Reducing Sickness Absence – Evidence Review

Sickness absence in the NHS

In 2017 NHS Digital estimated that sickness absence costs £1.1bn a year although doctors are significantly less likely to take time off sick than comparable private sector workers (McKevitt, Morgan, Dundas, & Holland, 1997). Ritchie (Ritchie, Macdonald, Gilmour, & Murray, 1999) studied sickness absence in four NHS trusts. Ritchie found that almost 60% of staff had no spells of sickness absence over a year and almost 20% had only one spell of sickness absence. Women were more likely to have time off sick than men and full-time staff were more likely to be off sick than part-time staff. 71% of all absences were for less than a week. The main causes of sickness absence were: respiratory disorders, digestive disorders and musculoskeletal disorders. Wright (Wright, 1997) studied long-term sickness absence in an NHS teaching hospital and found that musculoskeletal problems – back pain in particular – were the main reasons for absence accounting for 30% of total days lost. A third of those with musculoskeletal problems and a quarter of those with mental illness attributed the reason for their absence to work. Delays in waiting for treatment and anxiety about returning to work prevented people from returning to work sooner – only a minority of staff had been to Occupational Health and referral was often delayed

What can be done about sickness absence?

Sickness absence is a complex inter-relationship between people's physical and psychological health and their work environment. There is no 'magic bullet' but there are ways that employers can make a difference. In the NHS Buckinghamshire Healthcare NHS Trust won a national award for excellence in employee health and wellbeing and Five Boroughs have reduced sickness absence by giving staff fast-track access to physiotherapy (see attached). Brown (Brown et al., 2015) looked into the effectiveness of the EASY (Early Access to Support for You) sickness absence service in Lanarkshire. The services supplements existing absence policies and enables telephone communication between the absentee, their line manager and the EASY service from the first day of absence and referral to occupational-health services at day ten. The service was effective in reducing sickness absence in Lanarkshire by 21% compared to a 9% reduction achieved by cracking down on sick leave in the rest of Scotland

Odeen (Odeen et al., 2013) carried out a systematic review of workplace interventions designed to reduce sickness absence. It found moderate evidence that graded activity reduced sickness absence and limited evidence that the Sheerbrooke model and cognitive behavioural therapy reduced sickness absence.

There was moderate evidence that workplace education and physical exercise did not reduce sickness absence

Occupational health has an important role to play (Taimela et al., 2008) and a structured early intervention with an occupational physician can reduce sickness-absence rates (Ijmert Kant, Jansen, van Amelsvoort, van Leusden, & Berkouwer, 2008). Effective initiatives have tried to improve people's self-efficacy and self-management (Linden, Muschalla, Hansmeier, & Sandner, 2014). Shaw (Shaw, Main, & Johnston, 2011) recommended giving questionnaires to people to assess their perspective of physical-job demands, client-centred interviewing to highlight individual return-to-work concerns, early discussion with people about possible job modifications and the incorporation of people's workplace concerns in progress reports and summaries while Kant (I. Kant, Jansen, Amelsvoort, Leusden, & Berkouwer, 2008) found that structured early consultation with an occupational physician reduced total sickness absence in employees at high risk of future long-term sickness absence. Ektor-Andersen (Ektor-Andersen, Ingvarsson, Kullendorff, & Orbaek, 2008) found that a cognitive-behavioural team-based, individually-geared, low-intensity rehabilitation programme was cost-effective at helping people back to work. Blake (Blake 2013) examined the effectiveness of a five-year-long workplace wellness intervention which included health campaigns, provision of facilities and health-promotion activities to encourage employees to make health lifestyle choices and sustained behaviour changes. She found that the initiative had led to 'significantly-lower' sickness absence. Svensson (Annemarie Lyng Svensson et al., 2009) looked into the effectiveness of a multi-dimensional programme combining physical training, patient-transfer technique and stress management on reducing sickness absence in nursing students. Svensson found that – compared to a control group – the students who had taken part in the programme had significantly less sickness absence. However a follow-up study found that there was no reduction in sickness absence after three years (A. L. Svensson, Marott, Suadicani, Mortensen, & Ebbehøj, 2011). Toppinen-Tanner (Toppinen-Tanner, Böckerman, Mutanen, Martimo, & Vuori, 2016) studied the effectiveness of a group intervention focusing on building up preparedness for career management. 684 people in 17 organisations took part in the study which found the intervention was effective in decreasing the number of longer sickness absences. Michie (Michie, Wren, & Williams, 2004) found that increasing cleaners' control over their work and giving them more support led to a significant reduction in sickness absence of 2.3% over six months and in a study of Japanese nurses Ida (Ida et al., 2009) found that enriching nurses' professional experience, raising their sense of coherence and improving the organisational environment could all reduce sickness absence. Bailey (Bailey, 1984) looked into the effectiveness of autogenic regulation training

in a study on student nurses. Bailey found that autogenic regulation training helped significantly to reduce overall sickness absence.

Generally speaking exercise therapy is not an effective way of reducing sickness absence (Brox & Frøystein, 2005) (Faas, van Eijk, Chavannes, & Gubbels, 1995) and a preventive coaching intervention was also found to be ineffective (Duijts, Kant, van den Brandt, & Swaen, 2008). Munir (Munir, Yarker, & Haslam, 2008) studied chronically-ill workers and found that attendance-management policies were unfavourable towards them focusing on attendance despite illness. Employees were more likely to turn up for work when feeling unwell to avoid a disciplinary situation but support was only provided once illness progressed to long-term sick leave

Factors affecting sickness absence

These can be divided into three:

- Individual – psychological
- Individual – physical
- Organisational

Individual psychological

These include:

- Finding meaning in one's work reduced sick leave (T. Clausen, Andersen, Christensen, & Lund, 2011)
- Enjoying one's job reduced sick leave (C. A. Roelen, Koopmans, Notenbomer, & Groothoff, 2011) (Munch-Hansen et al., 2009)
- Feeling respect from one's supervisor reduced sick leave (Schreuder 2011)
- Feeling respect from one's fellow workers reduced sick leave (Schreuder 2011)
- Mental-health problems (Lamont 2017)
- Using drugs to cope with a mental-health problem (Lamont 2017)
- Lower levels of self-efficacy (Labriola et al., 2007)
- Having psychosomatic complaints (Duijts, Kant, Swaen, van den Brandt, & Zeegers, 2007)
- Experiencing burnout (Duijts et al., 2007)
- High fear-avoidance beliefs increased sick leave (Jensen, Karpatschof, Labriola, & Albertsen, 2010)
- Using problem-solving coping and social coping reduced sick leave (J. A. H. Schreuder et al., 2011)

Individual Physical

These include:

- Being physically active outside work reduced sick leave (Fimland et al., 2013)
- Not having a physically-demanding job reduced sick leave (Fimland et al., 2013)
- Subjective health complaints (C. A. Roelen, Koopmans, & Groothoff, 2010)
- Fatigue (C. A. Roelen et al., 2010)
- Back Pain (Wright, 1997)
- Smoking (Schreuder 2011)
- Drinking (Vasse, Nijhuis, & Kok, 1998) – abstainers are most at risk, then heavy drinkers with moderate drinkers having fewer days off
- Neck Pain (Ariëns, Bongers, Hoogendoorn, van der Wal, & van Mechelen, 2002)
- Going to aerobics or the gym reduced sickness absence (Eriksen, Bruusgaard, & Knardahl, 2003)
- Obesity (Harvey et al., 2010) (Ferrie et al., 2007)
- Being off sick in the past (C. A. M. Roelen, Koopmans, Schreuder, Anema, & van der Beek, 2011)
- Being unfit (Rasmussen et al., 2015)
- Lacking muscle strength (Rasmussen et al., 2015)
- Lacking flexibility (Rasmussen et al., 2015)
- Disturbed sleep (Akerstedt, Kecklund, Alfredsson, & Selen, 2007)

Organisational factors

- Workplace bullying was the single most important factor (Kivimäki, Elovainio, & Vahtera, 2000) (Niedhammer, Chastang, Sultan-Taïeb, Vermeylen, & Parent-Thirion, 2013)
- Strategies and procedures for managing leadership – reduced absence (Stoetzer et al., 2014)
- Employee development – reduced absence (Stoetzer et al., 2014)
- Good communication – reduced absence (Stoetzer et al., 2014)
- Employee participation and involvement – reduced absence (Stoetzer et al., 2014)
- Having corporate values and visions – reduced absence (Stoetzer et al., 2014)
- Looking after employees' health – reduced absence (Stoetzer et al., 2014)

- Reorganisations – increased absence (Eriksson, Engstrom, Starrin, & Janson, 2011)
- Insecure social relations fraught with conflict – increased absence (Eriksson et al., 2011)
- Incompatible demands – increased absence (Eriksson et al., 2011)
- Lack of trust – increased absence (Eriksson et al., 2011)
- Presenteeism – increased absence (Janssens 2013)
- More frequent structural changes (Bernstrom 2015)
- High levels of collective efficacy – reduced absence (Jensen 2011)
- Teamwork – reduced absence (Kivimäki et al., 2001)
- Low decision authority (Ariëns et al., 2002)
- A perceived lack of an encouraging and supportive culture in the workplace (Eriksen et al., 2003)
- Working in psychiatric and paediatric wards (Eriksen et al., 2003)
- Lack of fairness at work (Duijts et al., 2007)
- Inspirational leadership – reduced absence (Nyberg, Westerlund, Magnusson Hanson, & Theorell, 2008)
- Autocratic leadership – increases sickness absence in men (Nyberg et al., 2008)
- A relationship-oriented leadership style is linked to lower sickness absence (Jolanda A. H. Schreuder et al., 2011)
- Being exposed to violence and bullying (Clausen, Hogh, & Borg, 2012)
- High psychological demands (Niedhammer et al., 2013)
- Discrimination (Niedhammer et al., 2013)
- Poor promotion prospects (Niedhammer et al., 2013)
- A tense and prejudiced organisational climate (Piirainen, Räsänen, & Kivimäki, 2003)
- Low role clarity (Väänänen et al., 2004)
- Low fairness in allocating work (Väänänen et al., 2004)

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