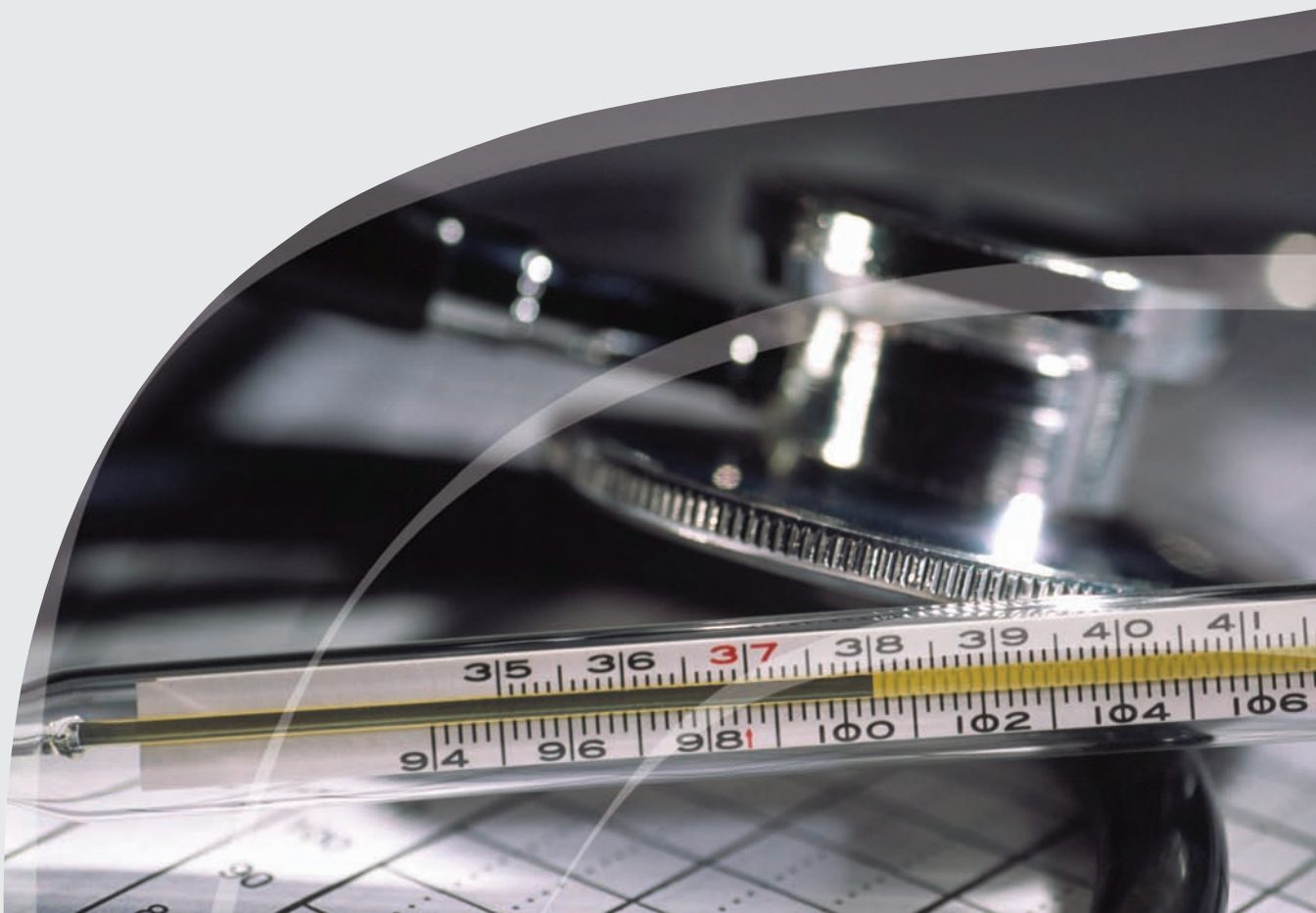




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The Management of Sickness Absence by NHS Trusts in Wales – Follow Up Report



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I have prepared this report for presentation to the National Assembly under the Government of Wales Acts 1998 and 2006.

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**Report presented by the Auditor General to the National
Assembly on 28 January 2009**



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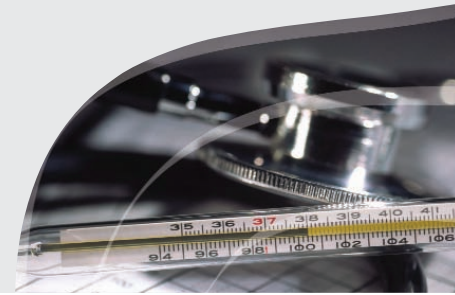
has been made to improve the management of sickness absence by NHS trusts in Wales over the five years since the previous Auditor General's report.

- 6 We concluded that trusts' management arrangements have improved generally but that sickness absence remains a significant problem. Taking account of the plans for NHS reorganisation later in 2009, the new local and national NHS bodies will need to embed good practice within their organisational culture, management structures and policies, and daily practice.

Average sickness rates have reduced since 2002-03 but sickness absence remains a significant problem

- 7 Following the previous Auditor General's report, the Assembly Government set a target for all NHS organisations to achieve a sickness rate of 4.2 per cent (of contracted time) or less, originally by March 2007. This generic target did not allow for the significant differences in trusts' previous sickness absence performance and, given that it implied a 30 per cent reduction from the average sickness absence rate of 6.0 per cent reported for 2002-03, was very ambitious.
- 8 Most trusts doubted whether the 4.2 per cent target represented a realistic goal, at least in the short term. However, the introduction of the target sharpened the focus on sickness absence management as part of trusts' overall performance management arrangements. The Assembly Government has not published trusts' performance against this target.

- 9 The NHS efficiency savings agenda has also helped to emphasise the potential financial benefits of reducing sickness rates. The costs of employing replacement staff cover have been a particular focus, linked to Assembly Government targets for a reduction in agency and locum staff expenditure (to less than 0.8 per cent of trusts' total staffing expenditure for 2008-09). Although relatively few trusts were able to provide firm figures with which to estimate its impact, sickness absence makes a significant contribution to the demand for replacement staff. For example, Cardiff and Vale NHS Trust attributed two-fifths of its £14 million expenditure on bank and agency nurses in 2006-07 to sickness absence (the Trust had already reduced its overall bank and agency nurse expenditure by £5.3 million between 2004-05 and 2006-07). Elsewhere, Swansea NHS Trust successfully recovered just under £73,000 in the 2007 calendar year in terms of the salary costs of staff absent from work due to an incident involving a third-party claim.
- 10 Trusts' arrangements for measuring sickness absence rates have changed following the introduction of the new England and Wales-wide NHS Electronic Staff Record (the ESR) in 2006-07. This new system reports on the percentage of calendar days (rather than contracted hours) lost per whole-time equivalent member of staff. Trusts have expressed concerns about whether, on a like-for-like basis, the ESR system's measurement of sickness absence automatically produces higher percentage rate figures. However, we have not seen any definitive evidence to support this view. Any reported increases in absence rates in the short-term following the introduction of the ESR may instead have reflected errors in these figures, either due to specific problems identified with the system, or because of trusts' unfamiliarity with it.



11 The average sickness absence rate reported across the NHS trusts in Wales since April 2004 has stabilised at between 5.3 and 5.4 per cent, equivalent to just under 14 working days per year, or just over 19 calendar days including weekends, for an employee working a standard five-day week. These figures represent a notable reduction from the rate of 6.0 per cent reported for 2002-03, which was equivalent to just over 15 and a half working days per year or just under 22 calendar days. We estimate that this reduction in sickness absence generated additional staff time in work worth at least £6 million per annum between April 2004 and March 2008. Nevertheless, trusts are collectively a long way from achieving the 4.2 per cent target and the reported rates of absence are still relatively high, although comparable with the levels of absence reported recently for the NHS Boards in Scotland and lower than for NHS trusts in Northern Ireland.

12 Some trusts have achieved significant reductions in sickness absence since 2002-03. However, there are still substantial differences in performance between trusts and across different staff groups within individual trusts. In 2007-08 trusts' overall absence rates ranged from 4.1 to 7.0 per cent.

13 Human Resource (HR) managers at North Glamorgan and Pontypridd and Rhondda NHS trusts recognised that the planned merger of the two organisations from 1 April 2008, creating Cwm Taf NHS Trust, was likely to have contributed to the increase in sickness absence reported by both trusts in 2007-08. Carmarthenshire and Ceredigion and Mid Wales NHS trusts also reported a notable increase in sickness absence during 2007-08 but this trend was not replicated at the other trusts involved in mergers from either 1 April or 1 July 2008. The findings of

the NHS Wales 2007 Staff Opinion Survey pointed to low levels of workforce engagement and concluded that uncertainty in terms of general change and the Agenda for Change pay system were impacting on employees' sense of job security. These issues may be contributing to the current levels of sickness absence reported across the service and, even if well managed, the current plans for NHS reorganisation are unlikely to improve the situation in the short term.

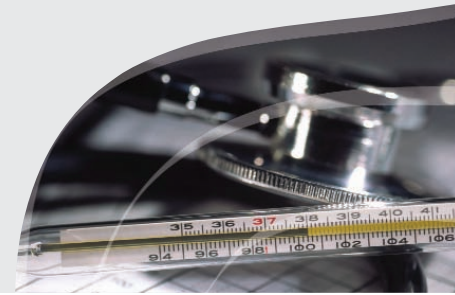
Trusts' sickness absence management arrangements have improved generally but more work is needed to apply good practice consistently

14 We found that most trusts had updated and improved their core sickness absence management policies, drawing on the guidance developed by the Attendance Management Steering Group. However, there is still room for further improvement, for example in terms of setting clearly defined thresholds (trigger points) for management intervention that help to identify and address at an early stage, and on a fair and consistent basis, any patterns of absence that cause concern. The Assembly Government has recently agreed, through the Welsh Partnership Forum, to develop a common suite of core employment policies for NHS Wales, including for sickness absence management.

15 Either as part of their overall sickness absence management procedures, or in many cases through the development of bespoke policies, trusts have been placing greater emphasis on the use of phased returns to work and redeployments to help resolve

longer term absence cases. However, there are differences in detail, for example in terms of the maximum duration of any period of phased return to work and the way in which lost time is recorded by individual trusts.

- 16** We also identified a range of examples of trusts taking action to provide additional health services for staff to access, such as physiotherapy provision, or ensuring that arrangements were in place to fast track staff to fill appointments cancelled by members of the public where possible. However, medical referrals for consultant care are still dealt with in line with the principle of clinical need. There has been no formal agreement in terms of any more overt fast tracking of NHS staff to NHS services ahead of members of the general public without taking account of clinical need.
- 17** Trusts' HR departments have generally been providing more active support in the management of sickness absence. Trusts had further developed, and were delivering, a range of training programmes in line with the principles of the minimum training standards developed by the Attendance Management Steering Group. The recent launch of the NHSWales@Once e-learning tool, which includes coverage of sickness absence management as one of four core modules, should also help to consolidate the training that trusts are already now providing.
- 18** HR managers were also more proactively involved in support of sickness absence management, for example by coordinating and monitoring sickness absence management related activity. Five trusts had created specific posts within their HR departments with a clearly defined remit to support the management of sickness absence. Nevertheless, it is clear that ensuring consistent and timely compliance with core sickness absence procedures is an ongoing challenge.
- 19** The ESR is now used by all NHS trusts in Wales to record and report on sickness absence trends. However, the wider development of the ESR has clearly proved more complicated and time-consuming than first envisaged and the system is not yet being used to its full potential to support sickness absence management.
- 20** Trusts expressed some significant concerns about the accuracy of the sickness absence information that was initially being generated from the ESR which, in turn, have affected the pace of development in terms of trusts expanding the range of sickness absence information that they record and report on, for example the medical causes of sickness absence. These issues have also meant that the Assembly Government has not, until recently, been confident that figures drawn centrally from the ESR reflect figures generated locally, limiting the scope to date for any central production of sickness absence benchmarking information. These problems appear to have been resolved, following work commissioned by the ESR Project Manager for Wales in 2007, and there is now a more common understanding across the NHS trusts in Wales as regards how best to use the system to record and report sickness absence.
- 21** Meanwhile, although there have been an increasing number of pilot projects, none of the NHS trusts in Wales have yet undertaken a wide-scale roll-out of the ESR's line manager self-service function for absence recording. This line manager self-service approach would provide for more real time data entry, thereby reducing the time taken and the risk of error in the collation and processing of staff sickness absence records. Some trusts have, in the meantime, moved ahead with the implementation of other rostering or time and attendance software that could interface with the ESR and provide the conduit for real time data entry.



22 The previous Auditor General's report drew particular attention to inconsistencies in the provision of Occupational Health services across NHS Wales and problems with often long waiting times for referral appointments. The Welsh Partnership Forum agreed, in 2005-06, that there should be a root and branch review of Occupational Health provision across NHS Wales. A draft review was prepared and submitted to the Partnership Forum, but was rejected and more work was requested. This work is ongoing. The Assembly Government has also been developing some web-based Occupational Health and Safety Standards framework guidance, drawing together existing policy, standards and good practice, although this is still to be published. Trusts have, in the meantime, taken forward action to improve the local provision of Occupational Health services, although the issues identified in the previous Auditor General's report are still a cause for concern, at least in some trusts.

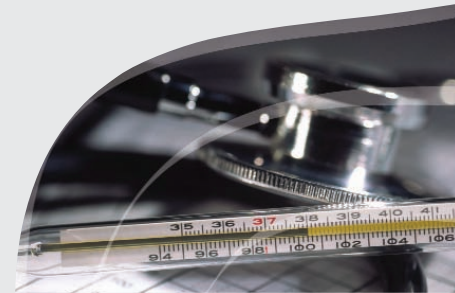
23 Trusts have also been working to try and achieve a gold rating as part of the Assembly Government's Corporate Health Standard for workplace health and well-being. As at March 2008, six trusts had achieved the gold standard compared with only two trusts at the time of the previous Auditor General's report, in January 2004. Three of the nine trusts (including Powys LHB) that had not achieved the gold standard were awaiting reassessment later in 2008 or had their reassessments postponed because of the impending trust mergers. None of the trusts has yet achieved the new platinum award within the Corporate Health Standard criteria which provides additional recognition of organisations' commitment in terms of their corporate social responsibility, reflected for example in their contribution to local regeneration and sustainable development.

24 As part of trusts' Corporate Health Standard related work there has been a particular recent focus on stress management, linked to the development of the Health and Safety Executive's (HSE) stress management standards. Effective stress management will be particularly important at this time of significant organisational change across NHS Wales. Trusts have also, over the past five years, developed a wider range of policies to address work-related stress, to support work-life balance and to try and discourage staff from reporting in sick when not themselves genuinely ill. However, work-life balance remains an issue of concern with 20 per cent of respondents in the 2007 Staff Opinion Survey disagreeing that they were able to strike the right balance between their home and work life, and 32 per cent indicating that they could not meet the requirements of their job without regularly working excessive hours.

Recommendations

- 1** The Assembly Government's current sickness absence target of 4.2 per cent (of contracted time lost) has sharpened trusts' focus on the need to reduce sickness absence, but for most trusts it remains an unrealistic short-term goal, particularly given the inherent sickness absence related risks presented by NHS reorganisation. In the medium-term achieving an NHS wide rate of absence of less than 5.0 per cent would represent further significant progress. **The Assembly Government should:**
 - a** **discontinue its use of the generic 4.2 per cent target and adopt a smarter approach to target setting which reflects the circumstances of each of the new local and national NHS bodies, with a focus on continuous improvement; and**

- b explore the practicalities of setting separate process related targets, for example around the speed of access to Occupational Health appointments in long term sickness absence cases or in response to particular sickness absence causes, such as stress related absence.**
- 2** Trusts have generally updated and improved their sickness absence related policies and procedures drawing on the guidance developed by the Attendance Management Steering Group. However, there are still differences in the detail of trusts' approaches with regards to trigger point thresholds for management intervention, or provisions for rehabilitation and redeployment including the extent to which formal policies have been developed to cover these provisions. **The Assembly Government has already agreed through the Welsh Partnership Forum to introduce a common sickness absence policy for NHS Wales and should work with the unions, and the wider service, to agree this policy in advance of the impending reorganisation. The Assembly Government should also seek agreement on extending this common policy approach to related topics such as rehabilitation and redeployment.**
- 3** There were initially widespread concerns about the accuracy of sickness absence figures produced from the ESR. However, these issues have gradually been resolved and users' confidence in the accuracy of ESR reports has improved. Now that there is greater confidence about the accuracy of sickness absence information generated from the ESR, **the Assembly Government should, in advance of and following the planned reorganisation, use this information to:**
- a produce regular benchmarking reports for the service showing, as a minimum, the headline rates of absence and associated costs, the predominant reasons for absence (where available) and analysis by common staff groupings;**
 - b work with local NHS bodies to identify and address any increases in sickness absence rates, or related problems such as an increase in staff turnover, that may occur during the process of NHS reorganisation and impact negatively on the ability of organisations to deliver continuity of service or meet their wider objectives;**
 - c publish headline trends in sickness absence across NHS Wales alongside other key staffing information, notably staff vacancies and staff numbers; and**
 - d report on the predominant underlying medical reasons for sickness absence and, as appropriate, plan and deliver Wales-wide interventions designed to address these issues (although the onus is still on individual NHS bodies to identify and address locally the reasons for sickness absence).**
- 4** While there have been local improvements in service delivery, the range and capacity of each trust's Occupational Health provision remains inconsistent. **The Assembly Government should:**
- a work with the Welsh Partnership Forum to progress as a matter of priority the ongoing review of Occupational Health provision across NHS Wales in the context of the wider plans for NHS reorganisation;**



- b** publish its NHS Occupational Health and Safety Framework guidance in advance of the creation of the new local and national NHS bodies to clearly identify for those organisations existing policy and standards relating to this area of their work; and
 - c** agree with relevant stakeholders some core indicators to measure the performance of Occupational Health services, for example, waiting times for referrals and did not attend rates.
- 5** The previous Auditor General's report, along with the Audit Committee's report and the guidance developed by the Attendance Management Steering Group and the ESR sickness absence subgroup already contained a large number of recommended actions for individual NHS bodies and/or the Assembly Government. Many of these recommendations are still relevant or are yet to be fully actioned and reflect general good practice principles that we would expect all organisations to be carrying out as part of their efforts to manage sickness absence. **Supplementing recommendations 2 and 4 on the development of related HR policies and the Occupational Health and Safety Standards framework guidance, the Assembly Government should draw on these previous reports and existing good practice to produce some consolidated sickness absence guidance for the new local and national NHS bodies. This guidance should include coverage of issues such as:**
 - a** internal performance management (both the monitoring of sickness absence trends and of compliance with core sickness absence procedures);
 - b** minimum data collection and reporting requirements, including guidance on the appropriate parameters to use when generating sickness absence reports from the ESR to ensure consistency of approach and guidance on data protection when recording the causes of sickness absence;
 - c** the provision of sickness absence training for managers and other staff; and
 - d** measurement of the extent of replacement staff cover attributable to sickness absence (accepting that there are sometimes multiple factors that create the demand for replacement cover).
- 6** Trusts have been developing a wider range of policies to support work-life balance and to provide for other types of leave to discourage staff from reporting sick when they are not themselves genuinely ill. The development of these policies is in line with recognised good practice and the wider drive to promote workplace health and well-being across the service. **In future, the new local and national NHS bodies should, alongside their monitoring of sickness absence rates, consider the amount of time lost to other types of special leave or during periods of phased return to work (where this time is not recorded as annual leave). This monitoring will help to determine the extent to which any future reductions in sickness absence may be due to changes in the way that absence from work is recorded, rather than representing a real benefit in terms of staff spending more time in work.**

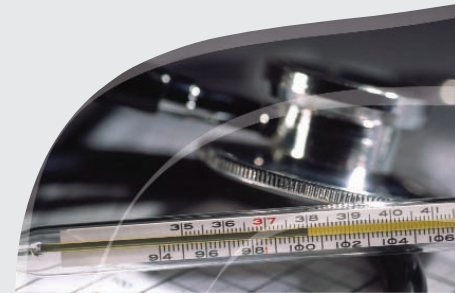
Part 1 - Average sickness rates have reduced since 2002-03 but sickness absence remains a significant problem

Assembly Government targets and the drive for efficiency savings have helped to focus attention on the need to reduce sickness absence

The Assembly Government has set NHS organisations a sickness absence target rate of 4.2 per cent or less although this may be unrealistic for most trusts in the short term

- 1.1** At the time of the previous Auditor General's report, the Assembly Government had set NHS trusts the target of reducing sickness absence by 30 per cent between 2000-01 and 2003-04. The previous Auditor General's report noted that this target was ambitious and that some trusts felt it would be difficult to achieve because they were already reporting relatively low sickness rates.
- 1.2** Subsequently, the Assembly Government set a new target for all NHS organisations to achieve a sickness rate of 4.2 per cent (of contracted time) or less. The original deadline for achieving this target was the end of March 2007, although the same target was set for 2007-08 and for 2008-09. This generic target did not allow for the significant differences in trusts' previous sickness absence performance and the Assembly Government did not set any milestone targets in advance of the original deadline.

- 1.3** Assembly Government officials have been unable to confirm the rationale for the 4.2 per cent target, although this rate was the lowest achieved by any of the individual NHS trusts as reported by the previous Auditor General for 2002-03. The 4.2 per cent target is no less ambitious than the previous target as it implies a 30 per cent reduction from the average sickness absence rate of 6.0 per cent in 2002-03. In setting future targets, the previous Auditor General recommended that the Assembly Government should use the levels of sickness absence reported by NHS trusts in England as a benchmark. NHS trusts in England had reported an average sickness rate of 4.7 per cent of contracted hours lost in the 2002 calendar year, emphasising the challenging nature of the Assembly Government's 4.2 per cent target.
- 1.4** Despite widespread doubts as to whether the new 4.2 per cent target is a realistic goal, its introduction did appear to have sharpened trusts' focus on this issue. We found that sickness absence has featured more clearly as part of trusts' internal performance management arrangements, including more regular reporting of sickness absence trends to trust boards and other management groups. Swansea NHS Trust had, for example, identified reducing sickness absence as one of its three key corporate performance priorities, alongside rates for healthcare acquired infections and lengths of stay for patients.



1.5 There has also been more active monitoring of sickness absence trends and management arrangements as part of the Assembly Government's overall monitoring of the Designed to Work strategy. However, the Assembly Government has not yet reported trends in sickness absence across the service alongside other key workforce information that it publishes, as recommended previously by the National Assembly's Audit Committee.

The efficiency savings agenda has helped to highlight the costs of sickness absence

1.6 The increasing focus on the need to identify and deliver efficiency savings has also helped to focus attention on the direct and indirect costs of sickness absence. However, under the new Agenda for Change pay system⁶, staff are entitled to retain pay enhancements for any planned antisocial hours even if they are off work due to sickness and trusts were concerned that this arrangement might encourage more sickness absence. For example, Conwy and Denbighshire NHS Trust had identified a marked increase in the levels of absence on weekends and bank holidays on two wards.

1.7 The Assembly Government has set targets to drive a reduction in the use of agency and locum staff⁷ and has established an All Wales Temporary Agency Nurse Staffing Contract in an effort to drive down costs. However, the overall impact of Agenda for Change on rates of pay for bank staff is not yet resolved and it is possible that bank pay rates will reduce depending on the historical rates of pay offered by different trusts. Lower rates of pay could lead to problems recruiting bank nurses and make trusts more reliant on costlier agency cover.

1.8 Trusts were generally able to provide evidence of enhanced controls over the use of replacement staff or efforts to address factors other than sickness absence, such as low ward staffing levels, that create the demand for them. By way of example, Cardiff and Vale NHS Trust successfully reduced its total expenditure on agency nurses by £5.3 million between 2004-05 and 2006-07. Gwent Healthcare NHS Trust reduced its agency nurse expenditure by £4 million between 2005-06 and 2006-07.

1.9 The previous Auditor General recommended that trusts should monitor the reasons for booking replacement staff shifts to enable them to estimate the wider costs of sickness absence, although we recognise that there may sometimes be multiple factors that create a demand for replacement staff. Although trusts' internal controls should require justification of the reason for cover, relatively few trusts were readily able to provide figures with which to estimate the amount of replacement cover due to sickness absence (Figure 1). At Bro Morgannwg NHS Trust the rollout of an electronic rostering system from January 2008, shortly prior to the Trust's merger with Swansea NHS Trust, was expected to facilitate more accurate reporting of the reasons for booking replacement nurses. North West Wales NHS Trust also began the rollout of electronic rostering in November 2007.

1.10 Trusts should identify and, if appropriate, pursue opportunities to reclaim sickness absence salary costs where staff are absent from work due to an incident involving a third-party claim. Trusts confirmed that, in principle, they had arrangements in place to identify and reclaim these costs. However, some

⁶ Agenda for Change is the new UK-wide NHS pay agreement which aims to simplify pay scales and structures, ensure employees are rewarded for good work and are given opportunities to develop and progress. In the longer term, this is expected to lead to improved efficiency and economy. However, there are cost increases in the short term. The Agenda for Change pay system applies to all directly employed NHS staff, except for doctors, dentists and some very senior managers.

⁷ The target for 2008-09 is for trusts to reduce agency and locum expenditure to no more than 0.8 per cent of their total staff costs, compared with the 2.0 per cent target set for 2007-08.

Figure 1 - Estimates of the impact of sickness absence on the demand for replacement staff cover in 2006-07

Trust	Evidence
Cardiff and Vale	The Trust attributed two-fifths of its £14 million bank and agency nurse expenditure to sickness absence.
North Glamorgan	The Trust reported expenditure of around £8.1 million on all replacement staff cover, with sickness absence estimated to account for around £2.5 million (31 per cent) of this total. The costs of cover for nursing staff totalled £2.8 million, of which £1.6 million (57 per cent) was estimated to be due to sickness absence.
Gwent Healthcare	The Trust reported bank and agency nurse expenditure of £2.8 million as a result of sickness absence (around one-fifth of total bank and agency nurse costs).
Ceredigion and Mid Wales	The Trust attributed just over half of all bank nurse shifts/hours worked to sickness absence.

trusts recognised that there was scope to strengthen these processes and figures to confirm the amounts reclaimed were not readily available in all cases. By way of example, Swansea NHS Trust reported that, in 2007, it had pursued 47 claims of which 40 had been resolved by the end of the year with the Trust recovering just under £73,000.

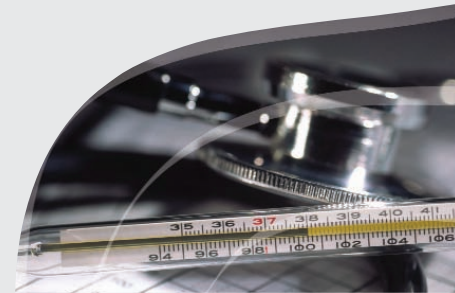
interpreting this calculation differently, for example whether staff who were absent but receiving no sick pay were included. Ceredigion and Mid Wales NHS Trust also recognised that its figures had been based on the available contracted hours at the start of each financial year. Changes in staffing levels and contracted hours throughout the year were not accounted for.

The average sickness rate of between 5.3 and 5.4 per cent since April 2004 is still relatively high, but compares favourably with the rate of 6.0 per cent in 2002-03

1.11 Trusts agreed, from April 2004 onwards, to calculate sickness absence rates based on the percentage of contracted hours lost, having previously been using six different approaches between them. However, we still found that, despite guidance from the Assembly Government, some trusts had been

1.12 The new England and Wales wide NHS Electronic Staff Record (the ESR), which was introduced across most of the NHS trusts in Wales during 2006-07, provides the basis for more consistent sickness absence reporting⁸. The standard reports within the ESR show the percentage of calendar days (rather than contracted hours) lost in a given period per whole-time equivalent member of staff. During the development of the ESR, Welsh trusts had expressed some concerns about moving away from the measurement of contracted hours lost but accepted that the main aim was to ensure consistency of approach. Ideally, measuring the contracted hours rather than calendar days lost would be a more exact

⁸ The ESR is a combined electronic HR and payroll system. The previous Auditor General's report described how the system was due to be introduced across all of the NHS trusts in Wales by the end of 2005. This timescale slipped by a further year and most Welsh trusts introduced the system from 1 November 2006 (North East Wales introduced the system in October 2004 followed by Conwy and Denbighshire and the Welsh Ambulance Services NHS Trusts which introduced the system from 1 May 2006).



approach⁹. However, we have not seen any definitive evidence to support speculation from some trusts that the calendar days approach has, by itself, produced higher sickness rates. Any increases in absence rates in the short-term following the introduction of the ESR may have reflected errors in the production and/or reporting of these figures (paragraphs 2.15 to 2.19).

1.13 The average sickness absence rate reported across the NHS trusts in Wales since April 2004, and both before and after the introduction of the ESR, has stabilised at between 5.3 and 5.4 per cent. Working patterns in the NHS are flexible and varied. However, an absence rate of 5.3 per cent is equivalent to an average of just under 14 working days of absence per year for a full-time employee working a standard five-day week, or to just over 19 calendar days including weekends¹⁰.

1.14 These percentage rate figures represent a notable reduction from the rate of 6.0 per cent reported previously for 2002-03, which was equivalent to just over 15 and a half working days per year or just under 22 calendar days. We estimate that this improved sickness absence performance generated additional staff time in work worth at least £6 million per annum between April 2004 and March 2008¹¹. However, trusts are collectively a long way from achieving the 4.2 per cent target. The reported rates are also considerably higher than some other commonly cited public and private sector benchmarks, although they are broadly in line with the absence rate reported recently for NHS Boards in Scotland and lower than the average rate across NHS trusts in Northern Ireland (Appendix 2)¹².

1.15 The previous Auditor General's report highlighted errors in the recording of sickness absence which meant that the real rate of absence for 2002-03 could have been at least 6.3 per cent. Most trusts had undertaken at least some local audit work and/or put in place other monitoring arrangements to help check for and correct errors. Trusts had also updated their processes for recording sickness absence, including in most cases combining self-certification and return to work interview forms. Given these changes, ongoing training (paragraphs 2.10 to 2.11) and the increasing corporate focus on sickness absence management, the Human Resource (HR) and other managers that we spoke with were generally confident that sickness absence was now being more accurately recorded.

1.16 The new Agenda for Change pay system has increased the annual leave allowance for many NHS staff. This increase might have been expected to support further reductions in sickness absence by improving work-life balance. However, the findings of the NHS Wales 2007 Staff Opinion Survey have also pointed to generally low levels of workforce engagement, especially as regards feelings of pride, a sense of belonging and recommending NHS Wales as a place to work. The survey also concluded that uncertainty in terms of both general change and Agenda for Change was having an impact on employees' sense of job security. These issues of morale and workforce engagement may be contributing to additional sickness absence. Even if well managed, the current plans for NHS reorganisation are unlikely to improve the situation in the short term.

⁹ The calendar days approach built into the ESR reflects the method used by the NHS to measure occupational sick pay but means that scheduled non-working days in the middle of any periods of absence are included and flexible working patterns are not fully taken into account.

¹⁰ On the same basis, the target rate of 4.2 per cent is equivalent to an average of around 11 working days or to just over 15 calendar days.

¹¹ This figure is based on the previous Auditor General's estimate that the total value of staff time lost in 2002-03 amounted to around £66 million. We have not accounted for increases in trusts' overall staff costs since 2002-03.

¹² The most recently published figure for NHS bodies in England dates back to the 2005 calendar year, when the reported average sickness absence rate was 4.5 per cent.

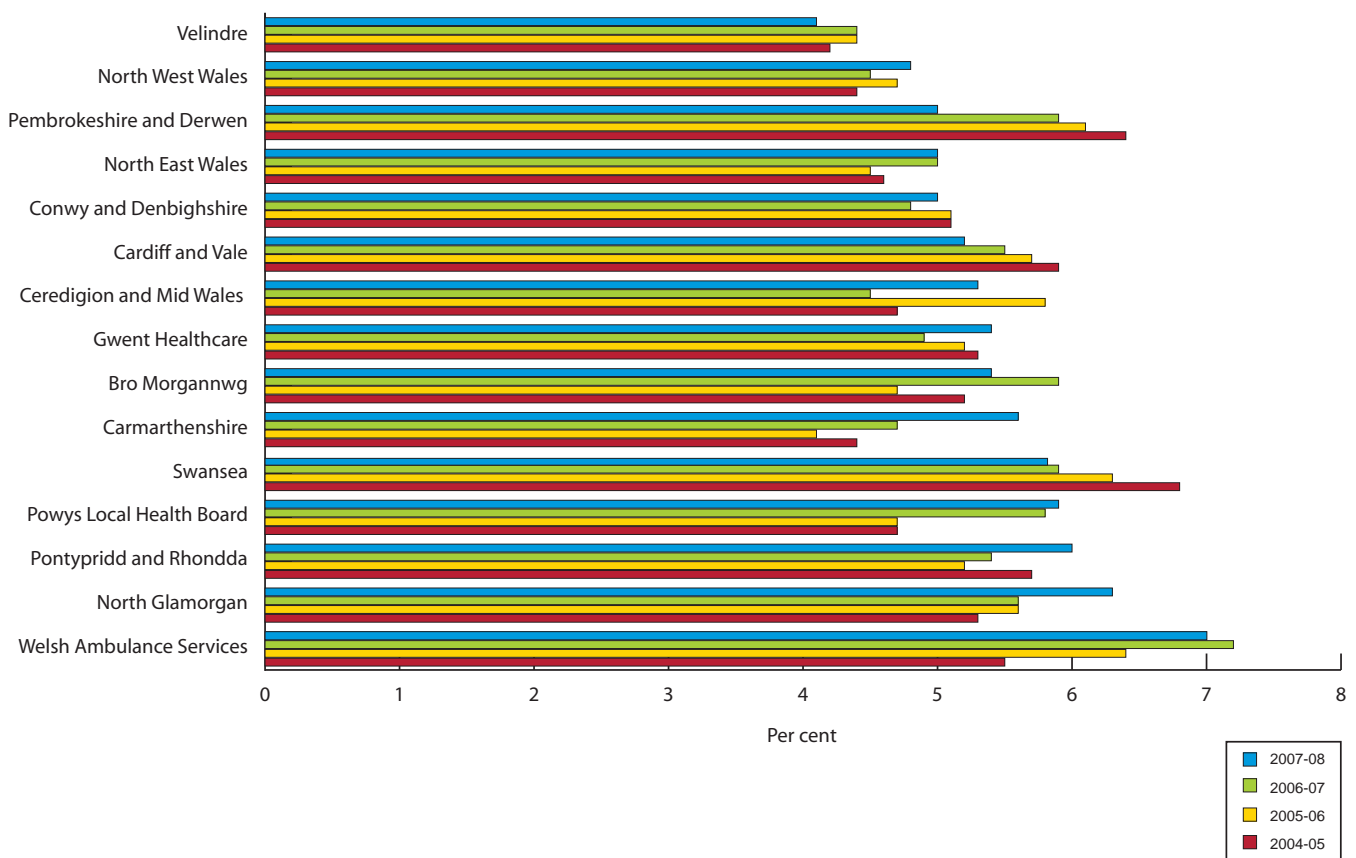
Some trusts have achieved significant reductions in sickness absence but, overall, there are still substantial differences in their performance

1.17 The levels of sickness absence reported by the NHS trusts in Wales ranged between 4.1 and 7.0 per cent in 2007-08 (Figure 2). This is almost identical to the range of between 4.2 and 6.9 per cent reported by the previous Auditor General for 2002-03, although trusts' positions within the range have changed. For example, despite still being a long way from

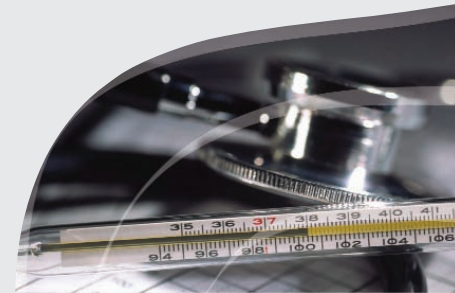
achieving the 4.2 per cent target, the recent performance of Bro Morgannwg, Cardiff and Vale, Pembrokeshire and Derwen and Swansea NHS trusts since April 2004 compares well with the rates of 6.5, 6.9, 6.8 and 6.5 per cent respectively for 2002-03¹³. Velindre and North West Wales NHS trusts are the only two trusts to have reported annual rates of sickness absence consistently below 5.0 per cent between April 2004 and March 2008.

1.18 North Glamorgan NHS Trust and Pontypridd and Rhondda NHS Trust (which merged to form Cwm Taf NHS Trust from 1 April 2008) each experienced a notable increase in

Figure 2 - Reported sickness absence percentage rates (April 2004 to March 2008)



¹³ Bro Morgannwg and Pembrokeshire and Derwen NHS trusts had previously reported a significant increase in their sickness rates between 2000-01 and 2002-03.



sickness absence during 2007-08. Both trusts reported that outbreaks of diarrhoea and vomiting affecting staff had contributed to the increase, but HR managers also recognised that staff anxiety and stress relating to the merger between the two trusts was also likely to have been a contributory factor. Of the other trusts involved in mergers since 1 April 2008 (Appendix 1), Carmarthenshire and Ceredigion and Mid Wales NHS trusts also reported a notable increase in sickness absence during 2007-08 but this trend was not replicated at Bro Morgannwg, Swansea and Pembrokeshire and Derwen NHS trusts.

1.19 Even if trusts perform relatively well in terms of their overall sickness rate, it is still important that they identify and tackle any problem areas. For example, despite the overall reduction in sickness absence at Pembrokeshire and Derwen NHS Trust, levels of absence in the Mental Health and Learning Disabilities division increased sharply during the second half of 2006-07 to more than eight per cent¹⁴. Following the development of a local action plan and regular monitoring the division's sickness absence rate for 2007-08 fell back to the 2005-06 level of 6.4 per cent.

1.20 Most trusts have monitored performance against the Assembly Government's 4.2 per cent target without establishing separate targets for different staff groups. HR managers at Carmarthenshire NHS Trust indicated that they had consciously adopted this approach, believing that differential targets would unfairly relieve the pressure to improve performance in areas that had not been managing sickness absence effectively. Gwent Healthcare NHS Trust was one of four trusts that had introduced locally agreed targets for different divisions (Figure 3).

Figure 3 - Divisional sickness absence targets introduced in 2007 by Gwent Healthcare NHS Trust

Division	Target (%)	Performance (January to December 2007)
Acute	3.9	5.2
Community and Mental Health	4.5	6.7
Women and Children	4.0	5.4
Diagnostics and Therapeutic	4.0	4.5
Non Clinical Services	4.6	5.7
Works and Estates	6.6	7.0

¹⁴ Despite this increase in sickness absence, improved controls over the use of agency staff and more effective utilisation of staff enabled the Trust to reduce the division's bank and agency costs by 23 per cent, from £884 to £678 thousand, between 2005-06 and 2006-07.

Part 2 - Trusts' sickness absence management arrangements have improved generally but more work is needed to apply good practice consistently

Sickness absence related policies and procedures have improved, including a greater emphasis on the use of phased returns to work or redeployments to resolve absence cases

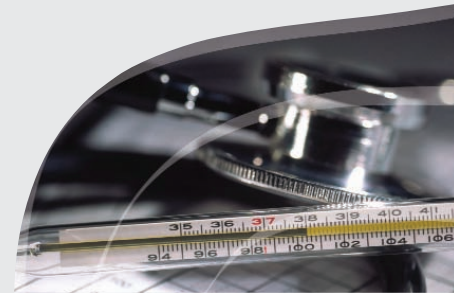
Most trusts had updated and improved their core sickness absence management policies drawing on guidance developed by the Attendance Management Steering Group

- 2.1** The Attendance Management Steering Group's report included some model sickness absence policy guidance. With the exception of Velindre NHS Trust, all trusts had reviewed, updated and improved their own sickness absence policies in light of this guidance. Velindre NHS Trust is currently consulting on a revised sickness absence policy. The Trust intends to introduce formally the revised policy before the end of the 2008-09 financial year.
- 2.2** The Steering Group emphasised the importance of setting defined thresholds (trigger points) to guide the timing of management intervention in response to frequent short term absence, but did not specify what these thresholds should be, leaving this decision at the discretion of individual trusts. Trusts had adopted different trigger point thresholds, but these were

typically based on the cumulative number of days of absence and/or separate periods of absence in a set period including, in some cases, the use of Bradford scoring¹⁵. Velindre NHS Trust had not set any specific thresholds for management intervention, although such thresholds do feature in the Trust's proposed revisions to its sickness absence policy. Ultimately, trusts need to be content that these trigger points help identify and address at an early stage any patterns of absence that cause concern (Case Study A).

- 2.3** Trusts' policies typically set out trigger points for sickness absence monitored over a period of up to 12 months. However, Gwent Healthcare NHS Trust had made explicit the need to consider any recognisable attendance pattern which gave cause for concern over a two-year period. In addition, and shortly prior to our fieldwork, Bro Morgannwg NHS Trust had initiated a review of the absence records of all staff over the previous four years. The Trust wrote to staff advising them of this work and making clear that unacceptable levels or noticeable patterns of absence would be addressed under the terms of its sickness absence policy.
- 2.4** Looking ahead to the planned reorganisation of the NHS, the Assembly Government has recently agreed with the trade unions and with the service (through the Welsh Partnership Forum) to develop a common suite of core employment policies for NHS Wales. Sickness absence management has been identified as a priority policy for this work.

¹⁵ Bradford scoring is a system of measurement to take account of the disruptive effect of frequent short term sickness absence as well as long term absence. Individual Bradford scores are calculated using the formula 'S x S x D' where S equals the number of different spells of sickness absence and D equals the total number of days absent, both in a specified period.



Case Study A - Examples of the use of sickness trigger points

Powys Local Health Board (LHB)

The generic sickness absence policy for LHBs, used by Powys LHB, states that: *'It is inappropriate to be absolutely prescriptive about the number of days an employee shall be away from duty before action should be taken. However, as a guide, five days in a three-month period taken over three separate occasions should be seen as significant.'*

The defined thresholds meant that staff could potentially be off sick for up to 20 days a year over multiple occasions without this being deemed significant. The local HR team was confident that regular meetings between HR staff and operational managers would highlight problematic absence trends even though these thresholds had not been reached. Nevertheless, the LHB has now introduced two new trigger points based on three separate episodes of absence in a six month period or a total of 12 or more calendar days of absence over a 12 month period. The LHB also intends to use the Bradford scoring approach to monitor frequent short-term sickness absence.

Pembrokeshire and Derwen and North Glamorgan NHS trusts

One of two trigger points used by Pembrokeshire and Derwen NHS Trust was 21 days absence in a 12-month period. This was a relatively high threshold, particularly if these days were accumulated over a number of different short-term periods of absence. However, the Trust's sickness policy also identified a separate trigger based on a relatively stringent Bradford score of 100 points, which should have meant that patterns of frequent short-term absence would be addressed sooner than by relying only on the 21-day trigger point.

In contrast, North Glamorgan NHS Trust was using a trigger point based on a higher Bradford score of 250. However, the Trust also monitored sickness absence against other triggers based on only 10 days or five episodes of absence in the previous 12 months (10 days absence over five episodes would itself yield a Bradford score of 250).

Trusts have placed greater emphasis on phased returns to work and redeployments to help resolve longer term absences although not all had developed specific policies to support decision making

2.5 The previous Auditor General reported that trusts were managing long-term absence following broadly similar management processes but defined long-term absence in different ways. The Attendance Management Steering Group recommended that long-term absence be classified as over 28 calendar days, which was reflected in trusts' revised policies. However, trusts should still look to intervene earlier where appropriate, for example in making referrals to Occupational Health services where staff have already been signed off by their doctor for a period longer than four weeks, or where the reason for absence gives a particular cause for concern (**Case Study B**).

2.6 The steering group's report emphasised the importance of considering options to support a return to work, either by offering a phased return, making other reasonable adjustments to working conditions, or by offering the opportunity of temporary or even permanent redeployment in a different role. Most but not all trusts had developed stand-alone policies covering rehabilitation and/or redeployment (**Case Study C**) and there was a general awareness that these approaches were increasingly being considered in an attempt to resolve sickness absence cases. As with their trigger points for management intervention, the nature of trusts' arrangements varied, for example the maximum duration of any period of rehabilitation and the way in which lost time during this period would be recorded.

2.7 The steering group also provided guidance on the fast tracking of NHS staff, pointing to the fact that trusts should consider the merits of dedicated pathways or fast tracking to physiotherapy services for staff with

Case Study B - Examples of early referral to or intervention by trusts' Occupational Health departments

Conwy and Denbighshire NHS Trust

The Trust piloted a scheme whereby Occupational Health staff proactively contacted any domestic staff who were absent due to sickness. This contact initially took place on day three of their absence although this was later changed to day six when the pilot was extended to all staff from the Facilities department.

The Trust's evaluation of this pilot showed that the sickness absence rates for facilities staff reduced from 9.3 per cent between January and April 2007 to 6.9 per cent for May to June 2007. The Trust went on to introduce telephone consultations between an Occupational Health nurse and absent members of staff at day six of their absence across additional departments and covering, in total, 14 per cent of the Trust workforce.

North West Wales NHS Trust

As part of a 'Six-Sigma' project to improve attendance management in its catering department, the Trust introduced immediate referral to its Health at Work department and pathology testing for catering staff with diarrhoea and vomiting. The purpose of this referral and testing was to ensure that staff were able to be diagnosed fit to return at the earliest opportunity, whilst maintaining controls to minimise the risk of cross-infection to other staff and patients. The Trust had been concerned that Health Protection Agency guidance on exclusions from work for individuals affected by gastrointestinal infections was encouraging staff to use diarrhoea and vomiting as a reason for absence.

Following the introduction of the immediate referral approach the Trust reported that the catering department's sickness absence rate fell from 5.7 per cent between April and October 2005 to around three per cent in 2006.

(Six-sigma is an integrated quality improvement framework based on the DMAIC approach, Define – Measure, Analyse, Implement, Control. The Trust introduced the use of six-sigma for service improvement in 2005-06).

Case Study C - Examples of trusts' redeployment and rehabilitation policies

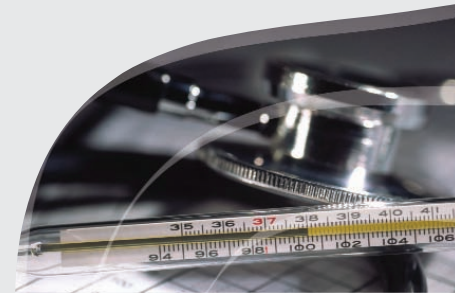
Bro Morgannwg NHS Trust - redeployment

In October 2007, Bro Morgannwg NHS Trust introduced a revised redeployment policy covering provisions for any redeployment, including staff who are unable to undertake their substantive role because of ill health. In revising the policy, the Trust had simplified its previous process of making three offers of redeployment. Under the terms of the new policy, were an individual to unreasonably refuse alternative suitable employment and fail to agree to undertake a 28-day work trial, they would have been removed from the Trust's redeployment register and their employment could have been terminated. The Trust reported a range of examples of successful staff redeployments including:

- a ward manager with shoulder problems that restricted her ability to lift had been brought back to work in a 'bed management' role; and
- a qualified nurse who damaged her shoulder in work and could not lift or undertake repetitive movements was undertaking a supernumerary role in a day hospital setting.

Ceredigion and Mid Wales NHS Trust - rehabilitation

The Trust published a new rehabilitation policy in February 2007 that allowed for a period of phased return on reduced hours where it was agreed that this would be beneficial to the employee and would facilitate a swifter return to work. Staff would be paid at full pay rates but were generally expected to account for at least some of the lost time during the phased return by using accrued annual leave (other lost time to be recorded as rehabilitation leave and not as sickness absence). The policy allowed for the phased return to continue over a period of up to 12 weeks (the Attendance Management Steering Group's guidance suggested six weeks) but emphasised that, in practice, most employees should be able to be rehabilitated back to their full working pattern in a shorter period. HR staff believed that this policy, alongside the existing redeployment policy, were being used to good effect where appropriate to support the resolution of sickness absence cases.



musculoskeletal injuries (applicable to staff who are off sick or those still in work but affected by an injury). Several trusts now provide a physiotherapy service as part of the wider Occupational Health service while others had agreed arrangements to fast track to the wider NHS service, particularly where there were opportunities for staff to fill appointments cancelled by members of the public. For example, in 2006 Powys LHB introduced a fast track to physiotherapy policy which meant that, on receipt of a referral from their GP or from the Occupational Health consultant, staff would be given the first available appointment.

- 2.8** On referrals for medical care, the steering group's report included a protocol agreed by the British Medical Association which allowed for appointments to be expedited, but still based in principle on the clinical need of the member of staff relative to other patients on the waiting list. This could essentially occur were it believed by the Occupational Health consultant or the staff members' GP that their condition had deteriorated and warranted reassessment.
- 2.9** If a return to work is ultimately deemed impossible, and ill health retirement or dismissal on capability grounds is concluded to be the most appropriate option, there is a financial incentive for trusts to reach this decision before staff reach the end of their occupational sick pay (a maximum of six months full pay and six months half pay). Paid notice can then be incorporated within the period of occupational sick pay, thus saving money. This approach is emphasised, for example, in the sickness absence procedure at North West Wales NHS Trust which states that: *'Discussions regarding all options must have taken place with the*

employee in light of the relevant medical advice that has been sought, such that in the event that the contract has to terminate on medical grounds, the termination date, following contractual notice, is never normally beyond the expiry of sick pay'.

HR departments have been providing more active support in the management of absence but ensuring compliance with core procedures is an ongoing challenge

The launch of an all-Wales e-learning tool should consolidate work that trusts have been undertaking to improve sickness absence management training

- 2.10** The introduction of the NHS Knowledge and Skills Framework¹⁶, linked to the Agenda for Change pay system, provides an opportunity to hold managers to account for their performance in discharging their sickness absence and wider workplace health and well-being responsibilities. North Glamorgan NHS Trust had, for example, proposed monitoring and reporting compliance with two key performance indicators relating to evidence of return to work interviewing and referral to the Occupational Health service for long-term absences.
- 2.11** The Attendance Management Steering Group recognised that there had been a particular deficit of skills-based sickness absence training for managers and proposed a set of minimum standards for managers and for new staff at induction, to underpin the development of training programmes to suit local needs. We have not sought to measure

¹⁶ The Knowledge and Skills Framework sets out the core knowledge and skills which those NHS staff covered by the Agenda for Change pay system need to demonstrate in their work so as to deliver quality services and provides the central structure for performance review, career development and pay progression under Agenda for Change.

Case Study D - The NHSWales@Once e-learning tool

The NHSWales@Once multimedia e-learning tool has been developed in partnership between the Assembly Government's Department for Health and Social Services, NHS Wales, the National Leadership and Innovation Agency for Healthcare and Morgan Cole solicitors.

The tool includes a range of general guidance (presented in text and video format), flowcharts, case studies, and the ability for managers to test their own knowledge and covers the following four key modules:

- sickness absence management;
- handling poor performance;
- handling grievances and dignity at work issues; and
- investigating and disciplining for misconduct.

NHSWales@Once builds upon and tailors for the NHS an e-learning tool that had already been developed by Morgan Cole (employment@once). The sickness absence materials within the tool were piloted at the Welsh Ambulance Services NHS Trust in Spring 2008 and launched at the Healthcare People Management Association's Welsh branch annual conference in June 2008.

The development of NHSWales@Once also forms part of the wider development of the 'Learning@NHS Wales' virtual learning environment which was formally launched by the Assembly Government and NHS Wales in December 2008 and can be accessed by NHS staff via <http://www.mle.wales.nhs.uk/>.

again the training received by individual staff¹⁷. However, trusts were generally able to demonstrate that they had further developed, and were delivering, a range of training programmes in line with the principles of the minimum training standards. The steering group also considered that there was merit in developing some national training materials, leading to the subsequent development of an e-learning package designed to provide NHS managers with up-to-date and comprehensive advice and practical guidance about a range of employment law practice (see **Case Study D**).

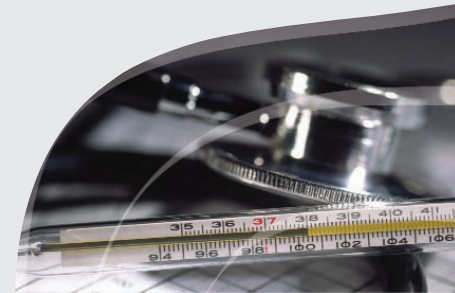
Several trusts had established posts within their HR department specifically to support the management of sickness absence

2.12 While it is important to emphasise the responsibilities of individual managers, effective HR support is also needed to help ensure that sickness absence is managed in a consistent way. The demands of the wider NHS HR modernisation agenda, including the

rollout of Agenda for Change, for some trusts the work required to support the recent mergers, and now the latest reorganisation, have clearly stretched resources within trusts' HR departments. Nevertheless, trusts were generally able to provide evidence of HR staff being engaged in a more proactive way in support of sickness absence management.

2.13 Conwy and Denbighshire, Cardiff and Vale, North East Wales, Ceredigion and Mid Wales and North West Wales NHS trusts had each established specific posts within their HR departments, tasked with coordinating and monitoring sickness absence management related activity (**Case Study E**). Alternatively, restructuring of the HR department in some other trusts had facilitated closer monitoring of sickness absence performance, with nominated HR managers providing closer support to service managers which appeared to have been well received.

¹⁷ We reported previously that 45 per cent of the NHS staff that we surveyed who had some responsibility for managing sickness absence had not received any formal training in core sickness absence procedures.



Case Study E - Employment of 'sickness HR officers' at Cardiff and Vale NHS Trust

In Spring 2006, Cardiff and Vale NHS Trust appointed two temporary sickness HR officers to work closely with service groups. The Trust initially focused the work of the officers on front-line staff in Medical and Mental Health, Surgery and Women and Children service groups where there were particular concerns about sickness absence rates.

The officers provide detailed support to ward managers for a period of time. This support includes help with records management and identification of staff with patterns of absence that cause concern and making a list of recommended actions. The officers will then check up on whether action has been taken in each case.

The Trust evaluated the impact of the HR officers and 75 per cent of the managers questioned agreed or strongly agreed that they had been effective. Around one-third of managers agreed that sickness absence had reduced since the sickness HR officers were introduced and 17 per cent said that they were now using less bank and agency cover for sickness absence. In early 2008 the Trust's HR Committee agreed to continue to support these posts.

Ensuring compliance with core procedures is an ongoing challenge

2.14 The previous Auditor General recommended that trusts should monitor compliance with core sickness absence procedures, such as return to work interviewing and intervention in response to frequent or long-term absences. Trusts have responded to this recommendation in different ways. As noted previously (paragraph 1.15), most trusts had combined their self-certification and return to work interview forms which should have helped to encourage return to work interviewing. Trusts' efforts to provide more effective HR support to the management of sickness absence have also included more regular monitoring of long-term absentees or staff who had breached other policy trigger points; and follow-up work to check on the action taken in response to these cases. This work had, in some cases, been supplemented by more formal sickness absence audit work, undertaken either by HR staff or by Internal Audit teams (**Case Study F**). The findings from this work suggest that, although there may have been improvements since the previous Auditor General's report, ensuring compliance with core sickness absence procedures is an ongoing challenge.

Case Study F - Audits of sickness absence compliance at North Glamorgan NHS Trust

Prior to the merger with Pontypridd and Rhondda NHS Trust, North Glamorgan NHS Trust embarked on a programme of audit work to measure compliance with its sickness absence policy. This work was focused initially on three directorates that demonstrated higher levels of absence (Medicine, Women and Children, and Commercial Services).

These audits measured compliance with a range of issues including:

- general record keeping;
- management responses to breaches of the trigger points set out in the sickness absence policy;
- the timeliness of referrals to Occupational Health for long-term absences and the conduct of sickness interviews with long-term absentees; and
- consideration of reasonable adjustments and/or redeployment as appropriate to facilitate a return to work.

The audits identified variable levels of compliance across the three directorates, averaging 46 per cent compliance for Medicine, 82 per cent for Women and Children and 75 per cent for Commercial Services. Generally, compliance with procedures for managing long-term sickness absence was better than for frequent short-term absence, with managers often slow to take action in response to trends in absence that breached the set trigger points.

The Electronic Staff Record is not yet being used to its full potential to support sickness absence management, although concerns about data quality have gradually been resolved

Widespread concerns about the accuracy of the sickness absence figures from the Electronic Staff Record have gradually been resolved

2.15 We have not explored the wider development of the ESR as part of this work, but this process has clearly proved more complicated and time-consuming than first envisaged. Trusts reported some significant concerns about the accuracy of sickness absence reporting and the general functioning of the system, particularly in the six months following the main November 2006 go-live date. At Cardiff and Vale NHS Trust, these concerns resulted in a gap of around eight months when regular formal reporting of sickness absence trends was put on hold. Meanwhile, Pontypridd and Rhondda NHS Trust continued to produce sickness absence figures using its legacy systems and processes through to the end of 2006-07 and Velindre NHS Trust did not start using the ESR system to report sickness absence trends until July 2007.

2.16 Adding to these problems was the fact that trusts were still on a learning curve in terms of their understanding and use of the system. Trusts' main focus in preparing for the introduction of the system was on ensuring that payroll arrangements operated effectively. Consequently, less time was spent preparing for the production of sickness absence and other management reports. Several trusts also indicated that the nature of the support

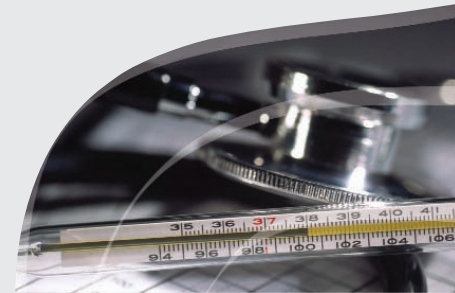
provided by the system supplier under the terms of the ESR contract did not fully meet their needs in terms of extending to assistance with the production of management information.

2.17 Given these initial problems, it is possible that the concerns about whether the measurement of absence in calendar days rather than contracted hours had increased trusts' absence rates (see paragraph 1.12) may have reflected errors in the recording and reporting of sickness absence using the system. For example:

- Gwent Healthcare NHS Trust recalculated and reduced by 0.4 percentage points the rate of absence reported for 2006-07 after it identified that absences were being inappropriately left open on the system despite staff having returned to work¹⁸; and
- North West Wales NHS Trust initially reported to us a rate of absence of 5.8 per cent for 2006-07 only to later identify that this figure incorrectly included maternity leave (the corrected sickness absence figure for the year was 4.5 per cent).

2.18 One key benefit of the ESR is the fact that the system can be used centrally by the Assembly Government to generate NHS-wide workforce reports from the ESR 'Data Warehouse'. However, trusts had also expressed concerns about the accuracy of reports from the Data Warehouse which were not reflecting the sickness absence figures generated locally. During 2007 the ESR Project Manager for Wales arranged for Trust representatives to come together as a group to help identify and address the reason for these differences. This group's meetings also provided an opportunity for trusts to develop a more consistent understanding of how best to record and report absence using the ESR.

¹⁸ In October 2007, the Trust introduced a more 'real-time' system with managers being asked to notify the payroll team as soon as employees are off sick and then to provide additional notification on their return to work. Any open-ended absences are subject to continuous review. Previously, sickness absence information was input onto the ESR by the Trust's payroll team based on retrospective timesheet records.



Guidance produced by this group was approved by NHS HR Directors and subsequently by the All-Wales ESR Benefits Realisation Programme Board in late 2007.

2.19 Over time the main problems experienced with sickness absence reporting from the ESR have been resolved and trusts have invested considerable time and effort to become more confident in their use of the system, and in the accuracy of the figures produced from it. Figures generated recently from the Data Warehouse for the 2007-08 financial year were generally consistent with those reported to us by trusts for the same period¹⁹. Consequently, the Assembly Government should now be able to make progress in terms of producing regular sickness absence benchmarking reports comparing trends at an organisation-wide and staff group level.

None of the trusts have yet undertaken a wide-scale rollout of the Electronic Staff Record's line manager self-service function

2.20 By facilitating data entry at a local managerial level, the ESR could potentially help to reduce the time taken and the risk of error in the collation and processing of staff sickness absence records. However, roll-out of this 'line manager self-service' approach was not an immediate priority for most trusts. In some cases, the problems experienced with the ESR had even resulted, at least in the short term, in additional record keeping.

2.21 North East Wales NHS Trust, which had been one of the original pilot sites for the development of the ESR, was the first trust in Wales to pilot test the manager self-service approach. An evaluation of the pilot, reported in July 2007, listed a number of problems with absence recording, including:

- establishing user responsibility profiles was difficult and, if not done correctly, meant that staff could have had access to confidential information that they had no right to see;
- the fact that the ESR system did not allow for the recording of part-day absences or phased returns to work; and
- managers in clinical environments found it challenging to record sickness absence in real time during the day meaning that data was often entered in batches at the end of the month but the system also made batch entry time-consuming.

2.22 The problems experienced by North East Wales NHS Trust informed further development of the ESR by the system supplier and several other trusts have since piloted the line manager self-service approach, the feedback from which has been more positive. However, these pilots have still been operating on a relatively small scale and none of the trusts have yet undertaken a full-scale roll-out of the manager self-service approach, although North West Wales NHS Trust has recently agreed a business case to take forward its implementation. Some trusts have, in the meantime, moved ahead with the implementation of other rostering or time and attendance software that could interface with the ESR and provide the conduit for real time data entry.

Trusts have been expanding the range of sickness absence information that they report from the Electronic Staff Record

2.23 Our previous report and the guidance produced by the Attendance Management Steering Group both emphasised the need for trusts to improve the breadth and consistency of their analysis of sickness absence trends.

¹⁹ Differences could potentially occur where reports are run locally and centrally at different times and, in the meantime, sickness records for the period concerned are updated locally.

The steering group recommended that, as a minimum, trusts should work towards reporting overall trends at a directorate and staff group level, differentiating between long- and short-term absences, and including analysis of the reasons for and costs of absence. However, the steering group also recognised that, given the impending roll-out of the ESR, there would have been limited value in any short-term upgrades to existing information systems. As a consequence, the breadth of analysis performed by most trusts had not changed significantly between the publication of the previous Auditor General's report and the introduction of the ESR.

2.24 Since introducing the ESR, and particularly after the initial problems with the system had been resolved, trusts have gradually expanded their analysis of sickness absence trends. For example, most but not all trusts are now collecting information to allow them to report on the causes of absence. However, there have been issues in terms of the proportion of absences that still have their cause recorded as not known/null, which can limit the value of trusts' overall analysis of this information. To encourage the submission of this information it is important that trusts communicate clearly to staff the purpose for which it is being sought, and provide assurances that the information will be processed and secured in a manner consistent with data protection legislation.

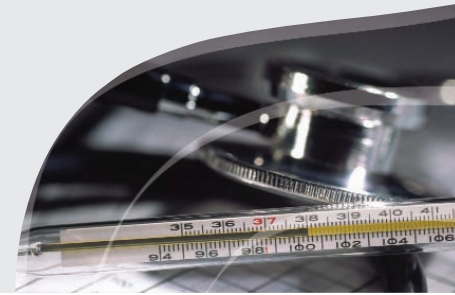
2.25 Overall, trusts' views on the benefits of the ESR in terms of the analysis of sickness absence trends have depended upon the sophistication of the systems that were in place previously. For example, the system was designed to produce reports on sickness absence salary costs but some trusts noted that, because these reports were based originally on average rather than individual salary costs, the results were less precise than they were gathering previously from their

legacy systems. Recent enhancements to the system mean that costing information is now based on individual salary costs.

There have been local improvements in service delivery but, overall, trusts' Occupational Health provision remains inconsistent

2.26 The previous Auditor General's report drew attention to the differences in trusts' expenditure on their Occupational Health services and the fact that some trusts appeared to be spending a disproportionate amount of time providing Occupational Health services for other organisations relative to the value of these contracts. His report also highlighted often lengthy delays in the process of referral to Occupational Health services.

2.27 Following its own consideration of these issues, the National Assembly's Audit Committee recommended that the Assembly Government should establish its own guidance and standards for the provision of Occupational Health services across NHS Wales and actively monitor the progress of trusts in meeting these standards. The Assembly Government has since been working to develop some Occupational Health and Safety Standards framework guidance which it now intends to publish as a web-based resource. This guidance will draw together existing information on relevant policies, standards and good practice, sitting alongside the requirements of the Corporate Health Standard which also includes an assessment of the provision of Occupational Health services ([Case Study G](#)). The Welsh Partnership Forum also agreed during 2005-06 that there should be a root and branch review of Occupational Health provision



Case Study G - The Occupational Health service at Conwy and Denbighshire NHS Trust

The overall range and quality of Occupational Health services provided by Conwy and Denbighshire NHS Trust for its 6000+ staff was highlighted for particular praise in the Trust's most recent Corporate Health Standard assessment.

Prior to the recent merger with North East Wales NHS Trust, the Occupational Health service employed just under 12.5 whole-time equivalent staff including a part-time consultant, five nurses (several of whom were qualified Occupational Health nurse specialists), physiotherapists, counselling staff, and administrative support. The Occupational Health department has been proactively developing its workforce and had undertaken role redesign with the introduction of different grades of Occupational Health nurse, and a new technician grade. The Occupational Health manager reported that this restructuring had improved staff skills, motivation and facilitated a more efficient deployment of staff in different roles.

The budgeted Occupational Health costs of £274,000 in 2007-08 were in effect heavily subsidised by projected income of around £156,000 from services provided to around 80 other organisations, although only an estimated 40 per cent of staff time was spent servicing these contracts. The Occupational Health team had surveyed service users and reported an 86 per cent satisfaction rate, with evidence that staff were returning to work sooner as a result of Occupational Health intervention.

across NHS Wales. A draft review was prepared and submitted to the Partnership Forum by the Occupational Health Review task and finish group, but was rejected and more work was requested. The remit of the review group has since been more clearly identified and its work is ongoing.

2.28 Trusts have, in the meantime, been able to provide some evidence of efforts to improve their local Occupational Health provision, as follows:

- Standardisation of referral forms and the deployment of Occupational Health nurses to screen referrals. For example, Gwent Healthcare NHS Trust introduced an Occupational Health nurse practitioner role in late 2005 to ensure that only staff that genuinely require a medical assessment are referred to the Occupational Health consultant (North East Wales and Conwy and Denbighshire NHS trusts also reported similar arrangements).
- The introduction of new software to assist with case management and to performance manage the service (for example at Carmarthenshire and North Glamorgan NHS trusts).

- Expanding the range of services offered, for example by employing counsellors or physiotherapists specifically to work within the Occupational Health department (although across Wales the provision of these services is still inconsistent).
- Improved engagement between the Occupational Health service, local managers and HR departments (in some cases by changing the reporting lines to mean that the Occupational Health service reported to the HR Director) and a greater focus on a case management approach bringing together all three parties.
- The provision of new facilities that are more fit for purpose, for example at North East Wales NHS Trust the Occupational Health department had relocated to a new building which made available additional clinic rooms and provided a more confidential environment for consultations and record keeping.

2.29 Despite these improvements, some of the issues identified in the previous Auditor General's report still remain. In particular:

- Concerns in some trusts about the level of resources and staff capacity to deliver the service, or to extend beyond a basic

Occupational Health service to become more fully engaged in workplace health and well-being initiatives.

- Waiting times for Occupational Health appointments still averaging up to six weeks in some trusts and as long as eight weeks in exceptional circumstances, a situation that is often exacerbated by employees failing to attend scheduled appointments.
- The risk that, for some trusts, the time spent servicing Occupational Health contracts was still disproportionate to the income generated by these contracts. For example, at Carmarthenshire NHS Trust the contractual income of £81,000 in 2006-07 was around one-third of the total Occupational Health expenditure and yet these contracts accounted for an estimated 65 per cent of medical time, up to 70 per cent of administrative time and 45 per cent of nursing time.

Trusts have been working to try and achieve the gold Corporate Health Standard for workplace health and well-being, with a particular recent focus on stress management

As at March 2008 six trusts held the gold Corporate Health Standard

- 2.30** The NHS Designed to Work strategy sets out the expectation that all NHS bodies should be working to achieve a gold rating as part of the Assembly Government's Corporate Standard for workplace health and well-being. Trusts have been undergoing reassessment for the

Corporate Health Standard following revision of the assessment criteria and the introduction of a new platinum award which takes account of the concept of corporate social responsibility²⁰.

- 2.31** Because of the ongoing process of reassessments, we did not examine in detail the Corporate Health Standard related activities undertaken by the trusts. However, there was evidence of positive action across most of the trusts and of efforts to put in place internal working groups and/or action plans designed to support work towards the gold standard.
- 2.32** As at March 2008, six trusts had achieved the gold Corporate Health Standard, compared with only two trusts in January 2004 (Figure 4). None of the trusts had achieved the platinum award although this was being targeted by North West Wales NHS Trust as part of its 'Health at Work Strategic Plan, 2005-2010', linked to which the Trust has been participating in a research project with the University of Warwick aimed at developing and evaluating health interventions to help reduce staff sickness absence.

There has been a particular recent focus on stress management

- 2.33** The Corporate Health Standard criteria cover a wide range of activities, policies and strategies. However, there has been a particular recent focus on stress management related policy development, audits, risk assessments and training, linked in with the development of the Health and Safety Executive's (HSE) stress management standards²¹. For example, Bro Morgannwg NHS Trust had allocated additional funding for the recruitment of a psychologist to work

²⁰ Consideration of trusts' corporate social responsibility includes their commitment to local regeneration and sustainable development, for example through their procurement, employment, building, transport and waste management practices. Before being able to apply for platinum accreditation, organisations must first achieve the gold standard against the revised Corporate Health Standard criteria.

²¹ <http://www.hse.gov.uk/stress/standards>

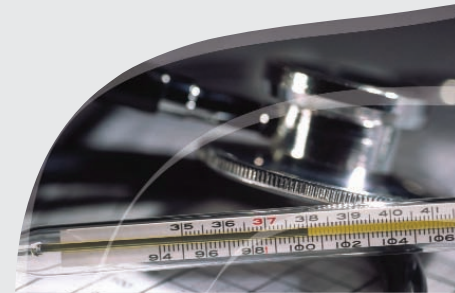


Figure 4 - Corporate Health Standard assessment ratings as at March 2008

	January 2004	March 2008
Bro Morgannwg	Silver	Gold
Cardiff and Vale	Silver	Silver
Carmarthenshire	Bronze	Bronze*
Ceredigion and Mid Wales	Bronze	Gold
Conwy and Denbighshire	Silver	Gold
Gwent Healthcare	Silver	Gold
North East Wales	Gold	Silver
North Glamorgan	Silver	Silver*
North West Wales	Silver	Gold
Pembrokeshire and Derwen	Gold	Gold
Pontypridd and Rhondda	Silver	Silver
Powys LHB	N/A	Bronze*
Swansea	Silver	Silver*
Velindre	Bronze	Bronze*
Welsh Ambulance Services	N/A	Silver*

Note: Trusts marked as ** were awaiting reassessment under the revised criteria later in 2008 or had not undergone reassessment because of the planned trust mergers.

within the Occupational Health department and ensure compliance with the HSE standards. Cardiff and Vale, Gwent Healthcare and Pembrokeshire and Derwen NHS trusts had also established employee well-being services, separate from the core Occupational Health service (**Case Study H**).

At Gwent Healthcare NHS Trust, mental health issues accounted for 24 per cent of management referrals to the Occupational Health service and 19 per cent of self-referrals in 2007-08.

2.34 Effective stress management will be particularly important at this time of significant organisational change across NHS Wales. The 2007 NHS Opinion Survey indicated that only 52 per cent of respondents felt secure in their jobs even before the more recent announcements regarding the merging of NHS trusts and LHBs. And although a majority of respondents agreed that they were able to strike the right balance between their home and work life, 20 per cent disagreed with this statement and 32 per cent indicated that they could not meet the requirements of their job without regularly working excessive hours. Overall, 14 per cent of the staff survey respondents also indicated that they felt that the only way to get time off for emergencies was to take sickness absence.

2.35 Over the past five years, trusts have developed a wider range of policies to support work-life balance or to provide for other types of leave to discourage staff from reporting sick when they are not themselves genuinely ill. To support its overall work-life balance policy, Cardiff and Vale NHS Trust had, for three years, employed a work-life balance manager drawing on external funding and has continued to support the position following the end of this funding period. Prior to its merger with Carmarthenshire and Pembrokeshire and Derwen NHS trusts, Ceredigion and Mid Wales NHS Trust had been consulting on a carers' policy having identified that some staff were taking time off saying they were stressed when they were actually looking after sick relatives.

Case Study H - Employee well-being services

Cardiff and Vale NHS Trust

The Trust established an Employee Well-Being service in 2005 which is lead by a consultant clinical psychologist and is strategically and independently placed between human resources, occupational health and organisational development and training. The service has three main strands;

- organisational interventions: working strategically with directorates and senior management to provide evidence based interventions which tackle stress at source;
- psycho-educational initiatives: for example, the delivery of stress awareness sessions and Trust-wide mandatory training for managers on stress in the workplace; and
- employee assistance: provision of a Trust-wide confidential counselling service which is accessible on four Trust sites and a specialist service for staff who are diagnosed as suffering from post traumatic stress disorder following work-related incidents.

The service generally deals with around 400 approaches to the service and 300 counselling episodes annually. Outcomes in relation to return to work figures demonstrate that half of all clients accessing counselling return to work immediately following counselling. In its first two years of operation, around five per cent of Trust staff had made use of the service's employee assistance programme.

The Trust has recently agreed to support the service with additional resources, taking the total annual funding for the service to £250,000. Consequently, the current whole time equivalent staff resource consists of: 1.2 x consultant clinical psychologist (increased from 0.3); a full time assistant psychologist, a full time counsellor manager, 1.9 x counsellors and 0.5 x administrative support.

Gwent Healthcare NHS Trust

In addition to supporting the Occupational Health department, the Trust established a dedicated Employee Well-Being service, with a budget of £127,000 for 2007-08. The service has three core strands, modelled on the structure of the service at Cardiff and Vale NHS Trust: individual support, educational initiatives and organisational interventions to address some of the systemic causes of employee well-being. The service also provides confidential debriefing to teams following difficult incidents and a service is available to managers to support reflection and problem solving in relation to other workplace problems. The aim is to support staff and so help to maintain attendance at work. Individual counselling support is also available with employees able to self-refer to the service.

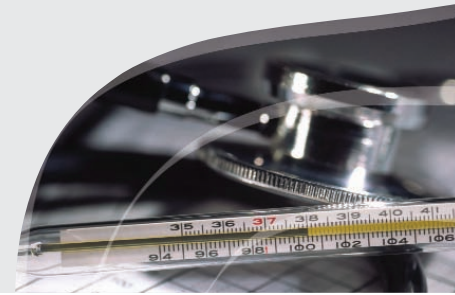
At the time of our fieldwork, waiting times to see the Employee Wellbeing service's counsellor were potentially as long as 12 weeks. However, the service subsequently took on another counsellor on a three day a week basis to help meet demand and, in early 2008-09, reported an average waiting time of four weeks.

Pembrokeshire and Derwen NHS Trust

The Staff Psychological Wellbeing service began as part of the Occupational Health service but subsequently expanded and became separately staffed and managed with the services of a part time consultant clinical psychologist, a full-time counsellor and a part-time secretary.

The wellbeing service's remit was initially just to provide counselling but this grew to include the prevention and management of staff psychological health issues as guided by the Trust's psychological well-being policy. Further details about the origins of the service are available among the Corporate Health Standard case studies published on the Assembly Government's website at: <http://wales.gov.uk/dphhp/publication/improvement/workplace/casestudies/casestudy2e.pdf?lang=en>

Some 74 per cent of those who accessed counselling through the service between July 2006 and June 2007 reported that it had helped them remain in work and 39 per cent reported having been assisted in returning to work specifically because of the services they received. The service was planning to look, in more detail, at the sickness absence records of staff before and after they access the service in order to help evaluate its impact.



2.36 As well as helping to reduce stress by promoting work-life balance, it is also important that trusts identify and address underlying causes of work-related stress such as general workplace conflict. For example, North Glamorgan NHS Trust had trained 39 mediators in conflict management amidst concerns that the new Employment Act 2002 (Dispute Resolution) Regulations, which came into force on 1 October 2004, had resulted in low-level disputes often accelerating into formal grievance processes.

Recent guidance on health clearance for NHS staff also requires additional pre-employment health screening

2.37 Trusts' arrangements for pre-employment health screening are generally based on an initial assessment of applicants' health declaration forms, to be followed by a face-to-face medical assessment if this is deemed necessary by Occupational Health staff. New guidance on health clearance²² is itself placing more of an onus on face-to-face medical screening for new 'healthcare workers', defined as those staff who have direct clinical contact with NHS patients. North Glamorgan NHS Trust was the only trust to report that all new starters were required to undergo medical examinations. The Trust recognised that this approach was unusual, although the well-publicised levels of ill health within its catchment area arguably strengthened the case for this approach. Occupational Health staff also reported that this screening often uncovered issues that were not identified on health declaration forms. Nevertheless, this practice is currently being reviewed by Cwm Taf NHS Trust.

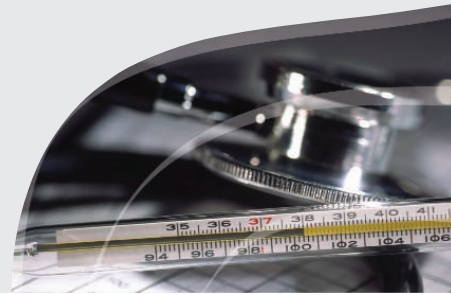
2.38 In undertaking pre-employment health screening, trusts clearly need to comply with their obligations under the Disability Discrimination Act. Rather than not taking on staff because of health problems, the more common scenario is that trusts will first seek to identify reasonable adjustments to working conditions, or other interventions, to support the individual concerned and to try and reduce the risk that working conditions lead to further health problems. In 2006-07, only one potential employee was ultimately deemed unfit for employment from a total of 234 individuals assessed by the Occupational Health department at Bro Morgannwg NHS Trust.

²² Welsh Health Circular 2006/86: Publication of guidance for the NHS on health clearance for health care workers: TB, Hepatitis B, Hepatitis C and HIV, Welsh Assembly Government, July 2007.

Appendix 1 - Methodology

- 1 During the 2007-08 financial year, we undertook local fieldwork to examine sickness absence management arrangements across what were, at the time, the 14 NHS trusts in Wales and Powys LHB²³. We also undertook a high-level review at the other 21 LHBs in Wales. However, the focus of this report is on the key findings and conclusions from our work with the NHS trusts in Wales and Powys LHB for consistency with the previous Auditor General's report, *The Management of Sickness Absence by NHS Trusts in Wales*, in January 2004.
- 2 We briefed the all Wales NHS HR Directors Forum and Assembly Government officials on the scope of our work in April 2007. We then asked trusts to complete a self-assessment questionnaire and submit additional supporting documentation, for example copies of sickness absence related policies and procedures, training materials, or other management reports.
- 3 We followed up the self-assessment questionnaire by undertaking a series of on-site interviews or focus group discussions with key staff, for example:
 - directors and/or deputy directors of HR and other HR staff;
 - service managers;
 - Occupational Health staff; and
 - workforce information staff (with responsibility for the production of sickness absence information from the ESR).
- 4 We did not repeat the type of work undertaken by the previous Auditor General with five NHS trusts to examine the accuracy of sickness absence recording, the extent of compliance with core sickness absence procedures, or the level of sickness absence training received by individual managers.
- 4 We produced local reports summarising our findings and conclusions, which considered whether each organisation had individually made good progress in improving its sickness absence management arrangements since the previous Auditor General's report.
- 5 To inform our local fieldwork and/or the content of this report, we also:
 - reviewed the action taken by the Assembly Government, either directly or through the work of the Attendance Management Steering Group, since the previous Auditor General's report;
 - discussed recent sickness absence related developments with relevant Assembly Government officials, although several of the key contacts within the Department of Health and Social Service's NHS HR team at the time of the previous Auditor General's report are no longer with the organisation; and

²³ On 1 April 2008, North Glamorgan and Pontypridd and Rhondda NHS trusts merged to form Cwm Taf NHS Trust; Swansea and Bro Morgannwg NHS trusts merged to form Abertawe Bro Morgannwg University NHS Trust; and Carmarthenshire, Pembrokeshire and Derwen, and Ceredigion and Mid Wales NHS trusts merged to form Hywel Dda NHS Trust. In addition, North East Wales and Conwy and Denbighshire NHS trusts merged to form North Wales NHS Trust on 1 July 2008. We refer throughout the report to the names of the NHS trusts as they existed prior to these mergers.



- attended the ESR sickness absence group that was established in 2007 by the ESR Project Manager for Wales to help identify and address the reason for the differences between the sickness figures generated locally by trusts and those being reported centrally via the 'Data Warehouse' (paragraph 2.18).

Appendix 2 - Wider public and private sector sickness absence rates

- 1 It is useful to consider the extent to which the average sickness absence rates reported by the NHS trusts in Wales differ from wider public and private sector trends (Table 1). However, differences in the approaches used by organisations to measure sickness absence rates have to be taken into account. The context of different organisations, for example their employee profiles and general working conditions, can also be a factor in higher or lower levels of sickness absence. And, as the previous Auditor General reported, the presence in work of NHS staff who are suffering from, or recovering after, illness of injury, presents its own risks to staff and their patients.

Table 1 - Comparison of recent sickness absence rates across the UK public and private sectors

Source ¹	Absence rate (%)	Average working days lost	Period of analysis
NHS trusts in Wales (and Powys LHB) ²	5.4	14.0	April 2007 to March 2008
NHS boards in Scotland ³	5.3	13.8	April 2007 to March 2008
NHS trusts in Northern Ireland ⁴	6.0	15.6	April 2007 to September 2007
UK Civil Service ⁵	(4.1)	9.3	April 2006 to March 2007
Chartered Institute of Personnel Development Survey ⁶	(3.5)	8	July 2007 to June 2008
<i>Public sector</i>	(4.3)	9.8	
<i>Private services sector</i>	(3.2)	7.2	
<i>Manufacturing and production</i>	(3.2)	7.2	
<i>Voluntary/not for profit</i>	(3.7)	8.5	

Notes

- 1 The Information Centre for Health and Social Care in England published an average percentage rate figure of 4.5 per cent for the 2005 calendar year, based on a combination of acute, ambulance, mental health and community, and primary care trusts, as well as strategic and special health authorities (<http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-sickness-and-absence>). More recent figures for NHS England have not yet been published since the phased introduction of the Electronic Staff Record.
- 2 Percentage rates for NHS trusts in Wales represent the percentage of calendar days lost per whole time equivalent member of staff. Average working days lost have been calculated by applying this percentage rate to a standard 260 day working year (or five-day week), including annual leave and bank holidays.
- 3 Percentage rate figures for NHS boards in Scotland are based on the percentage of contracted hours lost to sickness absence, as reported by the Information Services Division of NHS National Services Scotland (<http://www.isdscotland.org/isd/5253.html>). We have calculated the average working days lost on the same basis as for NHS trusts in Wales.
- 4 Percentage rate figures for NHS trusts in Northern Ireland are based on the percentage of working days lost to sickness absence per whole-time equivalent member of staff (based on a 260 day working year), as reported by the the Department of Health, Social Services and Public Safety in the Northern Ireland Executive (<http://www.dhsspsni.gov.uk/index/hrd/wpu/wpu-monitoring.htm>). Figures for the second half of 2007-08 have been published but exclude two of the six trusts due to concerns about data accuracy.
- 5 UK civil service figures are taken from the Cabinet Office report, Analysis of sickness absence in the civil service, 2006-07, published in February 2008 (http://www.civilservice.gov.uk/about/statistics/sa_report/contents.asp). The average working days lost are reported per 'staff year' which is counted as 225 working days, allowing for average annual leave and public holiday commitments. This approach affects the calculation for the average percentage rate which, if worked instead on the basis of a 260 day year to reflect the total contracted hours, as has been the customary approach in the NHS, produces a sickness rate of 3.6 per cent. Although the average working days lost is considerably lower than for the NHS trusts in Wales, there is significant variation between government departments with rates in excess of 15 working days per staff year in three medium sized departments (which have a total of between 1,000 and 10,000 available staff years, similar to the range in size of the NHS trusts in Wales), these being the Driver and Vehicle Licensing Agency, the Meat Hygiene Service and the Driving Standards Agency.
- 6 Taken from the Chartered Institute of Personnel Development's Absence Management – Annual Survey Report 2008 (<http://www.cipd.co.uk/subjects/hrpract/absence/absmagmt.htm>). The results are based on survey responses received from 819 UK based HR professionals in organisations employing a total or more than 2.3 million staff. The CIPD report calculates absence percentage rates on the basis of a typical year totalling 228 working days, allowing for annual leave and public holiday commitments. As with the Cabinet Office's civil service absence reports, if worked instead on the basis of a 260 day working year to reflect total contracted hours, this would produce an average percentage rate of 3.1 per cent across all of the survey respondents.