Fire and Rescue Service
Headquarters, Pirehill
DDI (01785) 898959
Please ask for Ora Yearwood

HUMAN RESOURCES AND ETHICS COMMITTEE

Thursday 30 June 2016
10.30 am
Room 1
Fire and Rescue Service Headquarters
Pirehill

(A Chairman/Vice-Chairman's Preview, for Mr M A Deaville and Mr G S Kallar has been arranged for 10.00 am)

Howard Norris
Secretary to the Authority
21 June 2016

A G E N D A

PART ONE

1. Apologies

2. Declarations of Interest

3. **Membership of the Committee** (for information)

M A Deaville (Chairman)	*T V Finn
G S Kallar (Vice Chairman)	Ms C Mitchell
Miss S A Bowers	J W Taylor
F A Chapman	M J Winnington
*R J Clarke	

* Denotes new Members of the Committee

4. **Minutes of the Meeting held on 15 March 2016**

5. **Discipline and Grievance Procedure Monitoring Report**

   Report of the Director of People

6. **Absence Monitoring Report**

   Report of the Director of People

7. **Annual Sickness Absence Analysis**

Report of the Director of People

8. **Job Evaluation Update**

Presentation by Sue Wilkinson, HR Manager

9. **Anticipated future items for consideration by the Committee**

For discussion:

- Firefighter Fitness Assessments – Further update
- Occupational Health Provision
- Further Training reports, as and when required
- Further Fire Control updates

10. **Date of Next Meeting**

Wednesday 7 September 2016 at 10.30 am.

11. **Exclusion of the Public**

The Chairman to move:-

"That the public be excluded from the meeting for the following items of business which involve the likely disclosure of exempt information as defined in the paragraphs Part 1 of Schedule 12A of the Local Government Act 1972 indicated below".

PART TWO

NIL

Possible Items for Scrutiny

Members are asked to consider if any of the items that have been considered by the Committee at its meeting today are in need of further scrutiny and whether the item should be referred to the Scrutiny and Performance Committee for further examination.

Item No. 4 on Agenda

MINUTES OF THE HUMAN RESOURCES AND ETHICS COMMITTEE HELD ON 15 MARCH 2016

Present: Sweeney, S J (Chairman)

Mitchell, Ms C Taylor, J W

Apologies: Kallar, G S; Winnington, M J; Bowers, Miss SA; Woodward, Mrs S E and Chapman, F A.

Also in Attendance: Mrs J Doran, Director of People and Mr T Wilson, Station Manager ESDG.

PART ONE

Documents referred to in these Minutes as schedules are not appended but will be attached to the signed copy of the Minutes. Copies, or specific information in them, may be available on request.

Change in Membership of the Committee

50. The Chairman advised of a further change of membership of the Committee following the change as stated on the Agenda. Mr Frank Chapman had replaced Mr John Francis with effect from 15 March 2016.

Minutes of the Meeting held on 3 December 2015

51. Mrs Doran referred to page 4 of the minutes (Note by Secretary) that addressed the typographical error for long term absence relating to mental health in the Absence Report for August 2015. She confirmed that the figure of 148 should have been entered as 43.

52. **RESOLVED** – That the Minutes of the Meeting held on 3 December 2015 be confirmed and signed by the Chairman.

Notes of the Staff Consultation and Negotiating Forum held on 2 February 2016

53. **RESOLVED** – That the Notes of the Staff Consultation and Negotiating Forum held on 2 February 2016 be received.

Discipline and Grievance Procedure Monitoring Report
(Schedule 1)

54. Mrs Doran updated Members on discipline and grievance cases and provided information on the usage and effectiveness of the disciplinary and grievance procedures. The information referred to cases during the period November 2015 to February 2016 which followed the last report that referred to cases up to the end of

October 2015. Statistical data for this period was attached to the report for Members' information.

There were 29 incidents of informal action recorded in that period. 12 of those incidents were related to sickness; 5 for wholetime staff, 2 for retained staff, 1 for wholetime retained and 4 for support staff.

17 minor disciplinary offences had been committed which related to conduct by members of staff and were for a variety of reasons, the majority of which (13) were issued to retained staff and related to issues in respect of responding to fire calls or a failure to complete mandatory learning or courses. Three of the notes were issued to wholetime/retained staff and the remaining one to a support colleague. There were no informal cases related to capability reported in that period.

Two cases of formal discipline was heard during that period of which one was issued to a retained member of staff and related to a conduct issue. The remaining case was for a member of the wholetime establishment. There were no outstanding appeals.

With regards to grievances or capability cases, three were heard during that period. Two cases were raised by wholetime members of staff challenging Service decisions, one regarding an enforced move and alleged victimisation which was fully investigated and not upheld. The other case was in relation to the opportunity to earn additional monies but although not upheld, did result in an amendment to a Service policy to clarify the issue. One grievance was raised by a support member of staff who challenged a salary offered following an offer made after an internal recruitment process. This was also rejected but a review of the recruitment policy had been requested.

Overall there had been no trend identified in relation to formal cases as the numbers of cases were similar to the previous period. There was an increase in the number of informal cases, particular in relation to sickness but it was explained that the reference period was longer than the previous period and therefore would account for this. Worthy of note, was that the period at the same time last year also saw an increase in informal sickness warnings and appeared to be a seasonal trend.

Members held a brief discussion on the report as presented. A Member referred to the informal incidents recorded and enquired if there was any trend developing inasmuch as the offences were from the same station. Mrs Doran advised that they could potentially identify trends if they were from a particular station or department and she would ask for this to be highlighted if this was the case.

55. **RESOLVED** – That the Discipline and Grievance Monitoring report be noted.

Absence Monitoring Report
(Schedule 2)

56. Mrs Doran updated Members on Absence levels within the Service and provided information on trends relating to reasons for absence due to sickness. The information referred to absences between November 2015 and January 2016 and was shown in comparison to the same period in 2014/15. The report also drew a comparison in relation to the reason for absence with the same period in 2013/14.

Sickness Absence by Employee Type – The data demonstrated a reduction in absence levels in 2015/16 overall when compared with the previous year. This had been most noticeable in the decrease in shift absence; however there had also been a sharp increase in short term absence for shift employees in January 2016 which may be attributed to the change to the Crewing Policy, which became effective on 1 January 2016. Absence levels for uniformed staff had decreased and were largely as expected. Support absence had remained largely similar to the previous year (4% increase overall).

Short Term Absence by Reason – Mental health related short term absence had been the highest contributor during this quarter, accounting for 21% of days lost. This had occurred despite the early intervention that was put in place through the Occupational Health provider. Colds, Flu and Chest infections accounted for a further 20% of short term days lost; this was a seasonally expected trend. Musculoskeletal absence was the third highest contributor, followed by miscellaneous absence (that is, absence where no documentation had been received to allow categorisation for reporting purposes) together with stomach and abdominal conditions.

In comparison to the same period last year, whilst the categories have remained unchanged, there had been a rise in mental health from the fifth highest to the highest contributor, although there had been a 40% reduction in days lost to musculoskeletal absence. Similarly the same categories were also present in the figures for the same period in 2013/14. This further indicated ongoing issues relating to musculoskeletal and mental health related absence, however it also indicated seasonal trends of colds, flu and chest infections, stomach and abdominal conditions, which one would expect at that time of year.

Long Term Absence by Reason – Similarly to the previous two years, musculoskeletal and mental health related absence were the two highest contributors to long term absence within the Service, despite the support put in place through the Occupational Health provider. In comparison to 2014/15, there had been a dramatic reduction in musculoskeletal absence, so whilst it was still the highest contributor, there had been a 44% decrease. Whilst mental health related absence had increased, it was only by 16 days, despite this being a 20% increase.

Other notable contributors were surgery and general screening, which was the third highest contributor for the third year running, followed by disease (cancer etc) as the fourth highest contributor. The Service had seen an increase in cases of cancer (there were no cases the same time the previous year) however, there were no trends or patterns in this category. Stomach and abdominal conditions were the fifth highest contributor, although it only accounted for a small proportion of the days lost. All cases were being managed through the Service's Occupational Health Provider.

Absence due to an Injury at Work – During this period, the Service had lost 42 days to absences attributed to an injury at work; this was largely the same as last year and could be attributed to the same individual and injury. This case was being actively managed through the Occupational Health Department.

In response to a question relating to referrals to Occupational Health (OH) for mental health conditions, Mrs Doran advised that support from OH is offered as soon as staff reported their sickness absence. This could include support from the counselling team. For more serious conditions external psychiatric experts were

available. A Member enquired if there could be links between stress and other absences. Mrs Doran stated that it was possible to have interlinked conditions for example where a musculoskeletal sickness absence could be linked with stress, although the cause absence was noted as that detailed in the individual sickness notes from the GP.

57. **RESOLVED** –That the report be noted.

Pay Policy Statement

(Schedule 3)

58. Mrs Doran reported on Section 38 of the Localism Act 2011 which required Fire and Rescue Authorities to prepare and approve an annual Pay Policy Statement. The Pay Policy for 2016/17 had been produced which took into account the requirements of the Act and was attached to the report.

Mrs Doran explained that there was a requirement for the Pay Policy to be approved before 31 March each year. In view of the timing, the Strategy and Resources Committee at its meeting on 2 March 2016 endorsed the Statement with a recommendation for approval by the Fire and Rescue Authority. It was stated that any comments made by Members of the Human Resources and Ethics Committee could be verbally received at the Fire and Rescue Authority Meeting on 31 March 2016.

In response to a Member's question regarding recruitment of Chief Fire Officers, Mrs Doran referred to Item 3.1 of the Policy which dealt with the level of remuneration paid and any differential indicated.

59. **RESOLVED** – That the Pay Policy Statement 2016/17 be reviewed and noted with no changes.

Trauma Risk Management (TRiM)

60. Mr Toby Wilson, delivered a presentation to the Committee which provided an insight into Trauma Risk Management (TRiM). TRiM began in the British military as a peer support programme designed to assist people that had experienced a traumatic event. It had been recognised that a traumatic incident had the potential to cause physical, emotional or psychological harm. It could cause distress symptoms such as unwanted thoughts or images, feeling numb or on edge or being upset or angry in anyone. Whilst most symptoms are resolved after a couple of weeks, some people could have persistent and impairing symptoms some years later.

The Service identified the TRiM Management Model used by the Royal Marines – March on Stress and adopted the National Institute of Clinical Excellence (NICE) guidelines published in 2005 that recommended 'watchful waiting' as a way of managing the difficulties presented by people with post-traumatic stress disorder (PTSD). The single session Critical Incident Debriefing which was still being used by many emergency services was therefore no longer recommended as the initial response to trauma. Mr Wilson outlined the reasons for the Service undertaking TRiM from a legal, moral and financial aspect:

<u>Legal</u>

- Health and Safety at Work Act 1974 – To ensure Health, Safety & Welfare of employees.

- Management of Health & Safety at Work Regs 1999 – Suitable and sufficient Risk Assessment of risks + Requirement for appropriate health surveillance.

Moral

- Because it is the right thing to do.
- Because the Service was a caring employer with a positive Health, Safety and Welfare culture that is embedded throughout the organisation.
- Because it underpinned the Leadership Message and Cultural Framework.
- Because it demonstrated to employees that their wellbeing is important to the organisation.

Financial

- Because not doing so could expose SFRS to a civil claim for negligence (Compensation).
- Because not doing so could expose SFRS to a Criminal Charge under the H&S@W Act (Fine).
- Lost time due to sickness.
- Overtime Payments/Sick Pay/Insurance Premium Increase.

TRiM Practitioners undertook specific training to allow them to understand the effects that traumatic events have on people and help them to deal with them. Mr Wilson is one of four TRiM Practitioners that have been trained to Manager level and is responsible for the planning and maintenance of an admin system and ensuring TRiM Workbooks are completed. The Managers also provide training and support to a number of TRiM Practitioners that operate throughout the Service. He stressed that the records were appropriately secure, protected and kept indefinitely by TRiM Managers and were not linked to HR. He advised that it was useful to have at least one operational member as part of the team although officially it was not necessary. There were also Tactical Advisors who dealt with the active management of exposure at incidents where a TRiM assessment would be considered. At a large incident, the debrief would be on a more formal footing.

Mr Wilson gave an in-depth summary of the steps taken following a traumatic incident. This included risk assessments and follow up procedures by means of a 'photograph' (which involves a very structured discussion about the incident together with observation) three days after the event and a further 30 days where a referral would be made to Occupational Health if deemed necessary. He stated that the three days post incident follow up was a deliberate delay which allowed the individual time to diffuse after an incident.

In response to a Member's question regarding questions asked following an incident, Mr Wilson advised that it was a structured process where conversations are held relating to the individual's thoughts at certain parts of the incident whilst observing emotions and acute signs of stress. He added that the Service was still very much aware of the stigma that is attached to showing emotion, therefore a TRiM assessment could sometimes be declined but by raising awareness it is hoped that this would improve.

In respect of offering TRiM to a wider audience, Mr Wilson advised that they were able to signpost non-employees and members of the public but from a corporate perspective there would be a vicarious liability involved. They had been in touch with

MIND who issued a leaflet that could be distributed to non-employees. Worthy of note was that interest had been received from the General Medical Council (GMC) on slight variations of the Service's TRiM model and Cheshire Fire and Rescue Service were also giving it great consideration.

Members thanked Mr Wilson for delivering an informative and interesting presentation.

61. **RESOLVED** – That the presentation be noted.

Anticipated future Items for consideration by the Committee

62. Members were asked to note the following items that would be considered for future meetings of the Committee.

- Occupational Health Provision
- Further Training reports such as Management Training
- Further Fire Control updates
- Firefighter Fitness Assessments – Further updates
- TRiM – Further update in 12 months

63. **RESOLVED -** That Items for future meetings be noted.

Date of the next Meeting

64. Members were advised that the next Meeting of the Committee was scheduled to be held on Thursday 30 June at 10.30am.

Exclusion of the Public

Upon the motion of the Chairman it was:-

65. **RESOLVED –** That the public be excluded from the meeting for the following items of business which involved the likely disclosure of exempt information as defined in the paragraphs of Part 1 of Schedule 12A of the Local Government Act 1972 indicated below.

Exempt Notes of the Staff Consultation and Negotiating Forum held on 2 February 2016
(exemption paragraph 4)

66. **RESOLVED** – That the Exempt Notes of the Staff Consultation and Negotiating Forum held on 2 February 2016 be received.

CHAIRMAN

Item No. 5 on Agenda

Stoke-on-Trent and Staffordshire Fire and Rescue Authority

Human Resources and Ethics Committee

30 June 2016

Discipline and Grievance Monitoring Report

Report of the Director of People

SUMMARY

The purpose of this report is to keep Members updated on discipline and grievance cases and provide information on the usage and effectiveness of the disciplinary and grievance procedures. This information refers to cases during the period 1 March 2016 to 31 May 2016, following the last report which referred to cases up to the end of February 2016.

RECOMMENDATIONS

The Members note the report contents.

Financial Implications

No financial implications

Legal Implications

There are no legal implications at the present time from the content of this report.

Equality and Diversity

There are no specific equalities implications at this time arising from this report.

Risk Implications

The potential risk implications of not following the current procedures may be increased litigation and cost to the Service, however, training and specialist advice and guidance in line with our procedures will reduce the impact.

Consultation and Engagement undertaken

None applicable to this period.

Other implications

None

BACKGROUND

As part of the ongoing process, this report updates and summarises the period 1 March 2016 to 31 May 2016. Advice and guidance continues to be provided to support line managers. Statistical data for this period is attached for members' information.

Informal Action

29 incidents of informal action were recorded in this period.

17 of these were related to sickness, 8 for wholetime, 4 for retained staff, 3 for wholetime retained and 2 for support staff.

9 minor disciplinary offences were committed relating to conduct by members of staff – these were for a variety of reasons, the majority of which (7) were issued to retained staff and related to issues in respect of not complying with contractual requirements. 2 were issued to wholetime staff for failing to follow a Service procedure. No conduct related warnings were issued to support staff.

There were 3 cases of capability which warranted informal action, 2 to support staff and one to a wholetime colleague.

Formal Action

No discipline cases were heard in this period which resulted in a formal sanction being issued.

3 grievances were heard during this period. Two cases were raised by wholetime members of staff, one challenging the Service decisions in respect of managing his case in line with a Service policy, the remaining two were challenging the behaviours of a manager, neither of these were upheld. Both cases were fully investigated to ensure that there was not an adverse culture within the department and Members can be assured that these are isolated incidents.

One capability hearing was convened for a wholetime member of staff – this related to poor decision making from a manager.

Trends

There is no trend identified in relation to informal cases as the number of cases is similar to the previous period. There has been a reduction in the number of formal discipline cases and it is hoped that this will remain the case. There were a few cases of staff resigning prior to informal and formal sanctions being issued.

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Formal Discipline

No discipline cases were heard that resulted in a formal sanction being issued.

Grievance		Subject	
CM	WT	Level of pay during sickness absence	Rejected, appealled and original decision upheld
Temp CM	WT	Perceived inappropriate treatment by Line Manager	Rejected, no appeal
Support	FT	Behaviour of manager during a 1:1 meeting	Rejected but further investigation into team management and possible mediation

Capability			
	WT	Poor management decision making	Written warning - 12 months

Informal

Role	**WT/RT**	**Subject**	**Reason**
Support		Absence	Level of attendance below the standard expected
Support		Absence	Level of attendance below the standard expected
FF	RT	Absence	Level of attendance below the standard expected
FF	RT	Absence	Level of attendance below the standard expected
FF	RT	Absence	Level of attendance below the standard expected
FF	RT	Absence	Level of attendance below the standard expected
FF	WT/RT	Absence	Level of attendance below the standard expected
FF	WT/RT	Absence	Level of attendance below the standard expected
FF	WT/RT	Absence	Level of attendance below the standard expected
FF	WT	Absence	Level of attendance below the standard expected
FF	WT	Absence	Level of attendance below the standard expected
FF	WT	Absence	Level of attendance below the standard expected
FF	WT	Absence	Level of attendance below the standard expected
FF	WT	Absence	Level of attendance below the standard expected
FF	WT	Absence	Level of attendance below the standard expected
FF	WT	Absence	Level of attendance below the standard expected
CM	WT	Absence	Level of attendance below the standard expected
Support		Capability	Poor standard of work
Support		Capability	Poor management decision
Manager	WT	Capability	Poor management decision
Support		Conduct	Unauthorised absence
CM	RT	Conduct	Failure to attend fire calls
FF	RT	Conduct	Failure to attend training course
FF	RT	Conduct	Failure to comply with management instructions
FF	RT	Conduct	Non attendance at drill periods
FF	RT	Conduct	Inappropriate behaviour
FF	RT	Conduct	Failure to comply with declaration
WM	WT	Conduct	Failure to follow Service procedure
WM	WT	Conduct	Failure to follow Service procedure

Item No. 6 on Agenda

Stoke-on-Trent and Staffordshire Fire and Rescue Authority

Human Resources and Ethics Committee

30 June 2016

Absence Monitoring Report

Report of the Director of People

SUMMARY

The purpose of this report is to keep Members updated on absence levels within the Service and provide information on trends relating to reasons for absence due to sickness. The information refers to absences between February and April 2016 and compares it to the same period in 2015. In relation to the reason for absence, the report also draws a comparison with the same period in 2014.

RECOMMENDATIONS

That Members note the contents of this report.

Financial Implications

There are no additional financial implications for the Committee to be aware of, however there is an associated cost to sickness absence both directly (occupational sick pay) and indirectly (covering the position during the post holder's absence).

For the financial year 2015/16, sickness absence cost the Service £674,600, which does not take into consideration hidden costs such as the loss of productivity or additional workload passed to colleagues in the post holder's absence, simply the sickness pay costs.

Legal Implications

There are no legal implications.

Equality and Diversity

It is possible that there may be equality and diversity implications as there could be links between a protected characteristic and absence levels (for example disability). At present, we do not have the ability to report on protected characteristics in relation to sickness absence although this will be available when Firewatch is fully implemented.

Risk Implications

There are no risk implications.

Consultation and Engagement undertaken

None applicable to this period.

Other implications

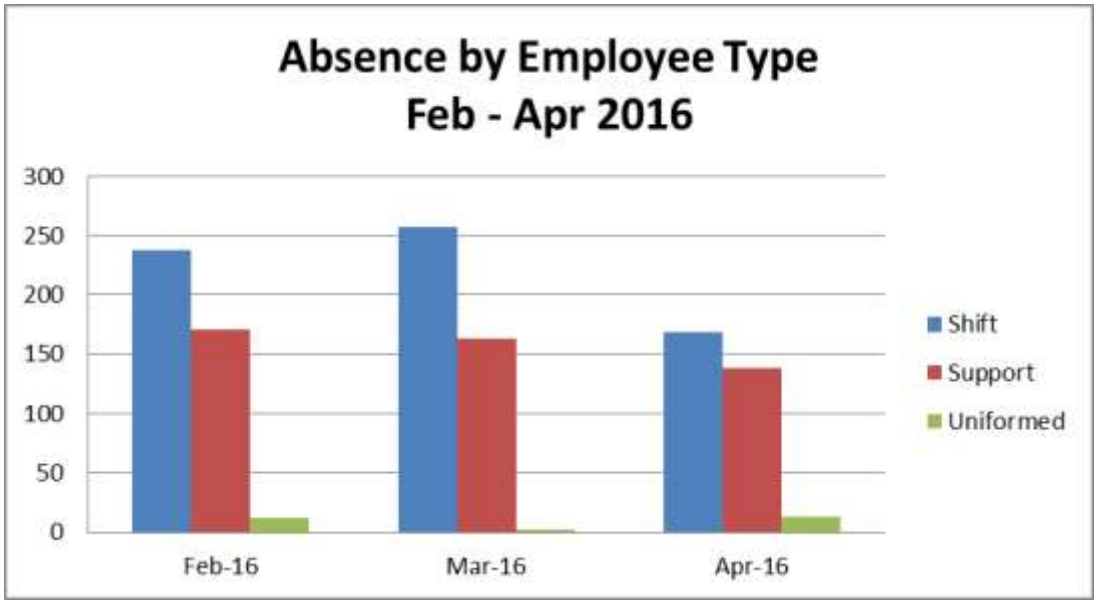
None.

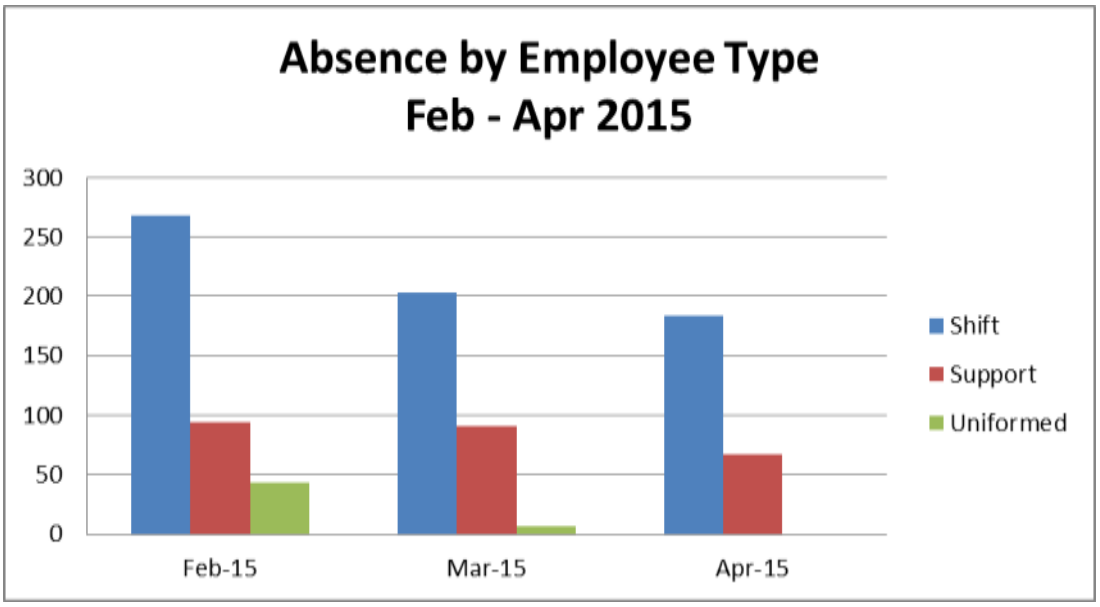
Background

This report updates and summarises the period 1 February 2016 to 30 April 2016 and identifies whether there are any trends. Statistical data for this period can be found below for Members' information.

NB Uniformed indicates operational personnel at Station Manager Level and above; Shift indicates operational personnel at Firefighter to Watch Manager level and Support refers to non-operational (green book) employees.

Sickness Absence by Employee Type





Overall, there has been a notable increase in absence overall in comparison to the same period in 2015. Uniformed absence has decreased by half, shift absence has increased very slightly (although is still largely typical) however there has been a significant increase in Support absence. A large proportion of this increase can be attributed to cases of surgery and post operative recovery, which

the Service cannot influence. Taking these absences out of the figures there would still be an increase, however not so significant.

Short term shift absence increased significantly during the first quarter of 2016, which appears to be linked to the introduction of a new Crewing Policy; that said, this began to decrease in April, however a decrease in absence would be expected in April and May. The Service is continuing to monitor short term shift absence.

Short Term Absence (Days Lost) by Reason

Feb-16	Mar-16	Apr-16	Reason	Feb-15	Mar-15	Apr-15	Feb-14	Mar-14	Apr-14
14	1	43	Mental (stress, anxiety, depression)	33	14	16	11	13	14
3	4	3	Skin	1	0	2	2	0	4
3	8	4	Head conditions (Eyes, Ears, Dental)	4	7	16	9	1	9
32	94	37	Musculoskeletal	66	64	26	40	23	55
12	0	14	Urinary or Genital Related	0	0	0	2	15	0
53	56	23	Cold, Flu, Chest Infections	42	39	27	52	51	17
19	10	15	Stomach/Abdominal Conditions	39	13	23	32	22	29
0	0	0	Blood Conditions	21	0	1	0	0	0
0	0	0	Poisoning/Reaction to medication	0	0	2	0	0	0
0	0	0	Pregnancy Related	0	0	8	8	0	0
34	12	7	Surgery/General Screening	7	30	14	4	4	0
0	13	14	Disease (Cancer etc)	16	0	6	0	2	4
55	13	12	Miscellaneous	8	29	10	14	11	15

Musculoskeletal absence remains the largest contributor to absence; although this was the second highest contributor in 2014, it has been the highest contributor to absence in the last two years. There appears to be a greater trend towards back and upper limb (including shoulder) conditions during this period. Colds, flu and chest infections have been the second highest contributor (and were the highest contributor in 2014) – this is an expected seasonal trend.

Miscellaneous absence, where the sickness documentation has not been received at the time of reporting, is the third contributor to absence, replacing stomach and abdominal conditions, which was third for the last two years. Whilst it is pleasing to see that stomach and abdominal conditions are no longer one of the top five contributors to absence, it does mean that departments and stations are not providing documentation in a timely manner. This is being addressed locally with teams. Mental health remains the fourth highest reason for absence and for the second year running, surgery and general screening is the fifth highest contributor to absence.

The Service is actively looking to address these trends and are continuing to implement an early intervention service with Occupational Health, whereby they will contact an employee upon receipt of notification of either a musculoskeletal or mental health related absence; a member of the Welfare or Physio team will call the individual to offer support.

Long Term Absence (Days Lost) by Reason

Feb-16	Mar-16	Apr-16	Reason	Feb-15	Mar-15	Apr-15	Feb-14	Mar-14	Apr-14
70	76	40	Mental (stress, anxiety, depression)	18	31	46	50	27	35
0	0	0	Skin	0	31	0	0	0	0
0	0	0	Head conditions (Eyes, Ears, Dental)	0	0	0	0	0	0
73	65	61	Musculoskeletal	120	287	38	118	147	86
0	0	0	Urinary or Genital Related	0	0	0	0	0	0
20	1	0	Cold, Flu, Chest Infections	0	0	0	0	21	0
0	12	0	Stomach/Abdominal Conditions	0	0	0	15	0	0
0	0	0	Blood Conditions	0	31	0	0	0	0
0	0	0	Poisoning/Reaction to medication	0	0	0	0	0	0
0	0	0	Pregnancy Related	0	0	0	0	0	0
19	36	36	Surgery/General Screening	30	0	0	13	3	0
10	21	11	Disease (Cancer etc)	0	31	16	15	15	0
4	0	0	Miscellaneous	0	0	0	0	0	0

Musculoskeletal related absence is the highest contributor to long term absence; this is consistent with the previous two years. Again, there appears to be a trend towards back and upper limb conditions, however there are also a small number of cases of lower limb musculoskeletal related absences. Mental health related absence remains the second highest contributor to absence, consistent with the previous two years.

Surgery and general screening is the third highest contributor to absence, which is consistent with the overall and short term absence figures above; this indicates that short term cases one month are likely to develop into longer term cases as the employee recovers, however the Service has little influence in actively preventing such absences. Diseases such as Cancer are the fourth highest contributor, although this has decreased from the previous two years, which is pleasing to read. Again, this is an area the Service can do little by way of proactive prevention work. Colds, flu and chest infections are the fifth highest contributor; anecdotally it appears there were some stronger strains, which might explain why we had both an increase in short term absence but also saw it contributing to absences over 28 days (largely during February).

All cases are being managed through our Occupational Health Provider.

Absence due to an Injury at Work

During this period, the Service has lost 67 days to absences attributed to an injury at work; this is marginally higher then last year and can be attributed to the same individual and injury, as well as an additional on duty injury. Both cases are being actively managed through our Occupational Health Department and we expect the figure will reduce significantly from July.

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Item No. 7 on Agenda

Stoke-on-Trent and Staffordshire Fire and Rescue Authority

Human Resources and Ethics Committee

30 June 2016

Annual Sickness Absence Analysis

Report of the Director of People

SUMMARY

This paper provides statistics regarding the Service's sickness absence data for the 12 month period April 2015 to March 2016, with a comparison to the previous year. The analysis shows the main causes of sickness absence and also gives a breakdown by staff group. The paper also provides details of current and planned intervention and prevention activities. Early intervention and access to personal advice and guidance will assist in the reduction of not only sickness absence but also encourage a culture of lifelong health and wellbeing, rather than 'keeping fit for the job'. Such activities will become increasingly important in the context of an aging workforce

The data shows that there has been a slight decrease in sickness absence from April 2015 – March 2016 compared with the previous year. The figures show that the main reasons for absence are still musculoskeletal and mental health, which is also the national picture. Whilst the Service has seen a sharp decrease in musculoskeletal related absence, it is still the highest contributor to absence. Mental health related problems remain the second highest reason for absence and this has increased year on year. There has also been an increase in surgery related absences.

Particular points to note are the increase in absence for Retained staff and an increase in Support staff absence particularly in relation to musculo skeletal issues. The Service has also seen an increase in short term shift absence since January 2016. This will continue to be monitored in the next quarter to better understand if there is a pattern. The Service will also monitor the percentage absence per month that is unaccounted for and therefore classed as 'miscellaneous.'

In comparison with other Fire and Rescue Services we are in the lowest 10 of the 31 Services that are part of the national benchmarking data on sickness absence with the Service's 4.43 shifts lost per Wholetime Firefighter being lower than the national average of 5.27 shifts. For Support Staff, the average was 5.5 days, which is also lower than the national average of 6.45 shifts. However Retained absence was high when compared to the benchmark data and the Service will need to look to learn from best practice in relation to the management of Retained absence.

Occupational Health, together with our Health and Fitness team have been providing proactive health screenings for staff, aimed in particular at Support staff who do not access

the annual fitness assessment. Occupational Health have also been providing early intervention input to arrange welfare calls and physio appointments for anyone booking sick with musculoskeletal or mental health reasons.

HR have included the management of sickness absence in the supervisory management programmes and work closely with Occupational Health and Managers on the case management of longer term absence.

The Service will need to continue to monitor absence and to take action in accordance with its absence management procedure as well as continue its proactive work in early intervention and prevention of absence.

Throughout the report, the categories are as follow

- 'Uniformed' denotes operational staff at Station Manager and above
- 'Shift' denotes Wholetime Firefighters, Crew Managers and Watch Managers,
- 'Support' represents all Support Staff
- 'Retained' denotes Firefighters, Crew Managers and Watch Managers within the Retained Duty System.

RECOMMENDATIONS –

That Members note the contents of this report for information and discussion.

Financial Implications

It is essential that sickness absence continues to be actively managed in order to reduce sickness absence cost in terms of reduced productivity and cover arrangements.

Legal Implications

The Service has a sickness absence policy and procedure to ensure good practice and legal compliance.

Equality and Diversity

Further analysis will need to be undertaken in relation to the statistical data and protected characteristics which will be assisted by Firewatch when all of the sickness absence data is reportable from this system.

Risk Implications

There is the risk of increased cost relating to sickness absence if current and future planned activity is not continued.

Consultation and Engagement undertaken

The information in this paper has been compiled by Human Resources, Occupational Health and the Health and Fitness Advisor. Monthly absences statistics are supplied by Human

Resources to Directorates broken down into stations/departments and are discussed at the Support Services Directorate.

Protective Security Consideration

The data produced does not identify any particular individuals and general trends only are identified.

Procurement and Social Value

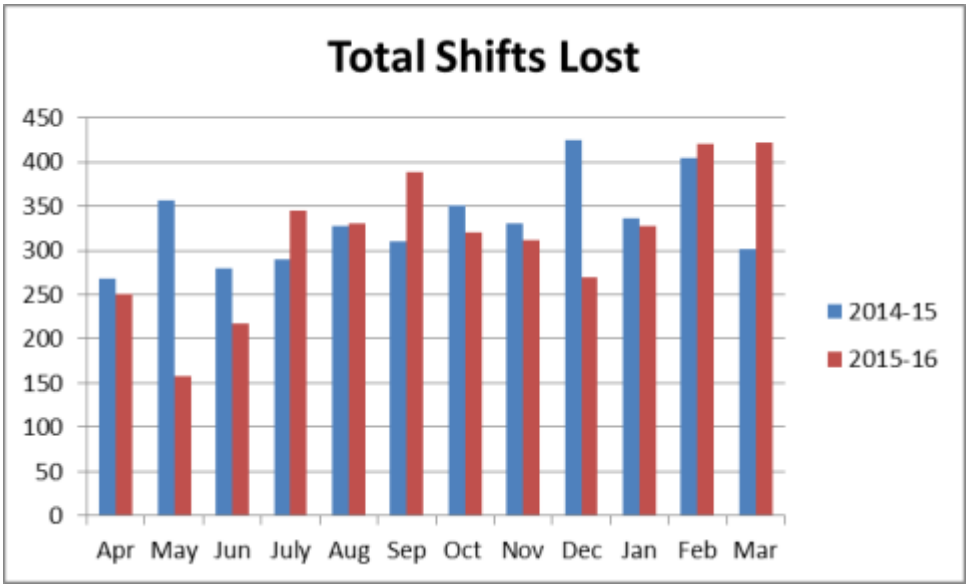
Not applicable

1. Sickness Absence Data

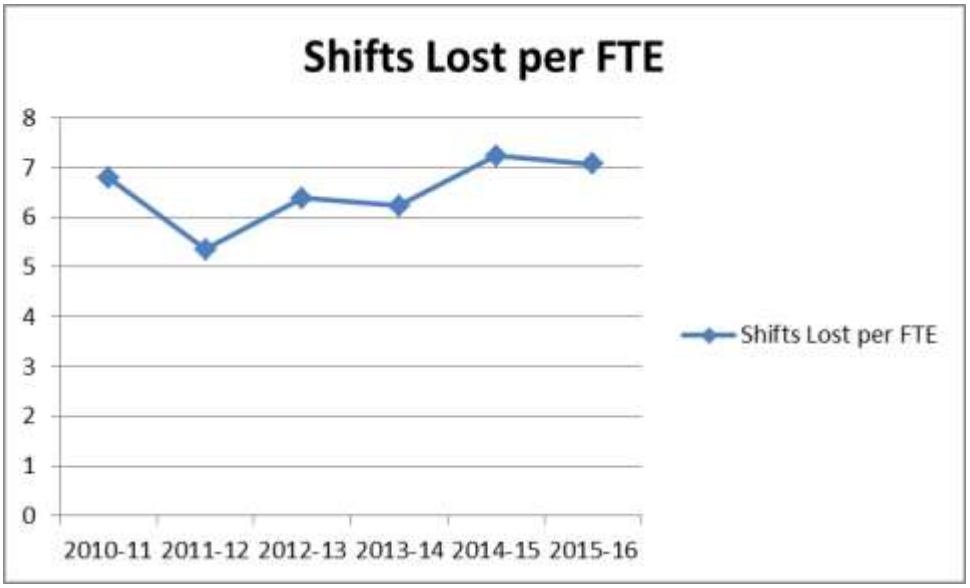
The following charts show the number of shifts/calendar days lost for sickness absence for 2015/16 and a comparison to the previous year for the same period.

1.1 Uniformed, Shift and Support

There has been a decrease in overall sickness absence with 3765 shifts lost in 2015/16 compared with 3980 shifts lost in 2014/15.

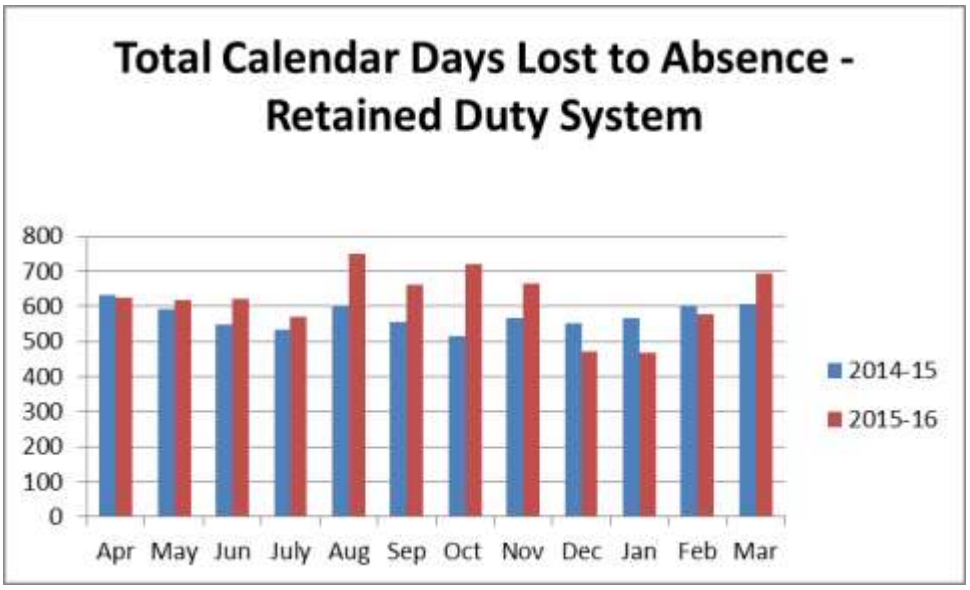


There has been a decrease from 7.24 shifts in March 2015 to 7.07 shifts in March 2016. The following chart details the average shifts lost per FTE over the last 5 years so we can compare this against previous years.

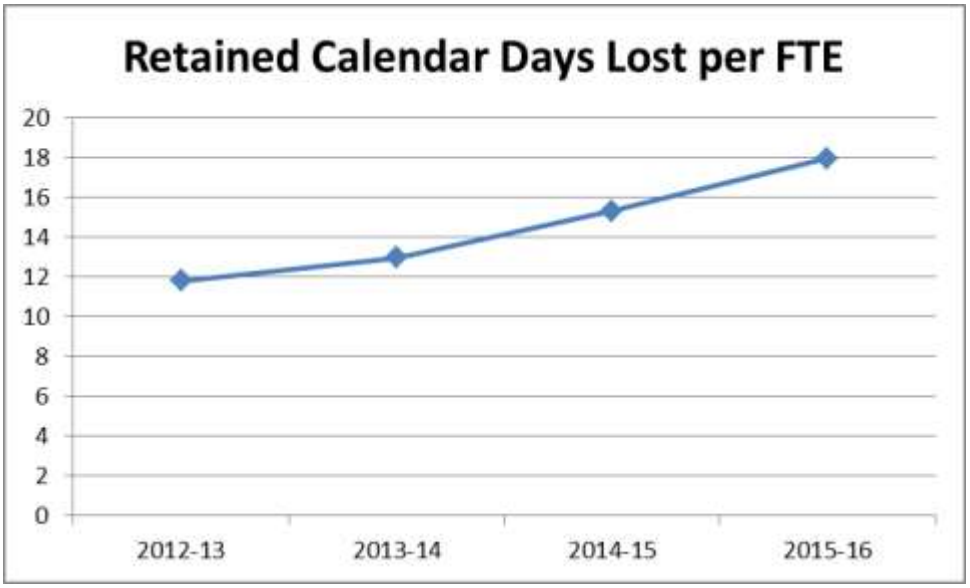


1.2 Retained

It should be noted that Retained absence is calculated in total calendar days however currently the reporting facility does not identify if cover is provided on all of those days. Therefore there may be an overestimation of sickness absence for Retained staff. It is expected that Firewatch will allow the Service to provide more accurate reporting in the future. Nevertheless there has been an increase in sickness absence identified with 7443 calendar days lost in 2015/16 compared with 6881 calendar days lost in 2014/15.



Taking into account the average sickness days per FTE there has been an increase from 15.33 days in March 2015 to 17.96 days in March 2016. The following chart details the average shifts lost per FTE over the last 4 years so we can compare this against previous years; please note the Service did not begin reporting on Retained absence until 2012-13.



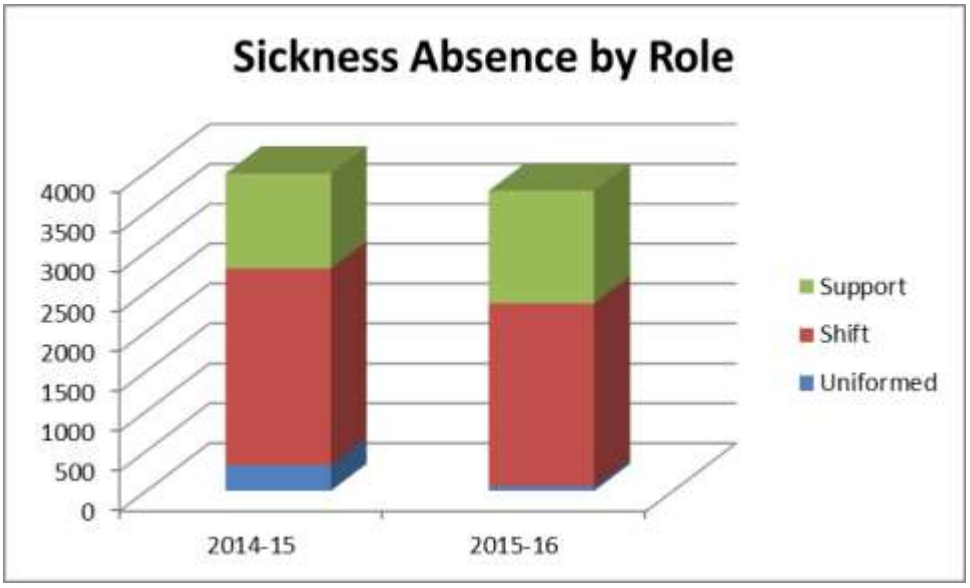
2. Sickness absence by role

Absence is distributed throughout the Service as illustrated below.

2.1 Uniformed, Shift and Support

There has been a decrease in sickness absence for operational staff and an increase in absence for Support staff.

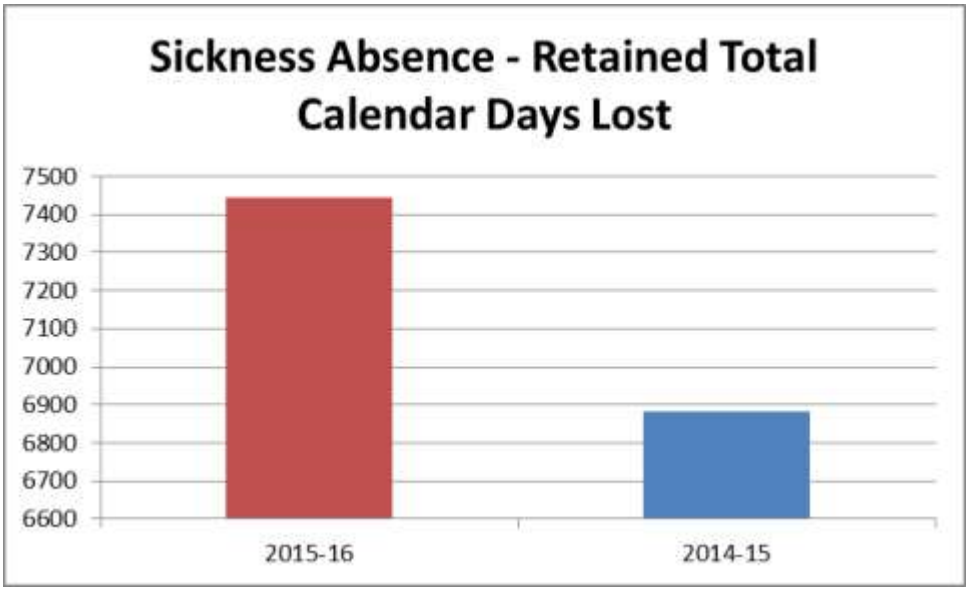
	Apr 2014 - Mar 2015	**Apr 2015 - Mar 2016**
Uniformed	320	57
Shift	2468	2295
Support	1192	1413



2.2 Retained

There has been a sharp increase in Retained absence.

Total Retained Days lost	
2015-16	7443
2014-15	6881



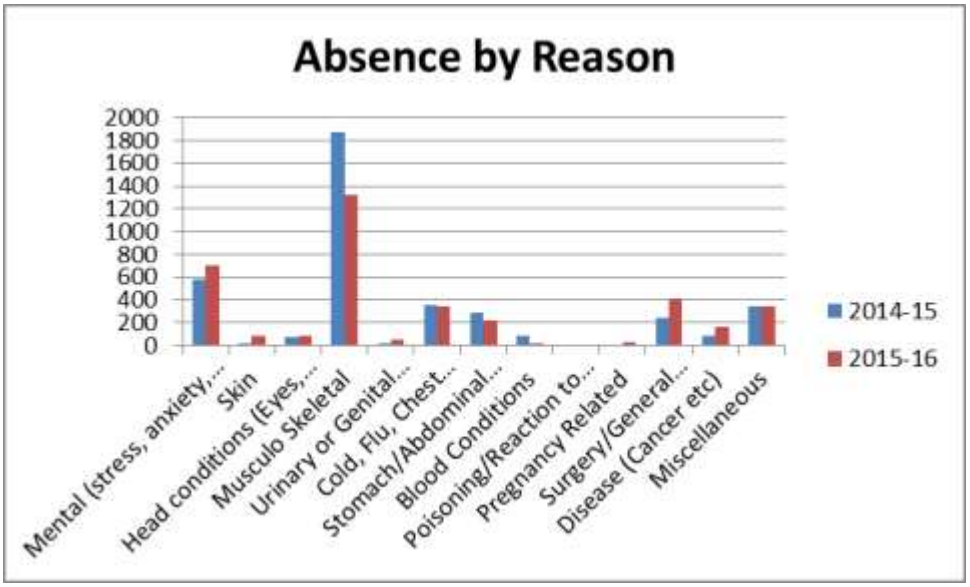
3. Causes of Sickness

Regular Management Information is provided by the HR department to Service Delivery Leads/Department Heads on a monthly basis via CMIT. This enables the Service to regularly and consistently monitor levels of sickness absence at individual, team and service levels. It also enables the Service to monitor the major causes of absence which are currently musculoskeletal issues and mental health problems (stress/anxiety/depression).

3.1 Uniformed, Shift, and Support

Whilst the Service has seen a sharp decrease in musculoskeletal related absence, it is still the highest contributor to absence. Mental health related problems remain the second highest reason for absence and this has increased year on year. Colds, flu and chest infections are the third highest contributor to absence; this is expected to some extent due to season trends (such as during winter and at the beginning of the schools' Autumn Term in September).

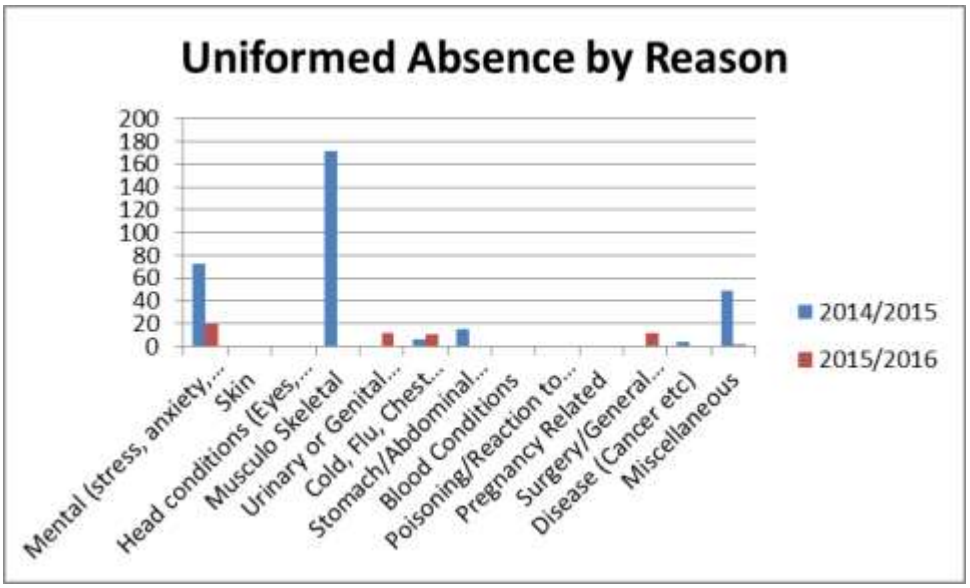
Although in a lower percentage increase, there have also been increases in cases of surgery and diseases such as cancer; there is far less preventative work the Service can do to try to prevent these occurrences.



The charts below also break down absence types by category of employee:

3.1.1 Uniformed

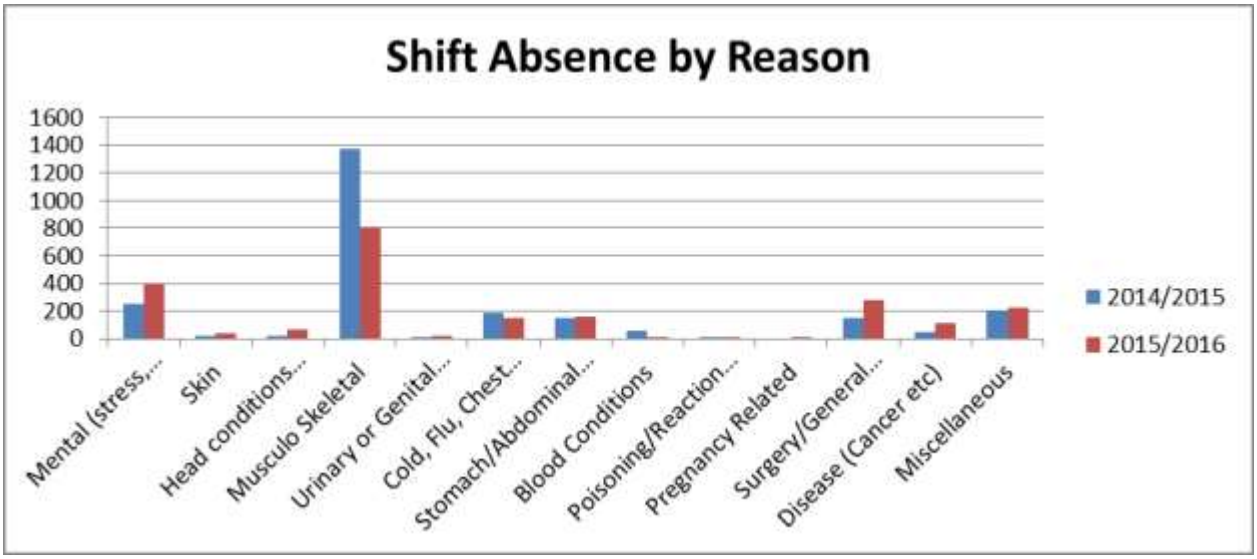
There has been a noticeable reduction in both musculoskeletal and mental health related absence in 2015-16 in comparison to the previous year. The highest increases are in urinary or genital related absences and surgery/general screening, however the number of shifts lost are not great (12 days each) therefore it is difficult to indicate any trends.



3.1.2 Shift

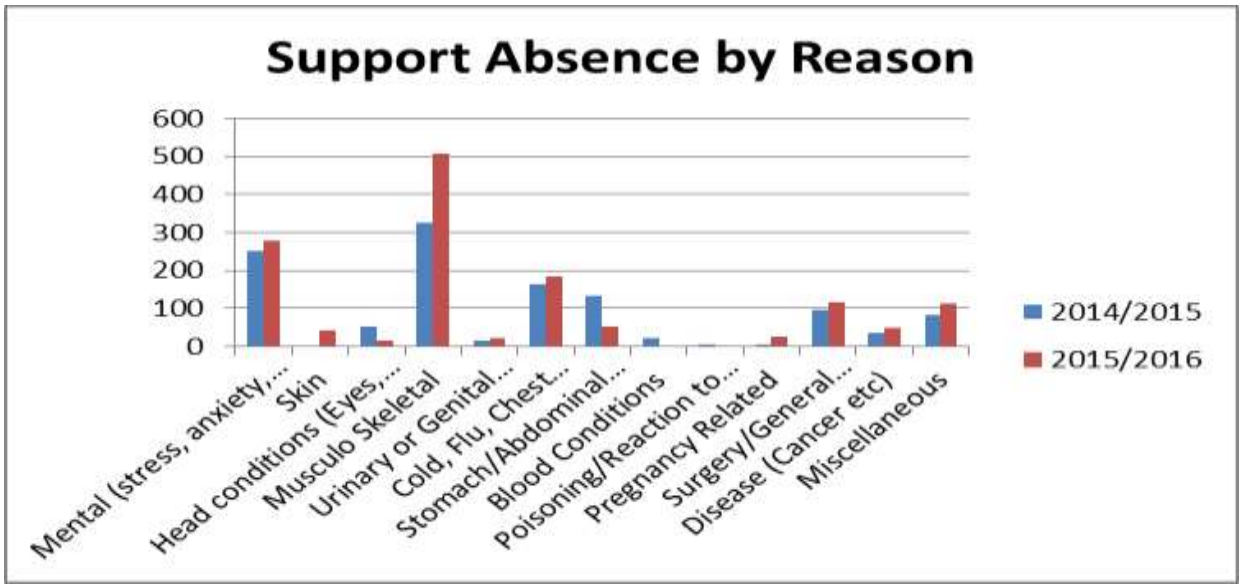
Pleasingly, there has been a sharp decrease in musculoskeletal absence (although this still accounts for the highest proportion of absence), as well as a decrease in colds, flus and chest infections, however there have been notable increases in mental health related absence,

surgery and general screening and diseases such as cancer. Whilst there is less preventative work the Service can undertake in relation to the latter two reasons, it is evident that further proactive intervention could be considered in relation to mental health.



3.1.3 Support

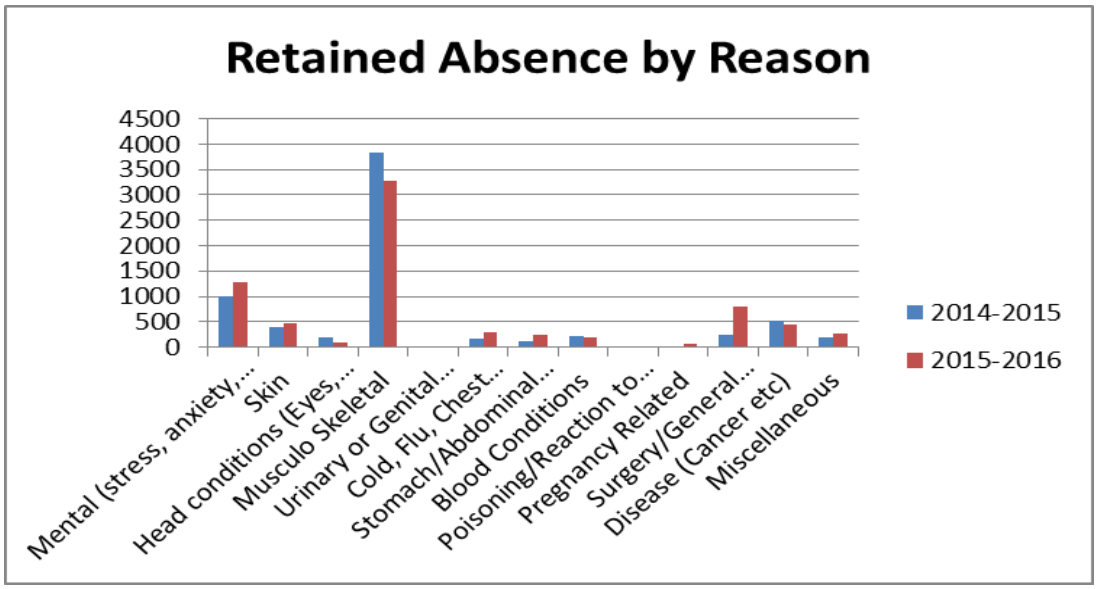
The most notable increase in absence is in relation to musculoskeletal conditions; however there has also been a slight increase in mental health related absence. With the exception of stomach and abdominal conditions, other increases and decreases within categories of absence have not been quite as pronounced in relation to the variance of days.



3.1.4 Retained

Similarly the main contributors to absence were mental health related absence and musculoskeletal absence. Whilst the Service has seen a slight reduction in musculoskeletal absence, it still accounts for 56% of absence overall. The Service has also seen similar

patterns in surgery/general screening and disease, although there has been a slight reduction in cancer within the Retained Duty System.



4. Long Term and Short Term Absences

Short term absence is defined as absences that are 1-27 days in duration and long term absence as 28 days or longer.

4.1 Uniformed, Shift and Support

In analysing which absences are short and which are long term, the proportion of short term and long term as part of overall absence has remained similar over the past 2 years at 51% absences being short term and 49% being long term in the current year compared with 48% and 52% the previous year. The Service has seen an increase in short term shift absence since the implementation of the new Crewing Policy in January 2016. This will continue to be monitored in the next quarter to better understand if there is a pattern.

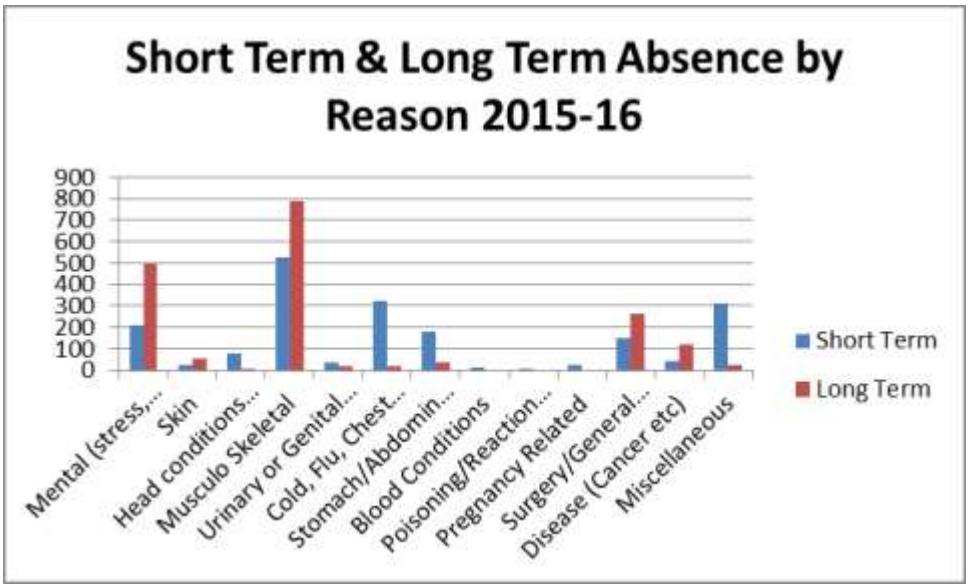
Short Term Days	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-16	151	73	130	146	146	200	170	158	105	219	225	211
2014-15	147	182	125	145	163	136	177	165	182	153	237	110

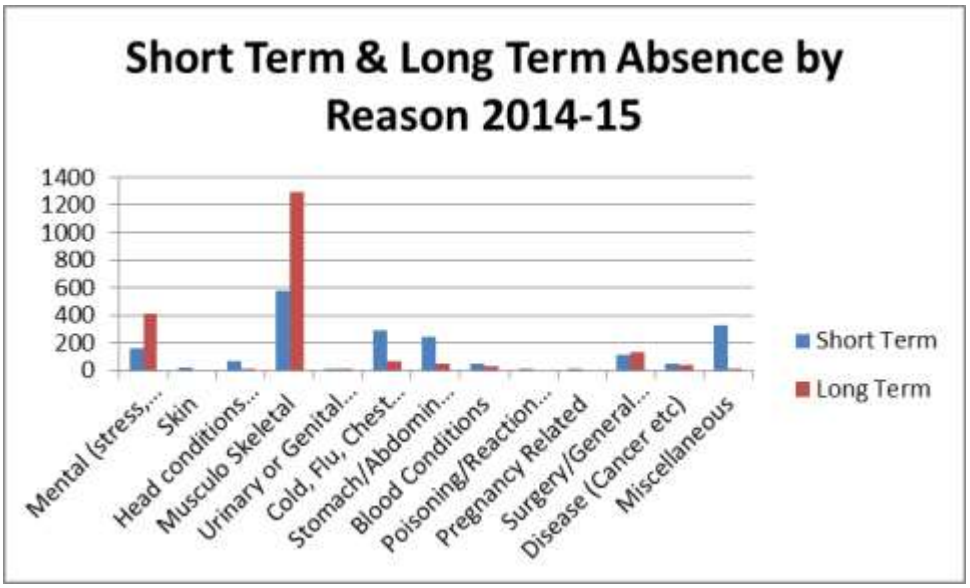
Long Term Days	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-16	100	85	88	199	185	189	151	154	165	108	196	211
2014-15	121	175	155	145	164	174	174	165	243	183	168	191


Short Term Shifts Lost
250
200
150
100
50
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
STShifts Lost 2014-15
ST Shifts Lost 2015-16


Long Term Shifts Lost
300
250
200
150
100
50
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
LT Shifts Lost 2014-15
LT Shifts Lost 2015-16

The chart below highlights that the categories with the highest long term sickness in 2015/16 are musculoskeletal absences, mental health and surgery/general screening. The greatest percentage decreases in absence overall have been blood conditions, stomach and abdominal conditions and musculoskeletal absences. Whilst musculoskeletal is the Service's highest contributor to absence, it has decreased from 1870 to 1318 shifts lost. Conversely, the Service has seen an increase in mental health related absence, which has increased from 575 to 704 shifts lost.



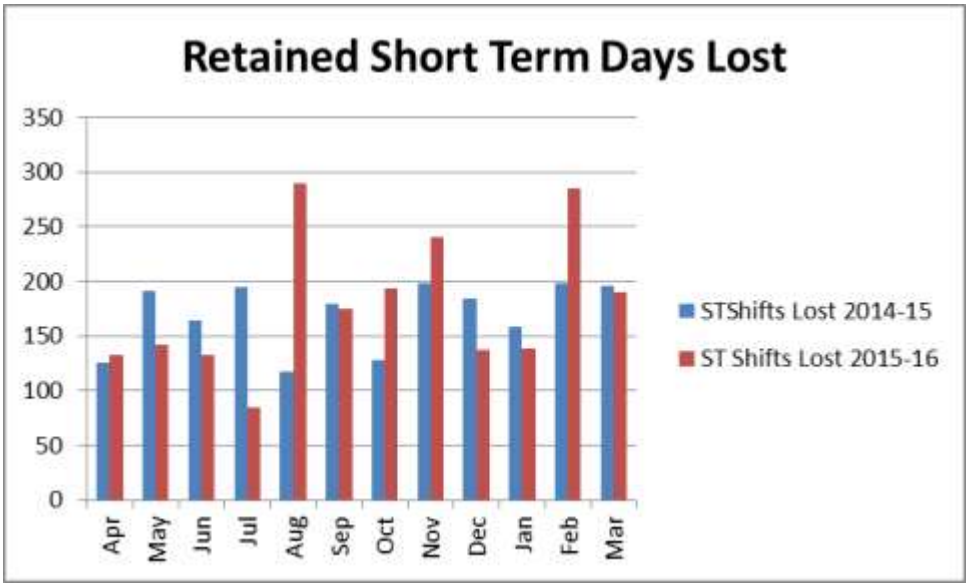


4.2 Retained

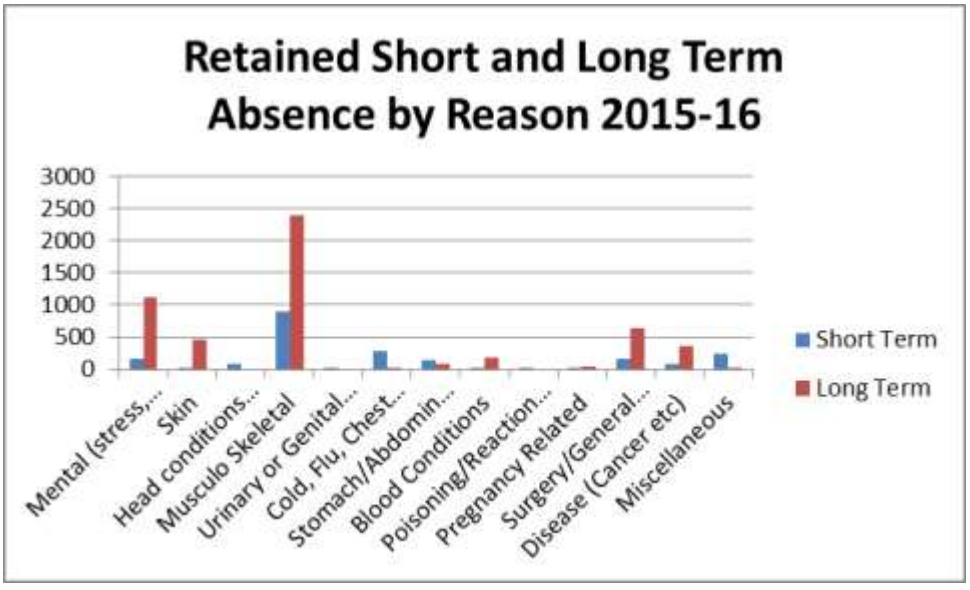
In analysing which absences are short term and long term (over 28 days), the proportion of both as part of overall absence has remained similar over the past 2 years at 29% absences being short term and 71% being long term in the current year compared with 30% and 70% the previous year.

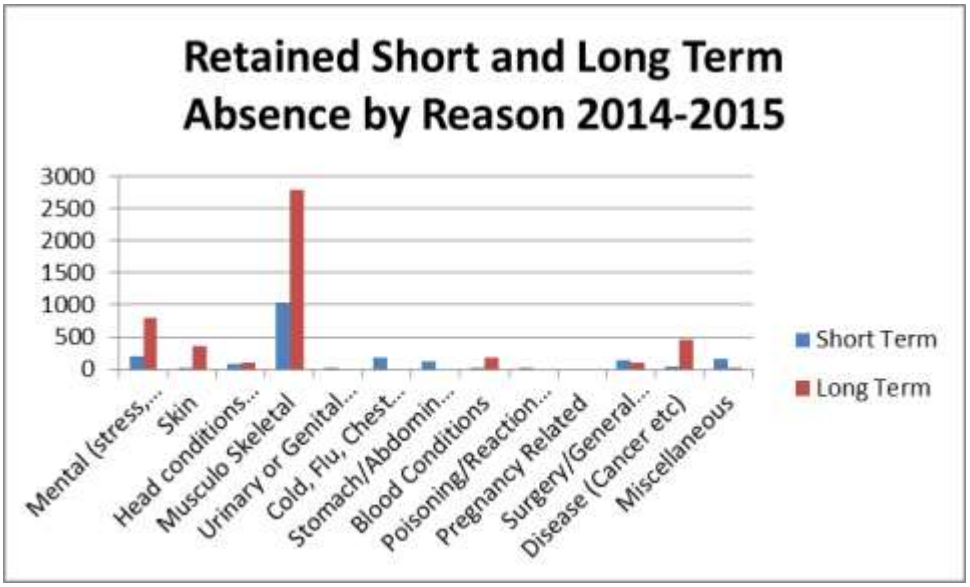
Short Term Days	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-16	132	142	133	85	290	175	193	240	137	139	285	190
2014-15	125	191	164	195	117	180	128	198	184	158	198	196

Long Term Days	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-16	493	475	488	484	460	488	528	426	335	328	291	506
2014-15	509	402	384	339	483	377	389	369	369	410	405	411



The chart below highlights that the categories with the highest long term sickness in 2015/16 are musculoskeletal absences, mental health and surgery/general screening. The greatest percentage decreases in absence overall have been head conditions, disease (cancer etc) and musculoskeletal absences. Whilst musculoskeletal is the Service's highest contributor to absence, it has decreased from 3841 to 3287 calendar days lost. Conversely, the Service has seen an increase in mental health related absence, which has increased from 1002 to 1227calendar days lost. The Service has also seen a sharp rise in surgery and general screening, which has increased from 245 to 801 calendar days lost.





5. Comparison with other Fire and Rescue Services

We are currently waiting to receive the annual data from the sickness absence survey collated by Cleveland Fire and Rescue Service.

Pleasingly, at the end of Q3 (December 2015) Staffordshire were in the bottom 7 of 31 Services that responded in relation to the percentage of total working days/shifts lost per Wholetime employee (FF to CFO). As the Service has recently seen higher levels of absence in the Shift category of worker, it is predicted that this percentage will be higher when the end of year figures are released. Support staff absence figures were also low; in the bottom 8 of 30 Services that responded with figures.

In relation to the number of shifts lost per person, Staffordshire was in the bottom 10 of 31 Services. The Service's 4.43 shifts per Wholetime Firefighter was lower than the national average of 5.27 shifts. For Support Staff, the average was 5.5 days, which is also lower than the national average of 6.45 shifts. Staffordshire are in the highest 5 Services within the UK in relation to shifts lost due to an on-duty injury (wholetime staff) and the highest 2 Services within the UK for retained days lost (out of 11 Services). Whilst this statistic is concerning, there are a low number of contributors including the fact that some staff have taken extended periods of sickness absence following their injury which has increased the Service's figures.

The Services' Retained absence is the highest of the respondees with 13.55 days per person, which sits far higher than the national average of 7.75. This may be due to the way we are calculating absence for Retained staff which could be overestimating absence, however we will continue to monitor our statistics against the national picture and look to learn from best practice.

6. Interventions in relation to sickness Absence

Early Interventions

A member of staff who reports sick with musculoskeletal or mental health reasons will be contacted by either the physio or the welfare advisor in Occupational Health to offer immediate support. 90 numbers of staff were contacted in this way during this period.

Return to Work Interviews

An important part of our actions in relation to reducing sickness absence is the effectiveness of the return to work (RTW) interview. This should not be a 'tick box' exercise but a supportive approach to identify if any support needs to be put in place to prevent reoccurrence of the absence. The HR team have included the purpose of return to work interviews in the training that they run for supervisory managers to further explain to managers the importance of the return to work interview.

HR have also improved the chasing of receipt of RTW forms and sickness documentation; absence management administration forms one of the primary tasks of the HR Apprentice and having this additional resource has allowed the team to be proactive in chasing outstanding documentation on a weekly basis. That said, on average, 3-5% of absence each month is unaccounted for (Miscellaneous category) meaning the documentation has not been received from the department or station. The Service would not expect the percentage to be so high as even if the employee were off on the last day of the month, payroll generally runs on or just after the 18th of each month, leaving over two clear weeks for the documentation to be sent to HR.

Review of Cases

In terms of the effective working between Occupational Health and HR the two teams held an away day in January to discuss communication and ways of working. As an outcome of this away day it was agreed to hold a quarterly case conference where long term cases are reviewed. In addition to this there is now a weekly meeting between one of the HR Business Partners and Occupational Health where cases are reviewed. Whilst this has only been recently implemented, early anecdotal feedback indicates this is proving effective as it makes better use of the time spent with the OH team to discuss cases and ensure cases are progressed without unnecessary delay.

7. Prevention activities

Health Heart Clinics

Between September 2015 and March 2016, 8 'Heart Health Clinics' were held around the county. These were aimed at, although not exclusive to, support staff and included measures of blood pressure, body composition, blood glucose and cholesterol, lung function where indicated (clinical history or operational exposure) and individual lifestyle advice.

A total of 64 people attended (67 total appointments including reviews), 12 of whom were operational staff. Of those seen 12% were advised to visit their GP due to either suspected hypertension or elevated blood lipids (glucose, cholesterol or both) and on follow up 8% of those referred had either had further tests or been prescribed medication. Approximately 20% of attendees fell outside of the 'healthy weight' category and also fell short of the recommended 150 minutes of cardiovascular exercise per week. However several were already engaged with various weight management initiatives.

Pedometer Challenge

November 2015 saw the start of a small 8 week team pedometer challenge designed to encourage staff to walk more – the goal being the recommended 10,000 steps a day for health. Fifteen teams and three individuals signed up, totalling 103 active participants (a further 50 pedometers were given out to individuals who chose not to sign up to the challenge

but wanted to engage). Research suggests that the average person walks between 3 – 4,000 steps per day with office workers often as low as 2,500.

Baseline data of 'usual activity' was collected for the first three days, then participants were actively encouraged to increase their step count based on their individual starting point. Ideas, motivation and support were provided via the team captains who were supported by the Health & Fitness Team. Despite initial enthusiasm, there was significant attrition which made data analysis and any outcome measures difficult, with only one team successfully completing the challenge and submitting a full data set. Pedometer inaccuracy, lack of motivation and interestingly the fact that 'the leading team' were perceived to be unbeatable was a barrier to many in continuing with the challenge. The data collected suggested that, other than the aforementioned team, average step count was between 4 – 5,500 steps per day and in line with UK data; being well below the suggested activity level for health. The 'leading team' were significantly higher, recording closer to a daily average of 8,000+ steps per day.

Epidemiological evidence suggests that the sedentary nature of modern life; where an unprecedented amount of people spend 70% of their waking hours seated is a real threat to health. Guidance from an expert group published in 2015 suggests that desk based workers should be encouraged to progress towards accumulating 2hrs/day of standing and light activity during working hours (Buckley, Hedge, Yates et al., 2015) alongside other health promotion activity. This is an area for further exploration.

Weight Management Clinics

Weight management advice and support is available from the Health and Fitness team for both support and operational staff. There has been a recent pilot of lunchtime weigh-ins and an associated take up of one to one appointments. This is an area with significant potential to impact upon individual health and wellbeing from both a physiological and psychological perspective.

Blue Light Pledge

The Service signed up to Mind's Blue Light Pledge on 1st November 2015. An action plan was produced as part of the pledge detailing how we as a Service will undertake to reduce stigma in relation to mental health and this action plan is monitored by the Wellbeing, Equality and Culture Steering Group. The actions include ways to share the personal stories of our staff and we have had a number of stories shared in Burning Issues which we hope will decrease stigma. The Service has been used by Mind as a case study for developing the Blue Light Pledge.

Mind training

One of the actions on our Blue Light Action plan was to provide training to managers on mental health to raise awareness and understanding of mental health within the workplace. Mind ran 4 workshops in December, February and March. Evaluation is currently being undertaken with a view to running further workshops in the next training year.

8. Future Activities

Blood Pressure (BP) Portals

Hypertension (high BP) affects approximately 1 in 4 people in the population and is unsurprisingly reflected as one of the most common issues highlighted through routine health and fitness assessing. Portals where a BP monitor, associated guidance, information and log sheets to enable individuals to track their own BP are proposed to be made available at every station and at HQ (July 2016). Such preventative activity is hoped not only to assist with early intervention and therefore a reduction of lost working time but also to enhance individual awareness of health and wellbeing.

Drop in Clinics

A rolling schedule of drop in clinics whereby support and operational staff have the opportunity to access individual lifestyle advice at a convenient location is scheduled to be piloted over the summer. A member of the Health and Fitness team will be accessible on station on at least one day a week to enable easier access to advice outside of the health and fitness assessing programme. It is hoped that early intervention and access to personal advice and guidance will assist in the reduction of not only sickness absence but also encourage a culture of lifelong health and wellbeing, rather than 'keeping fit for the job'. Such activities will become increasingly important in the context of an aging workforce.

Support Staff Activity

Given the sedentary nature of the majority of support staff roles, it is pertinent to consider innovative and novel ways of reducing time spent inactive. Recent research has focussed on the active promotion of standing/walking meetings, creating an environment which encourages standing and frequent short breaks from static positions as accepted norms. For example, software to help discourage lengthy periods of time focussed on computer work, breakout areas or small meeting rooms where standing pods are available and continuing to create a culture where staff feel empowered to do this have all been shown to increase measures of health and wellbeing and impact upon sickness absence.

Personal training Qualification

The Service is currently offering the opportunity for staff to enrol in a programme organised through the FBU which leads to a personal training qualification. The programme is a 15 month programme and will enable participants to qualify as a Level 3 Personal Trainer developing knowledge and understanding of anatomy, physiology, fitness and nutrition. We will ask that those who complete the programme act as a source of additional support regarding health and fitness in their team to support the work of the health and fitness team.

9. Conclusion

It is evident that the Service has some issues in relation to its levels of sickness absence which although reducing is still a significant cost both in financial terms and for the individuals and their colleagues. It will continue to work with our Occupational Health Unit to provide both an early intervention service to any employee that books sick with mental health or musculoskeletal absences as well as the self-referral or management referral routes.

The Service is continuing to undertake proactive work in the area of health and wellbeing and has developed a health and wellbeing strategy and action plan which addresses the key categories of sickness absence, namely mental health and musculoskeletal problems. It is important that the sickness data is regularly monitored and that both the Service as a whole and individual managers are proactive in absence management and prevention.

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