CASE STUDIES

WELLBEING IN HOME CARE (BELGIUM)

1. Organisations involved

Familiehulp

2. Description of the case

2.1. Introduction

Familiehulp is the biggest integrated service for home support in Flanders and Brussels. It is an autonomous non-profit organisation within the Christian employees' organisation ACW.[1] Familiehulp has 12,000 employees.

The organisation's core mission is providing family care involving personal care, housework and psychosocial support in emergency situations. These services include support with regard to the home, family and social network.

People can contact Familiehulp for various types of assistance, including family care, elderly care, cleaning services, maternity care, babysitter service, babysitter service for sick children, care for people with dementia, psychiatric home care, palliative care, chore assistance, transportation services, and the provision of hot meals. Furthermore, the organisation runs five crèches.

Pictures: Familiehulp provides various types of assistance, including family and elderly care

[1] ACW is the Christian Workers Movement, an umbrella organisation that includes the ACV trade union, the CM mutuality, organisations for youth, women and elderly, a holiday organisation and a service that provides care in the home. Its membership runs at over four million.

Familiehulp consists of three levels: the care regions, the interregions and the headquarters.

The care regions are responsible for:

- providing professional care and services for clients
- contributing to the development of quality care and services (networking, drafting the annual action plan, etc.).

The interregions are responsible for:

- guiding the care regions by providing expertise and support with regard to care and services
- supporting the care regions by providing expertise and support with regard to human resources
- administrative and financial management
- the link between care regions and headquarters in the development and implementation of policies.

Headquarters are responsible for:

- positioning the organisation in relation to the government, the healthcare sector, and privileged partners
- managing the development and implementation of policies
- submitting policy proposals to the board of directors.

For providers of home care, the continuity of care and a motivated staff are of great importance. However, this sector is often confronted with high levels of absenteeism, and employees within health care often have to deal with high levels of stress and physical strain.

The personnel policy of Familiehulp was initially very fragmented. The different regions were each responsible for their own personnel policies and hence also for the Wellbeing at Work policy (refer also to BOX). This resulted in a great variation in approach between the regions.

In 2005, the support services were made more centralised so as to achieve a clear policy covering the different regions, including the establishment of a uniform policy of Wellbeing at Work. One of the first actions within this new approach was the systematic recording and processing of absenteeism. The goal was to draw up a balance sheet and to determine the situation with regard to absenteeism in the organisation: according to age, region, function, etc. From this analysis of the figures it was evident that short-term absenteeism in particular was much higher than in other organisations.

Wellbeing at Work in Belgium

In Belgium, Wellbeing at Work ('Welzijn op het werk' in Dutch, 'Bien-être au travail' in French) is actually conceived and defined by the Act of 4 August 1996, which transposes the Framework Council Directive 89/391/EEC of 12 June 1989 into Belgian law. This Act is literally named the 'Act on Wellbeing of Workers in the performance of their Work'. It defines Wellbeing at Work as "the entirety of factors regarding the circumstances under which work is carried out" (art. 3, §1, 1°). In order to strive for Wellbeing at Work, measures need to be taken in seven specific domains:

- 1° work safety
- 2° protecting workers' health at work
- 3° psychosocial load caused by work, including violence, harassment and sexual harassment at work
- 4° ergonomics
- 5° work hygiene
- 6° embellishing the workplaces
- 7° the enterprise's measures regarding the natural environment, relating to their influence on points 1° to 6°.

The Wellbeing at Work Act defines that a stepwise approach should be taken towards risk management and healthier workplaces, based on the Deming cycle (PDCA: Plan-Do-Check-Act)[2]. In deliberation with the members of the hierarchical line and the Services for Prevention and Protection at Work, employers have to draw up an overall prevention plan for a term of five years, during which the preventive activities to be developed and implemented are programmed. Based on this written prevention plan, an annual action plan needs to be put in writing in order to promote Wellbeing at

[2] http://www.balancedscorecard.org/TheDemingCycle/tabid/112/Default.aspx

Work during the following accounting year.

2.2. Aims

It is generally accepted that absence is an indicator of wellbeing in an organisation. It can be seen as an expression of general dissatisfaction, poor policy or poor working conditions. In order to tackle the high absence rates, the organisation decided to implement an absenteeism policy, fully integrated into the overall Wellbeing at Work policy.

Familiehulp therefore started the project 'Ik wil er wel-zijn' (the Dutch name is a play on words, as it can mean either 'I want to be there' or 'I want wellbeing'). This project was carried out with the support of the European Social Fund (ESF). The ultimate goal for Familiehulp in using this approach was to ensure that employees feel good at work and to increase their wellbeing. This would eventually lead to lower absenteeism rates.

The starting-points were as follows:

- the decision-making latitude for 'grey absenteeism'[3] can be influenced by reducing the need for absenteeism (the subjective need to take time off work) and the opportunity for absenteeism (the arrangements in the organisation for absenteeism); and
- preventive action relating to workload and stress can ensure a better balance between capacity and workload, and in some cases this can prevent illness and thus improve staff wellbeing.

In order to achieve the above objectives, several actions were taken, including:

- bringing about a change in the manner of dealing with frequent sick leave
- designing tasks in order to reduce the workload of front line workers
- training supervisors.

All these actions were performed in several phases.

2.3. What was done, and how?

Measurement is knowledge

In the first phase (2007-2008), absenteeism data for the entire organisation were recorded and analysed in order to discern the causes of the high rate of sick leave. In addition, a survey was carried out of 400 employees (front line workers and white-collar workers), trying to find out more about the underlying reasons of absenteeism. These actions revealed two important demands: firstly, the demand for decreased workload and stress, and secondly, the demand for more contact with supervisors.

[3] In 'white absenteeism', the reason for not showing up at the workplace is perfectly legitimate (people are really sick and not able to work for various reasons). In contrast, 'black absenteeism' occurs when the person involved is not sick at all (and might even be working somewhere else, fixing up his house or taking a vacation). The person involved is thus actually committing fraud. The area in between white and black absenteeism is known as 'grey absenteeism' and represents the biggest percentage of workplace absenteeism. (Taken from: Hesseling & Partners, http://www.hesseling-partners.nl/english/reducing-workplace-absenteeism.htm)

An anonymous email address was created for employees to submit suggestions and solutions.

This phase of the project resulted in a vision text on sick leave and wellbeing, and a number of concrete proposals for dealing with short-term sick leave at Familiehulp.

Reduction of workload for front line workers

The above experiments were part of the first pillar on which the ESF project 'Ik wil er wel-zijn' rests: actions that lead to a positive approach of sick leave in which involvement of the supervisor was made central and employees feel trusted.

The second pillar of the project was the preventive/proactive approach, based on the idea that an increase of the staff wellbeing will eventually result in a decrease of absenteeism. A good match between the workload and the capacity of personnel can make this possible. A project team was set up for this purpose. This team consisted of front line workers, supervisors, executives, a health and safety adviser (prevention adviser) and an external consultant with expertise in work assessment and ergonomics. The project team came up with a number of practical proposals for reducing workload. They also developed a tool for achieving a better balance between workload (specific to the situation with the client) and work capacity (specific to the employee): the 'TOM' score. 'TOM' stands for the Dutch for 'customised tasks'.

The TOM tool takes a 'basic snapshot' of the workload for a front line worker in a specific client situation. Through the completion of a questionnaire and task sheet for each client situation, a score is arrived at. This composite score consists of five key numbers, each referring to a particular type of load:

- Physical load: the extent to which aspects specific to the client's situation have a physical influence.
- Psychosocial load: the extent to which aspects specific to the client's situation have a motivational and emotional influence.
- Organisational load: the extent to which aspects specific to the client's situation and connected with the organisation of work, create workload.
- Load due to working conditions: unhygienic, unsafe and/or uncomfortable working conditions.
- Load due to time pressure: the extent to which the relationship between tasks and time is properly balanced.

This TOM score is entered for each client situation (e.g. as an additional step when starting in a new client situation) and can be used in different ways to better align work capacity and workload.

The tool has the following possible applications:

- preventively, during preparation of the work schedule: for example by ensuring that not all client situations with a high score for 'psychosocial load' are allocated to the same care worker
- when work capacity is temporarily or permanently reduced: the tool offers the possibility of adjusting the schedule or excluding certain tasks for certain workers (for example, in the context of reintegration programmes for employees who have been off work, retention, age-conscious personnel policy, etc.)
- when increased workload is reported: causes can be detected using this tool and 'alarming' situations can be detected and addressed.

Positive approach of sick leave

In 2009, the comprehensive absenteeism policy began to be developed.

A number of experiments were set up within different care regions: continuity discussions, direct sickness reporting to supervisors, a sworn declaration for a single day of sick leave instead of a doctor's note and cessation of the system of examining doctors. More importantly, in this stage of development ways were sought of identifying and reducing the workload for front line personnel. For this purpose the 'TOM' tool (see below) was developed in order to achieve a better match between a worker's capacity and the workload created by specific client situations.

Continuity discussions

The first action to improve staff wellbeing at work relates to continuity discussions, and has been applied in all care regions. The name refers to the objective of the discussion, which is to ensure 'continuity of care and service'. During the discussions, the supervisor and employee search together in an atmosphere of trust for solutions that ensure a better balance between capacity and workload. The contents of the discussion vary according to the situation, but the discussion must lead to agreements, actions, plans, etc.

Implementation of new procedures

Next to the continuity discussions, some new procedures were implemented and tested:

- *Direct sickness reporting:* In one of Familiehulp's eighteen care regions (Care Region A), an experiment was conducted for one year (from 1 January 2010 to 31 December 2010) to determine whether a system of direct sickness reporting would also have a positive effect on attendance levels at Familiehulp. However, the experiment did not involve full direct reporting of sickness to the supervisor; this is because the person on duty (i.e. reception) needs to be informed first, since in the event of sickness they alert the clients and arrange any replacements. In the experiment, the employee continued to phone the person on duty, who made a note of the necessary information and then put the employee through to the sector leader's mobile phone.
- *Sworn declaration for a single day of sick leave:* In 2010, the employees in one of the care regions (care region B) were no longer asked to provide a doctor's certificate for a single day of sick leave, but to fill out a 'sworn declaration'. For the employees, this was a sign of being trusted, and it also had the added benefit of lower doctor's costs.
- *Cessation of the system of examining doctors:* In the literature there are both proponents and opponents of a system of examining doctors. The cessation of the system of examining doctors is consistent with the 'Ik wil er wel-zijn' project, since Familiehulp wishes to make trust and involvement of the supervisor central, and examining doctors do not fit with a positive approach to sick leave.

2.4. What was achieved?

The different actions and experiments within the project 'Ik wil er wel-zijn' were carefully tested and evaluated.

Since 2009, the above-described *continuity discussions* have been held throughout the whole organisation. The records show that in 2009 approximately 6% of employees (the main groups are caregivers, home helpers and service voucher workers) took part in a continuity discussion. In 2010, this percentage rose to about 10%. The effect of the continuity discussions is analysed at two levels. Firstly, there is the direct effect ("Do these discussions lead to a behavioural change in the workers concerned?"); secondly, there is the indirect effect on the entire group of workers, including those who were not involved in any continuity discussion. The continuity discussion proved very effective in reducing the amount of short-term sick leave. Furthermore, employees are positive towards these interviews because they have the chance to collaborate with the supervisor in searching solutions for

underlying issues. To improve the quality of the continuity discussions, training for supervisors was set up. At first, during the continuity conversations, supervisors failed to go beyond the level of an absence conversation. Training was therefore necessary to teach supervisor not to end the conversation after the reasons for absences were identified. The final goal of the conversation lies indeed in searching individual and collective prevention measures to promote the wellbeing in the organisation.

The evaluation of the newly implemented procedures lead to the following conclusions:

- Direct sickness reporting: An evaluation of the new approach showed that the experiment with direct sickness reporting in Care Region A did not lead to a decrease in sick leave. Moreover, the records and discussions afterwards show that the effort and cost of this system are not proportionate to the result.
- Sworn declaration for a single day of sick leave: The results after the evaluation period were not conclusive. Additional research is required to provide certainty about these results and to gain a better understanding of the effect on the organisation and the cost of sick leave.
- Cessation of the examining doctor system: On the basis of this experiment it can be said that the system of having an examining doctor costs more than it yields. The indirect (threshold-raising) effect in this experiment is difficult to determine, given the strong differences in the number of continuity discussions conducted.

The *TOM tool*, which was developed to achieve a reduction in the physical and psychosocial workload of front line workers, has already been tested twice by a group of sector leaders. The tool is currently being further refined and adjusted. The greatest strength of this tool is the fact that it gives insight into an employee's work content, conditions and balance, and brings to light opportunities for making improvements. This is not easy in home care situations, since there is an ever-changing work environment for each client.

On the basis of these evaluations, it was decided to carry on with the continuity discussions, the TOM tool and the cessation of the examining doctor system. It can reasonably be concluded that the project 'Ik wil er wel-zijn', with its different actions to tackle sick leave and promote wellbeing, was successful. The different project steps and actions are all included in the overall prevention plan (2010-2014) and the subsequent annual action plans (based on this overall prevention plan, refer to BOX above), and as such fully embedded in the organisation's wellbeing at work policy. The overall action plan sets out different goals, which are translated into specific objectives to be achieved in the period 2010-2014. Three of these goals are directly linked to the project 'Ik wil er wel-zijn', namely: 'Encouraging and facilitating safe behaviour of each employee', 'Paying continuous attention to the health of employees', and 'Each employee is entitled to a safe workplace'. Further promoting the continuity conversations and improving and consolidating the TOM system, are important steps in reaching these goals.

Next to a positive evaluation of the project in terms of staff wellbeing, the cost of sick leave in 2010 was estimated EUR 1.3 million euros less than it would have been if the absenteeism rate had remained the same as in 2008 and 2009.

2.5. Success factors

- Initially, within the large organisation of Familiehulp, a great variation existed between the personnel and wellbeing at work policies and approaches of the different care regions. In 2005, the support services were further centralised in order to achieve a uniform approach - also at the level of wellbeing at work.

- A systematic recording and processing of sick leave enabled to draw up a balance sheet and to determine the situation with regard to absenteeism in the organisation. These data formed the basis of a business case and the start of the ESF project 'Ik wil er wel-zijn'.
- The initial assessment revealed two important demands from the front line workers: firstly, the demand for decreased workload and stress, and secondly the demand for more contact with supervisors. The organisation opted to approach sick leave in a positive way, with a key role for the supervisor and by building trust in teams and workplaces.
- The project led to several experiments in different care regions, enabling thorough comparisons and evaluations. The successful experiments were continued and implemented in the rest of the organisation; other actions with poorer results were ended. In some of the project actions, Familiehulp used the support of external experts.
- A project team, consisting of front line workers, supervisors, executives, a health and safety adviser (prevention adviser) and an external consultant, was set up in order to investigate how to achieve a better match between the physical and psychosocial workload and the capacity of personnel.
- The project steps and actions are part of a broader perspective of wellbeing at work, and therefore included in the overall prevention plan (2010-2014) and the subsequent annual action plans.

2.6. Further information

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2.7. Transferability

The successful project will now be further disseminated throughout the entire organisation. In addition, new experiments will be set up to further evaluate the unconfirmed projects.

The Flemish/Belgian care sector is showing considerable interest in this theme, and the organisation receives frequent requests to present its approach and results at various forums.

Familiehulp's approach in placing sick leave within the broader perspective of wellbeing at work therefore seems to be a message which may prove useful in different care settings, and also in other sectors.

3. References, resources:

Familiehulp, http://www.ikwilerwel-zijn.be/ (Project website in Dutch)

Familiehulp, http://www.familiehulp.be (Homepage)