million working days are lost each year due to absence, costing the economy L12 billion” (Murray, 2003, pg. 9). Of this L12 billion the NHS, one Britain’s largest organizations, takes a substantial chunk. The NHS Assembly in Wales, for instance, reported total of £66 million (2002-2003) of staff time lost and £14 million in replacement bank, agency and locum staff (National Audit, 2002). Research in the area suggests that the NHS is not alone. In the United States, Canada and Australia many studies have been conducted to address current increases in sickness absence rates.

Recently, there has been an “upsurge of public interest in the incidence of absence and its potentially damaging consequences on output” (CBI, 1996). In 1996 the Confederation of British Industries published a report that addressed public concerns estimating absenteeism levels by region and industry. All in all, the study claimed that sickness absenteeism accounted for 187 million working days lost in the UK and cost business 12 billion in 1996. The survey indicated that “the increase in absenteeism reported among non-manual staff arises from low morale and motivation, largely caused by uncertainty over job insecurity and lack of investment in staff development” (CBI, 1996). Interestingly, the MCF survey conducted during the same period found that 37% of respondents said their jobs had become less secure in the last year, and 30% said that they had become less secure over the last three months (1996). Amongst Health professions in this same survey, a high 46% responded that their jobs had become less secure. It is possible that increasing levels of competition, restructuring, delayering and cost-cutting has indirectly created an “absenteeism environment”. That more specifically, cutbacks have added to stress levels and created pressure on employees to work longer
hours. As a result of current changes, the CBI report (1996) argues that employees are increasing evaluated on their ability and willingness to increase their time, visibility and presence at work. That sickness absenteeism may not itself be the problem but rather a symptom of changes within society. Regardless, the increase in frequency of absenteeism and its associated direct and indirect expenses cannot be ignored.

In fact, the “total cost of operating a business has increased an average of 10 percent of payroll costs because companies lack effective and coordinated employee absence and health management strategies” (Kweller, 1998, pg 1). The cost of salary and replacement of the workers who are away is only the beginning. Experts claim that absence damages “the morale of the people who cover for those absent and deprives organizations of the skills and knowledge making planning impossible and playing havoc with productivity” (Murray, 2003, pg. 9). In a health service or shift environment such as the NHS, this effect is compounded. Absenteeism becomes a “cyclic” concern. This means that not only those scheduled with the absent employee are affected but also those having to reduce backlog following the occurrence. The problem is about “10 percent of staff account for 50 percent or more of total absenteeism” (Anonymous, 2000, pg 1). Employees who continually let the team down by not turning up for work can cause real problems for management. For instance, cost of managerial time, effect on scheduling, effect on productivity, cost of termination/ rehiring, etc. are costs not even included in the standard calculation.
Across industries, both not-for-profit and for-profit firms are assessing policies and administrative processes to reduce sickness absenteeism. They claim that “acceptable practices to reduce absenteeism should be relatively inexpensive to administer and should not rely on harsh disciplinary procedures” (Enz & Dalton, 1987, pg 82). Thus, the criteria developed for sickness absenteeism alternatives within this field study included: (1) the alternative must be realistic & relatively inexpensive; (2) the alternative must not rely on harsh disciplinary procedures (retaining trust and satisfaction); (3) the alternative must be consistent with current system and ERS implementation and; (4) the alternative must not be difficult to implementation or disrupt service. Across all firms, statistics reveal that managers are developing a similar set of criterion. Managers are focusing away from sickness causes towards a system that facilitates the management of sickness absenteeism, allowing managers to pinpoint and address bottlenecks within their own organization that may be contributing to higher absenteeism levels. Kweller, for instance, refers to this move towards absent management programs as “the next quantum leap” (Kweller, 1998, pg 1). That more firms are introducing sickness absence policies, systems and procedures to deter high absenteeism levels. Of course, while many firms “write it off as a minor annoyance and don’t measure the real costs, others “recognize the real costs but become resigned to it” (Anonymous, 2000, pg 1). There are several problems surrounding this issue. First, sickness absence in the United Kingdom is only verifiable to some degree. “Under the department of Social Security’s procedures in respect of certification of sickness for national insurance purposes, doctors are not obligated to issue statements covering the first week of sickness from work” (Chatterji and Tilley, 2002, pg 674). This yields a significant amount of
“non verifiable absence”. Secondly, managers do not know where to start. For instance, before implementing new policies, systems or procedures managers must “define the types of absence that need to be addressed and to ensure that cases are being recorded” (Fowler, 1998, pg. 44). This requires both “attendance targets and benchmarking exercises, which depend on accurate data” (Fowler, 1998, pg. 44). A breakfast seminar held in May of this year indicated many organizations seem unable to address the problem (Mercer Human Resources Consulting, 2004).

The key is to first set up an accurate recording system and then to strike a balance. To find a combination of policy, structure and culture that balances the happiness of the employee with the needs of management. That said research in this area for the most part has not been complementary. Despite efforts and as noted in our study of sickness absence within the NHS “critics feel strongly that much of the absence research does not serve the practicing manager” (Enz & Dalton, 1987, pg 82). That “investigations directed at the causes and remedies for sickness absence have been referred to as bewildering and concede that much of the research in traditional study of absenteeism is not designed to be very informative” (Enz & Dalton, 1987, pg 82). Enz and Dalton (1987, pg 82) refer to these as “relatively serious indictments” suggesting that “factors which have been reported to lead to employee absenteeism are of little, if any, practical value to the manager” (Enz & Dalton, 1987, pg 82). Take for instance, a study that regressed variables such as age, sex, ethnicity, etc. as contributing to high levels of absenteeism. Such information, just plainly has no value in a unionized and regulated environment. Nevertheless Enz and Dalton (1987, pg 81) claim that most research efforts have had this
Ceredigion and Mid Wales NHS Trust: Sickness Absenteeism

common objective: “to determine the causes and reduce the incidence of employee absence in the workplace”.

In 2002, Chatterji and Tilley conducted a study on sickness, absenteeism, presenteeism and sick pay. They distinguished between presenteeism which they defined as “the flip side of absenteeism” or more specifically “unhealthy workers turning up for work if their productivity is adversity affected by their health state” and absenteeism (Chatterji and Tilley, 2002, pg.678). Utilizing preexisting pay models, they attempted to develop the optimal contract utilizing both participation and compatibility constraints. They were able to show that “the optimal contract involves offering: (1) a wage that is strictly higher than the sickness pay offer, and (2) a sickness pay that is strictly positive” (Chatterji and Tilley, 2002, pg.678). That by reducing sickness pay to half or nil entitlements, management may actually be increasing presenteeism. More broadly they contend that, “any attempt at reducing the potential productivity loss from absence has to be offset against the potential productivity loss from presenteeism” (Chatterji and Tilley, 2002, pg.678). In most firms, this may be considered a valid tradeoff. However, in a medical environment for self explanatory reasons, presenteesim is unacceptable. Thus, reducing sick pay entitlements was not approached as valid consideration for the Ceredigion and Mid Wales NHS Trust. However, in any other industries productivity over presenteesim may be valid consideration.

Various models have been utilized throughout history to explain sickness absence. However, the “labour/leisure choice” model described by Chatterji and Tilley was titled
Ceredigion and Mid Wales NHS Trust: Sickness Absenteeism

the traditional model of absence (2002, pg.671). The traditional model claimed that
desired hours are determined from the worker’s indifference curve and the budget
constraint each worker faces. That a “gap” experienced between desired and official
hours set by the employer provides the motivation for absence. Thus, absence is seen as
mainly an attempt by workers to bring actual hours worked more in line with desired
hours by effectively working less than the official hours required by the job. (Chatterji
and Tilley, 2002, pg.671) An internet search on this model indicated that from 1981 to
1992 this theory resurfaced in literature published by Alien (1981), Dunn and
Youngblood (1986) and Barmby and Treble (1991), Brown 1994 and Kahana and Weiss
(1992). The theory concludes that by offering sick pay, firms are in effect “increasing the
workers’ incentives to absent themselves even more, thus potentially driving a greater
wedge between actual hours worked and official hours set by the firm” (Chatterji and
Tilley, 2002, pg.671). If this is the case, management should consider intervening to
reduce subordinate hours, hiring more part-time employees to fill full-time positions, etc.
Furthermore, the employees depicted in this theory experience an “informational
advantage”. Perhaps, surveys, focus groups, interviews, etc. would lessen this advantage
and allow management to actively work with the employee to alleviate the differential. If
indeed this is the case, it appears that managerial intervention would be an effective
strategy to reduce sickness absenteeism.

In 1999, Pelled and Xin conducted a study on mood and its empirical association
with employee withdrawal behavior, absenteeism and turnover. The study included 148
employees in a single division of a large electronics company. They introduced mood in
two dimensions: positive affectivity and negative affectivity (Pelled and Xin, 1999, pg. 2), noting that "high positive affect is most clearly represented by mood terms such as active, elated, and enthusiastic" whereas negative affect is "represented by terms such as distressed, fearful, and nervous" (Pelled and Xin, 1999, pg. 3). Using these two dimensions as independent variables, Pelled and Xin developed a regression equation to explain absence. They found that positive affectivity displayed a high negative beta value (-8.94) while negative affectivity a positive beta value (3.96). Job satisfaction was introduced to moderate the influence of these two dimensions. Pelled and Xin (1999) found “PA to be negatively associated with absence, and NA to be positively associated with both absence and turnover” (pg. 16). On a general level, these results suggest that “unpleasant emotional states experienced in a given situation encourage escape from that situation, while pleasurable emotional states discourage such escape” (Pelled and Xin, 1999, pg. 16). The results of Pelled and Xin’s study have important implications for management interested in reducing sickness absence in any organization. Their study implies that understanding and managing emotions in the workplace as well as increasing job satisfaction can reduce employee withdrawal behavior. For example, employers such as the NHS “may want to monitor employees' moods and job satisfaction levels carefully so that appropriate steps can be taken to prevent absence and turnover” (Pelled and Xin, 1999, pg. 16). The key is that, there is a “carry over” associated with both mood and absence. Basically, in a health service environment, job satisfaction can not only mediate absence but on the same premise mediate moods that affect quality of patient care. Recommendations such as counseling programs and improving work environment
ergonomic keyboards, back support, lighting, etc.) may be one avenue to reduce sickness absence rates and improve patient care.

In 1994, Landeweerd & Boumans undertook a study of nurses in 16 randomly chosen hospitals in the Netherlands. Nurses were taken from ICUs (Intensive Care Units, also including coronary care units and combined ICU-CCUs) as well as in the general departments (surgical and/or internal) and asked to complete a questionnaire measuring the relevant variables. These relevant variables were then analyzed using a correlation and step wise regression method to determine characteristics of the job that positively affected them (minimizing avoidable absence) and negatively effected them (contributing to unavoidable absence). Landeweerd and Boumans found that “the job characteristics feedback and clarity, autonomy, promotional and growth opportunities and patient attending and caring as well as social-emotional leadership, expectations, positively affect nurses' reactions” and the work dimensions work pressure, instrumental leadership and task-oriented nursing care system appear to have negative effects” (1994, pg 3).

Research demonstrated that “sudden changes in the patient's condition, the number of different instruments and the equipment they have to work with, emergency admittances, etc. may well be challenging to the nurses and thus lead to feelings of job significance, but at the same time they increase psychological and psychosomatic complaints” (Landeweerd & Boumans, 1994, pg 3). All things considered, vertical enrichment may increase satisfaction within the workplace, giving employees a chance to make decisions that visibly affect their goal. Similar studies conducted in 1998 reveal that “improving job design, managing career expectations and rebuilding trust and loyalty” (Hayday, 1998,
Ceredigion and Mid Wales NHS Trust: Sickness Absenteeism

pg. 3) help to prevent sickness absence. In fact in 2002 a similar study conducted by Pousette and Hanse, tested for multi-group invariance in measurement and structural models between job characteristics, psychosocial intervening variables, health outcomes and sickness absenteeism. Pousette and Hanse’s study (2002) showed that since job characteristics can potentially be amended, the findings (showing occupation-specific models more plausible) have important implications for the differentiation of prevention and intervention in different occupations. Their results indicate that “it is important to examine different occupational contexts in detail to better understand how certain psychosocial factors at work influence strain in different occupations” (Pousette and Hanse’s, 2002, pg. 1).

In 1987, Enz & Dalton introduce the concept of an absence culture, “a culture that legitimizes and encourages absenteeism” (Enz & Dalton, 1987, pg 85). Their research concluded that some organizations may actually suffer from a culture which supports and encourages informal behaviors such as absence taking. That while the entire organizational culture may appear to be sanctioning absence, subcultures exist that may foster it. In these subcultures, “leave taking is considered a common practice, motivated or planned in advance and considered legitimate by coworkers” (Enz & Dalton, 1987, pg 85). This dichotomy of culture into two distinct subgroups is still seen in organizations today. In fact in 2000, Lindeboom, Maarten, Kerkhofs, Marcel, concluded that differences in absenteeism levels were due to working climate and the quality of management (pg. 9). That clustered sick rates may also reflect the “dynamics of sickness absenteeism: existing absenteeism requires temporary replacement and reallocation of
tasks” (Lindeboom, Maarten, Kerkhofs, Marcel, 2000, pg. 9). They claimed that such disturbances put pressure upon the organization and are likely to raise the hazard of sickness incidence of the remaining workers. Once high, Lindeboom, Maarten, Kerkhofs, Marcel (2000, p.9), claim sickness absenteeism would therefore tend to stay high. The survey conducted in the Ceredigion and Mid Wales NHS Trust indicated that such a subculture may in fact exist. That, more specifically, while one department or division may monitor and control absenteeism another may encourage it. It is a problem that exists in larger organizations and is seen predominantly within the public service industry, especially in jobs that are considered boring, tedious, unrewarding, strenuous jobs or “low status”. In each situation, a line manager may unconsciously find absence acceptable. The problem is that once absence culture is established it is considered “resilient”, “enduring” and “stable” overtime. It is described by Enz and Dalton as the “glue that binds employees together” (Enz & Dalton, 1987, pg 85). They claim that new employees are then socialized into this culture and thus the “rules of the game are perpetuated over time” (Enz & Dalton, 1987, pg 85). Changing this environment in any company is a challenge. However, in the NHS factors such as unionization further complicate the change process. If an employee who has seniority legitimizes absences, a strong set of norms may resist, encouraging leave behavior. Furthermore, line managers as “hands-on service providers” are often too busy to enforce sickness absence policies. Too often they ignore existing policies and in doing so “tacitly condone leave-taking” (Enz & Dalton, 1987, pg 85). The solution is then to establish new networks and reestablish new norms. To open the subcultures up to new information via networks that cross boundaries into new departments and new divisions. For this reason, establishing a
new formal system of networks was posed as a recommendation for the Ceredigion and Mid Wales NHS Trust. Correspondingly, Enz and Dalton (1987) concluded that “the problem of poor attendance is not an individual one, but a social one, because a network exists to support and encourage taking days off” (pg. 85). By changing these networks, managers effectively weaken the existing structure leaving an opportunity to monitor, predict and change the current culture. To do so, Enz and Dalton recommended eight managerial strategies. Their strategies consisted of “increasing managerial attention & administrating policies, attendance supporting rewards, absence reducing sanctions, redesigning work, role modeling, reducing non-work conflicts, altering selection, promotion criteria and finally, employee removal” (Enz & Dalton, 1987, pg 85).

Other authors such as Fowler (1998) allude to similar recommendations. Fowler (1998) for instance describes Enz and Dalton’s first step in greater detail. He claimed that calculations of sickness absence must be “comparable and clearly defined” (Fowler, 1998, pg.2). While he recommended telephoning employees during absence and introducing return to work interviews, flex schemes, financial awards, welfare counseling and healthy living programs, three of his recommendations stood out above all others. One, to select the type of statistics reporting system that enables absence management to take place, two to introduce a computerized recording system to reduce record keeping and for producing analyses of attendance, three, to set up health unit within the organization to address immediate illness concerns. (Fowler, 1998, pg. 2) He claimed that “10 separate one-day absences may be far more disruptive than two weeks of genuine illness” (Fowler, 1998, pg. 2). Since “line managers are the only people who know when
an employee is absent, particularly for short, unspecified periods” they should be provided with the data, precedents and healthcare options that may help to prevent it.

As early as 1973, researchers such as Chadwick-Jones and Nicholson, distinguished between avoidable and unavoidable absence which they referred to as type “A” and “B” respectively. Since then Dalton and Perry (1981), Winkler (1981) and Dilts, Deitsch and Paul (1985) have focused deliberate strategies to manage “type A” avoidable absence. More specifically, they looked at raising income, implementing sickness policies, providing proof of absence, etc. Dalton and Perry (1981), for instance, found that organizations which pay more money have higher absenteeism rates, that as income increases employees buy leisure given they have a greater amount of expendable income. Other studies of the time established that higher rates of sickness absence could be attributed to higher accumulation of sick leave, lack of sickness certification, non-reimbursement of earned but unused sick leave, etc. Dalton and Enz claim that “control through the use of absenteeism policies may be effective in reducing avoidable and chronic absenteeism” (1987, pg 79). Dalton and Enz’s recommendations are listed as follows:

- Provide less generous paid sick leave such as \( \frac{3}{4} \) day per month rather than 1 \( \frac{1}{2} \)
- Allow for higher accumulations of sick leave so that employees so not lose benefits if they do not use them
- Allow for some compensation for employees who have earned sick leave but have not used it if they quit, retire and so forth
- A “waiting day” policy could be adopted to discourage one day absences
- A sick leave certification policy could be put in place
- Other benefits could be tied to actual hours worked so that employees with more absenteeism would receive proportionately less vacation, retirement and so forth

(Dalton and Enz, 1987)
Hayday (1998) builds upon and summarizes past literature in this area claiming that back-to-work interviews, trigger points, medical certificates also reduce sickness absenteeism. However, Hayday (1998) makes an important distinction that others in the past did not make. He said that three key elements are essential for any attendance strategy to be successful: (1) organizational culture of attendance, (2) clarity of roles and (3) clarity of procedure. While most literature reviewed to date refers to organizational culture, Hayday is the first to introduce role and procedural clarity together.

Since the mid 1980’s, whether it is the pay, mood, job characteristic, satisfaction, personality or culture, sickness absenteeism is said to be reduced by selection, compensation, job enrichment, sickness absence policies and general management strategies. There has evidently been a shift away from the approach of “absence control in favour of more enlightened attendance management strategy which provides a working environment which maximizes and motivates employee attendance” (Hayday, 1998 pg. 3). However, while literature has seemingly shifted away from general causes of sickness absence the management of sickness absence is still appears to be relatively new area of study. New strategies have yet to be found and empirical as well as theoretical studies yet to be conducted. Further research conducted on the effectiveness of certain reporting and statistical systems as the first step to absence management would be helpful. Furthermore, there seems to be confusion surrounding the process of sickness management, where to start and how to implement it. While research does indicate that statistics must be gathered, reporting must be accurate, a policy must be developed, targets set and managerial strategies implemented phase by phase, a simplified approach
that is useful for all managers has yet to be discovered. Perhaps future theorists might integrate change management together with sickness management to develop a more detailed and comprehensive model for organizations, such as the NHS, to utilize.

Section Four: Reflection and Analysis of Project Process

Overall, I found the experience working on my field project “management of sickness absence management within the NHS” to be rewarding. I crossed cultural boundaries and gained hands-on consulting experience that may result in better patient care. In retrospect and in the future, I would keep my hands-on intense and focused approach the same. I have benefited from attaining measurable, quantifiable data surrounding the change and the resulting specific yet conservative recommendations posed. On the other hand, this field project did suffer from various limitations. More specifically, I feel that in the future I could: (1) prepare consulting samples, templates and outlines, (2) portray professionalism in every aspect, (3) adopt a multistage approach, (4) ascertain a team and finally, (5) exploit time efficiently.

Consulting Samples, Templates and Outlines

While I did prepare for this consulting experience in advance, I admit that I did not know what to expect. I went into the consulting experience having conducted research on the current sickness absence policy, the NHS and the Assembly’s National Audit Report for the NHS in Wales, which I found quite comprehensive. However, I had not yet developed a distinct proposal to present to my project sponsor and project contact in our first meeting. Instead, our first meeting consisted of a semi-structured interview that I
prepared in advance. My intention was to develop a firm understanding of current and past change attempts before narrowing the conversation to deliverables. This is due to my understanding that multiple audits conducted in the same area but conducted differently and not tied together just create further complexity. This was the case and the Ceredigion and Mid Wales NHS Trust. The change itself was out of control, the data gathered was unorganized and unutilized and the Trust had a team of four human resource employees leading the change of fifteen hundred. It was evident that data needed to be incorporated together comprehensively into one document, added to and updated. That said I was presented with several alternatives. I had to way the viability of each alternative against my criteria, to eliminate implausible options. In the future, I would not include the client such a detailed analysis. It is possible, for instance, that the client might have demanded an alternative that was not within my timeframe, budget or power. I found it important that client expectations stay realistic. That, more specifically a change process often takes years to implement and not to expect miracle results overnight. I feel that expectations could, in the future, be unified through the introduction of precedents in the industry (similar change processed and outcomes) and by introducing “samples” of previous consulting work completed. I feel that to truly clarify the expectations similar samples, templates and outlines could be introduced.

**Professionalism**

It is important that the field project coordinator is perceived as professional and capable at all times. In my experience this includes dress, tone as well as organization. From experience, this meant taking an assortment of neat, ironed clothing for in and out of the
office, including the bag they were carried in. A small suitcase on wheels is best. In hindsight, while I packed appropriately I did not take the easiest bag to carry. My duffle bag was too bulky, difficult to carry in trains and just generally looked untidy. Secondly, inadequate preparation for travel reflects poorly on any consultant conducting a study. Maps, living arrangements, transport, etc. should all be organized in advance to avoid dependency. Overall, however, confidence seemed to be the key. As a consultant, I needed to radiate confidence in my abilities, my decisions and my recommendations. Indecision coupled with my quiet demeanor, only created doubt in my own mind and surely others. The key was to make a decision, rationalize it and stick to it. I feel that confidence is essential during two particular points in the field project. First, confidence must be established during the initial meeting. This would commence with a firm introduction that lays out my needs, my demands and my strategy. Research of precedents in the industry prior to the first meeting will help with a backing in this area. Second, recommendations must be written and delivered in a confident but sensitive manner. To develop data that leads directly to the recommendations without question. During this project, this was my greatest area of concern. If the director sensed my interviews were heading towards a particular conclusion that they did not support, they would be quick to point this out. I feared their in-depth knowledge of their system and quick dismissal of previous audit recommendations would leave me in a disadvantaged position. However, it seemed that open communications and the proactive “prepping” of management (having them form the same conclusions from the current analysis before presenting them) helped ease their acceptance. While I was unhappy with my approach
to the initial meeting, I was satisfied with my approach to the recommendations. A “learning conversation” approach to discrepancies seemed to work wonders.

A Multistage Approach

As for the project, I would recommend a dual-stage approach. Step one meeting the client, holding key interviews, preparing the charter, gathering the preexisting data and deciding on the type of study. Step two conducting the study, whether it be quantifiable for qualitative it is important that time between the two phases is taken to consider what information is needed, what is in the best interest of the client and what process fits with project budget and timelines. I have learned that the initial stage of the project must also set the tone. By that I mean, working long hours, establishing authority with the organization and gaining access to needed information, employees and documentation. I learned that as time goes on the novelty and interest of directors in the project diminishes. New initiatives may come up for consideration and current projects not given the attention they deserve. In the organization I dealt with, I found a top heavy interview process to work best. By that I meant, interviewing the directors and board members first, before working down the organizational hierarchy. By accessing information when interest is highest, directors are willing and able to provide more support, allocate greater amount of resources, give more suggestions and make time personally to help out. This interaction takes the project to the next level by increasing both quality and ease of delivery.
The Team

As a student working alone, I admit to having limited time, resources and capabilities. The cliché “more heads are always better than one” captures my dilemma. In hindsight, I should have created a “team”. Data collection is expedited and recommendations are a result of group brainstorming and reflection. The benefits are undeniable. Even coming is a single consultant, a team or committee that includes internal experts, external experts, data collectors and data entry personnel could really minimize time. While I did, of course, consult NHS experts, interview line managers and human resource staff I realize now that I could have requested assistants to help me out. Furthermore, a sickness absenteeism focus group could be set up immediately. Basically, even alone I could have set up a team of supporters to run ideas through who know the business, enabling me to step back and access the greater picture, listen to debate and highlight key areas of concern.

Utilization of Time

The utilization of time is an extremely important factor of the project in several cases. Similar to the recording of sickness absence, information collected in a study must be recorded immediately to reduce errors and bias. Upon reflection perhaps a tape recorder or pre-prepared template may help to reduce the transcription errors following interviews. I found that reflection must also take place immediately. In the case of qualitative structured interviews, often days elapse before their final amalgamation and transfer into the report. Insights once experienced during the process are lost and difficult to recover. Therefore, I have learnt that time be taken to document these insights and perhaps write a
review following each unique encounter. While it is recognized in large studies quantitative studies this is not always possible. A highlight, note or classification scheme could be developed to address both efficiency and accuracy. Secondly, time taken between the initial contact, reports and final submittal is also crucial. The relationship must be administered to and updates provided on a regular basis. The key is to keep those directly involved in the project working for you and to not let interest diminish. This can be accomplished through personalized emails, phone calls and visits if possible.

I worked long hours, sometimes 7am to 7pm. I found that this intense approach funneled my search in the right direction. Every employee knew who I was and put aside daily duties knowing I was only in town for a short period of time. That said, this also contributed to the consistency of my paper. Interviews were conducted with management within the same time period and with employees within the same period decreasing the chance of discrepancy and increasing accuracy of data.

I realize that given my limited knowledge of the medical sector I am not in a situation that I feel comfortable making overall strategic generalizations. As a result, this project takes a micro and not a macro prospective to managing sickness absence. Quantifiable and qualitative data is provided but only as it relates to this specific change initiative and the implementation of the future ERS system, not taking into account other departmental initiatives that may be running simultaneously in the Trust. Understandably, the CEO will have to make tradeoffs. While the Ceredigion and Mid Wales NHS Trust is the smallest of Trusts in Wales, it still comprises over 1500 employees, several hospitals, and multiple unions with over 15 wards/departments. In addition, the NHS is highly
regulated. Recommendations must take all governing bodies into account. It is not a simple process nor was it a simple trip. It required extensive travel and arrangement of accommodation/transport to and in both Cardiff and Aberystwyth. However, I do believe that this field project “Managing Sickness Absenteeism within the National Health Service” satisfied its original purpose. In future consulting/field projects, however, for the sake of efficiency I would approach the above stated aspects of my delivery differently.
Bibliography

Literature


Perry, Phillip, 1996. “Smart tips for tackling the pesky no-show problem.” Materials Management in Health Care, Vol. 5 Issue 11; p60-63


Interviews

Jo Davies, In-person interview. June 7th & June 10th, 2004


Company Specific Information

Auditor General for Wales, Management of Sickness Absence by the NHS Trust in Wales's presentation to the National Assembly, January 2004.


National Audit Office Wales, Management of Sickness Absence by the NHS Trust report prepared for the Auditor General for Wales, October 3rd, 2003.

National Audit Office Wales, Managing Sickness Absence in NHS Wales: Findings from a Sub Group of Deputy Directors (Wales), 2001/2002 (Draft)

National Audit Office Wales, Sickness Absence Management in NHS Wales: Ceredigion and Mid Wales NHS Trust survey results, 2003

National Audit Office Wales, Study of Sickness Absence Management in NHS Wales, March 10, 2003
Appendix A

Verbal notification of illness by employee (to line manager/supervisor)

Absence recorded on individual’s attendance record (if applicable) and on individual/departmental timesheets.

- Return to work interviews after any period of absence
- Employee self certification for the first seven days of absence
- Medical certificates for absences over seven days

Attendance records and copies of self certificates and medical certificates to be kept on personal files

Timesheets sent to payroll.

Original copies of self certificates and medical certificates sent to payroll

Sickness absence statistics generated manually by departments and forwarded to personnel for collation

Absences recorded and sick pay entitlement tracked on the payroll system

(National Audit Office, 2002)
Appendix B

Project Charter

Background

The 15 Wales NHS Trust’s today still remains true to principals upon which they were founded in 1948. These are listed below:

- To provide comprehensive care
- To provide this care to everyone in the UK (they have the right to use it)
- To provide care on the basis of people’s clinical need – not on their ability to pay (http://www.wales.nhs.uk).

Recently, however costs have been on the increase enough to threaten fundamental principals and require Assembly Department Intervention. Between 2003 and 2004, for instance, the NHS website indicates that Wales spent approximately £3.8 billion. Of this £3.8 billion, as Wales’ largest employer (with over 81,000 staff), a substantial amount was spent on sickness absences among employees. In fact, an audit conducted in 2003 by the Auditor General for Wales and presented to the National Assembly in 2004, indicated that sickness absence, on average, accounted for 6% of contracted hours in comparison to the 4.7% of the NHS trusts in England (National Assembly, 2004). Upon closer examination of absence records held by NHS trusts the auditor general increased this figure, claiming that current levels have been understated due to errors in recording. If this finding is indeed correct, this would adjust the level of sickness absence to at least 6.3% of contracted hours in 2002-2003. Basically, an increase that would not only affect the quality of patient care that the NHS trusts are able to provide but also “exacerbate the service delivery problem caused by staff shortages and vacancies” (National Assembly, 2004). As such, this discrepancy has been noted to cost NHS trusts in Wales an additional £400,000 per annum in sick pay on top of the recorded £66 million (in 2002-2003) of staff time lost and £14 million in replacement bank, agency and locum staff (National Assembly, 2004), not including cost associated with general management and termination/hiring.

As one of the 15 NHS Trusts in Wales, the Ceredigion/ Mid Wales NHS Trust must heed the recommendations of the Assembly’s NHS Wales Department to “address the overall quality and consistency of sickness absence management through improvements to existing procedures” (National Assembly, 2004). More specifically, develop a standard definition of sickness absence, review sickness absence recording systems, train managers, calculate accurate cost data, improve and maintain awareness among employees, develop an implementation plan and targets with deadlines, monitor the reasons/develop categories for sickness absences and establish minimum headline levels in each department. While Ceredigion/Mid Wales NHS Trust admits to experiencing a significant “gap” in reporting sickness absence between its HR and payroll departments, it has chosen to take a more proactive approach. Having already produced a ten page
attendance policy and associated communication plan, the Ceredigion and Mid Wales
NHS trust plans to look into factors that are presently inhibiting its change efforts and
that may in the future. In fact, the Mid Wales NHS Trust aims to reduce sickness absence
in 2004 further by approximately 5.5% of contracted hours to a target of 4.2% set for the
end of 2006. Such a reduction would not only decrease costs and increase effectiveness
of care delivery but also earn the trust the Assembly’s Corporate Standard “Gold”
Assessment indicating significant improvement in this area.

Scope & Objectives

Business Objectives

The overall business objective for Ceredigion and Mid Wales NHS Trust is to “provide
high quality integrated health care for the people of Mid Wales” (Annual Report,
2003/03). Most importantly, to increase the quality of care provided to patients by
indirectly reducing costs and time allocated to the management of absenteeism. That
said, by reducing absenteeism the Ceredigion and Mid Wales NHS Trust will “free-up”
capital required to fund needed programs (i.e. updating equipment, opening beds,
shortening waiting lists, etc.) as well as improve working conditions within each
directorate. This would be reflected in the Trust’s Assembly’s Corporate Standard
Assessment that reflect commitment to the promotion and protection of workplace health
and by meeting and hopefully exceeding recommendations made by the Auditor General
for Wales in January of 2004. In particular, by increasing the Assembly’s current
assessment from “bronze” to “gold” and by reducing percentage absenteeism of
contracted hours to 4.2% whilst facilitating implementation of the national ERS system
scheduled to arrive in 2005/06.

Project Objectives

To assess the Ceredigion and Mid Wales NHS Trusts current situation utilizing various
“change management” models, analyze cost data/policies and create recommendations
and an associated implementation plan for management that will increase the accuracy of
their sickness absence reporting system and improve management of sickness absence
within the Trust. In particular, this would involve the analysis of preexisting data, audits,
correspondence and interviews. In effect, to propose specific recommendations
following interviews with departmental managers, cost/trend assessment of gathered
absenteeism data, literature review and compliance assessments of recently imposed
policies. The project objectives being… to reduce the 5.5% of contracted hours absent to
4.2%, the 22,943 working days lost of the trusts 1443 employees while taking current
future initiatives such as the implementation of a standardized ESR system scheduled for
2005.

The scope of the project will not include:

- Actual implementation of the proposed recommendations to improve
- Comparison’s between the English & Welsh absenteeism policies
- Assess causation of absenteeism
Ceredigion and Mid Wales NHS Trust: Sickness Absenteeism

- Directly compare Ceredigion and Mid Wales NHS Trust to any other MHS trust in the region

Project Assumptions:
- Client provided details will be assumed to be accurate as all interactions will be via in-person, email and telephone
- Client will return telephone calls and emails within two business days
- Access will be provided to some staff for in-person interviews
- Access will be provided to documents (auditor reports, cost/financial and NHS data), manager and company personnel if deemed beneficial for both parties.

Project Organization

Project Sponsor: Jo Davies - Director of Human Resources
Project Contact: Dawn Thomas – Deputy Director of Human Resources
Project coordinator: Dawn Thomas – Deputy Director of Human Resources
Project consultant: Laura J. Sowden

Stakeholders

Additional internal stakeholders:
Change Sponsor – Assembly’s NHS Wales Department/ Chief Executive
Change Advocate – Dawn Thomas – Deputy Director of HR
Change Advocate – Jo Davies – Director of HR
Targets: Directorate Manager, clinical directors & divisional general managers
Targets: Employees in all directorates
Target/Change Advocate: Ward/line Managers

External Stakeholders:
Ceredigion Local Health Board’s decision-making board which is made up of local doctors, a nurse, other health professionals, members of the local council and voluntary organizations, and others to represent the voice of patients.
Ceredigion Local Health Board’s executive team – that put the decisions into action and provide services for the public.
Ceredigion Community Health Council (CHC)
Patients
Tax payers

Project Management

Laura Sowden will provide the Project Sponsor an update on June 20th and June 30th as to the progress of the project.

Phases, Schedule & Work Plan
Ceredigion and Mid Wales NHS Trust: Sickness Absenteeism

<table>
<thead>
<tr>
<th>Phase/Activity</th>
<th>Duration</th>
<th>Target Completion Date</th>
<th>Deliverables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquire necessary background, interview staff</td>
<td>9 days</td>
<td>June 6th - 22nd, 2004</td>
<td>Draft background and scope document for Sponsor sign off</td>
</tr>
<tr>
<td>Research statistical trends, alternatives and best practices (other NHS practices)</td>
<td>5 days</td>
<td>June 22nd - 30th, 2004</td>
<td></td>
</tr>
<tr>
<td>Analyze options and prepare recommendation</td>
<td>10 days</td>
<td>June 30th - 3rd, 2004</td>
<td></td>
</tr>
<tr>
<td>Create a recommended implementation plan</td>
<td>10 days</td>
<td>July 3rd - 10th, 2004</td>
<td></td>
</tr>
<tr>
<td>Complete final report &amp; presentation</td>
<td>5 days</td>
<td>July 15th, 2004</td>
<td>Final report provided to Sponsor</td>
</tr>
</tbody>
</table>

Project Charter Signoff

Laura Sowden agrees to conduct research and analysis at the project company, upon the issue as outlined in this document. The project team agrees to present its findings to the project company on the dates as agreed above according to mutually agreed-upon project plan and statement of scope. The project company agrees to allow a version of Laura Sowden’s academic report to be published by Simon Fraser University and placed in the Universities library, according to the terms specified in this document (confidentiality of details can be maintained and project may be held out for one year upon request).

<table>
<thead>
<tr>
<th>Approvals</th>
<th>Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Sponsor</td>
<td>Jo Davies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Contact</td>
<td>Dawn Thomas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Team Member</td>
<td>Laura J. Sowden</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Academic Supervisor</td>
<td>Gervase Bushe</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix C

- Bronze corporate standard assessment
- 22,943 lost working days (approximately 15.9 days per employee per year lost)
- 5.5% of contracted hours lost to absenteeism
- No record of cost and casual data
- Inaccurate absence reporting process, inconsistency in process perception among directorates

- Gold corporate standard assessment
- 4.2% of contracted hours lost to absenteeism
- Alignment with implementation of ESR system
- All data, cost, casual & process utilized to implement programs and make decisions
- Accurate absence reporting process (no “gap” between payroll & HR)
## SWOT Analysis

### Strengths
- Only 1443 employees, smallest trust in Wales creates a local, kind one-on-one environment
- Proactive Human Resource team
- Potential to develop an HR Committee
- New more comprehensive for just implements
- HR staff with experience writing absence policies within the NHS trusts
- Line managers our hands-on & familiar with employee jobs and routines
- Implemented new absenteeism forms that retrieve casual data consistent with that of the ERS coming in 2005
- Introduction of absence communication plan and PowerPoint presentation
- All front line managers will be trained and provided with a computer during the implementation of the ERS system

### Weaknesses
- Multi-level reporting (3 to 4 authority levels)
- Limited communication channels due to multiple authority levels that make it difficult to stay connected
- Line managers have limited time available for training
- Limited training available
- Face irregular working patterns – nurses adopting the work of those absent, flex shifts, PT workers, shift switching, etc...
- Shortages exacerbate stress levels and create a ongoing cycle
- Unrecorded absences
- Documentation that spends unnecessary time in transit due to outsourcing of payroll
- Employee perceive HR as a punitive function
- Internal lack of consistency among departments
- Not all employees have computer access or are comp. literate

### Opportunities
- Scope for the improvement in the provision of occupational health services
- Scope for significant improvement of cost management, scheduling (min levels), record collection, etc.
- Improving the communication flow
- Improving HR’s interactivity within the Trust
- Potential to align all systems
- New policy may drastically reduce redundancy and increase effectiveness of recent changes.

### Threats
- Always benchmarked against Trust’s that are much bigger
- Large regulatory body that sets targets and imposes mandatory changes that may not align with current internal initiatives
- Budgets and funding provided according to ratings in certain areas
- Inconsistency among Trusts in Wales
- Compensation programs regulated by the Welsh Assembly Government
- Unionized environment makes it difficult to change policies