RAPID ACCESS TO TREATMENT AND REHABILITATION FOR NHS STAFF
INTRODUCTION

Rapid access is a system which will secure rehabilitation and occupational health treatment for NHS employees with a view to facilitating a return to work which is, as fast as practical, and reasonable. This will benefit the employee, the employer and patients.

This guide is intended for trust boards making decisions about how to manage rapid access services for staff in their organisation. It supports the core services set out in the NHS Health and Wellbeing Improvement Framework (2011) which emphasised the importance of:

— Timely intervention – easy and early treatment for the main causes of sickness absence in the NHS
— Rehabilitation – to help staff stay in work during illness or return to work after illness

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<tr>
<th>Rapid access is an efficient scheme which will:</th>
<th>Rapid access is not:</th>
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<td>— contribute to substantial savings for the NHS</td>
<td>— prioritising the health needs of NHS staff to the detriment of other patients.</td>
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<tr>
<td>— lead to a more consistent and healthy workforce, resulting in better patient care</td>
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<td>— reduce pressures on colleagues resulting from sickness absence including likelihood of reduced morale.</td>
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ORGANISATIONAL BENEFITS

Organisations that have implemented a rapid access scheme have reported the following benefits:

— Reductions in levels of sickness absence delivering savings on sickness costs and contributing to meeting national targets
— Considerable reductions in agency staff costs
— Improved staff satisfaction scores on the annual staff survey
— Improved satisfaction scores on annual patient survey.
IMPACT ON SICKNESS ABSENCE OF IMPLEMENTING RAPID ACCESS

The benefits of managing the treatment and rehabilitation of staff on sick leave can be considerable as the basic costs of sickness absence include:

— Payment to the individual while they are on sick leave (frequently full salary during the first six months of leave)
— Replacement costs for agency or bank staff
— Indirect costs such as increased pressure on colleagues
— Potential adverse impact on productivity and continuity of care from use of bank or agency staff
— Resourcing management costs.

Sickness absence also has a serious impact on employees, including:

— Adults that have been off work for long periods have a high prevalence of depression and anxiety irrespective of the initial cause of absence
— Depression and anxiety set in as early as six weeks after first becoming sick and is often the cause of extended sickness absence
— With back pain, the likelihood of return to work reduces as absence continues
— Children of households where a parent is not at work also have poorer health outcomes, thus long term absenteeism has a broader impact on public health.

SUPPORTING EVIDENCE

Alongside the results of existing schemes there is strong academic evidence that a facilitated return to work is a positive move. Some examples are noted below.

Getting back to work, a 2002 report from the Association of British Insurers and the Trades Union Congress concluded that medical recovery can be accelerated and enhanced by an assisted return to the workplace. It also states that successful rehabilitation improves long term prospects in terms of physical and mental wellbeing, quality of life, employment and reintegration back into working life. The report highlights an organisation where number of days lost to musculoskeletal disorders reduced by 47% after introducing a fortnightly on-site physiotherapy clinic.

In 2003 the Public Accounts Committee recommended that healthcare professionals on sick leave should be given rapid access to treatment and rehabilitation. Healthy staff, better care for patients – the realignment of occupational health services to the NHS in England sets out a challenge to the NHS to act on that recommendation in order to reduce physical pressures on frontline workers and financial pressures on NHS organisations.
Dame Carol Black’s report, *Working for a Healthier Tomorrow*, highlights the adverse effects of lengthy absenteeism on health and wellbeing ranging from the cost of absence to the effect on children of those on sick leave. It emphasises the importance of the workplace as a forum for improving wellbeing and advocates the introduction of services that facilitate earlier return to work.

This early intervention approach was echoed in the *NHS Health and Wellbeing Review (Boorman review)* in November 2009.

Boorman recognised that common health conditions such as musculoskeletal disorders and mental health conditions are responsive to early, effective intervention, enabling staff to return to work quickly and benefiting the individual, the trust and patient care. Boorman recommended nationally agreed service standards for early intervention.

A report entitled *Is work good for your health and wellbeing?* (Gordon Waddell, A Kim Burton TSO 2006) pulls together a huge amount of research showing the benefits of being in work rather than at home during musculoskeletal and cardio-respiratory rehabilitation periods in situations where this is possible. The benefits of supported employment programmes for those with mental health problems are also highlighted.

The British Society of Rehabilitation Medicine report (*Vocational Rehabilitation*) concludes that early, focused management and an earlier return to work will improve the quality of life for those with a disability due to illness or injury. It advises that there is a window of opportunity while people still see themselves as ‘sick’ and able to return to work, before they see themselves as ‘disabled’ and unable to return.

*Job retention and vocational rehabilitation: development and evaluation of a conceptual framework* (James et al. 2002, 2003) found that a proactive approach to facilitating the early return to work and continued employment of ill and injured workers had benefits for individuals and organisations. They cite that when off for 4-12 weeks an employee has a 10-40% risk of still being off after one year, and after that it is unlikely they will ever return to work. They also claim that a successful return to work increases by 35% for those offered reasonable adjustments, with subsequent absence periods for these employees reducing by 71%.

**WHAT SHOULD EMPLOYERS DO?**

Annex Z of the NHS staff handbook recommends that in order to avoid premature and unnecessary ill health retirement, employers should consider the following interventions as early as possible, and at the latest, within one month of an employee taking sick leave:

1 **Rehabilitation** – identifying appropriate ways of supporting staff to remain in work or return to work at the earliest opportunity through interventions with appropriate treatment. This will mean providing staff with direct access through appropriate dedicated resources such as physiotherapy and cognitive behavioural therapy.
2 **Phased return** – enabling staff to work towards fulfilling all their duties and responsibilities within a defined and appropriate time period, through interim flexible working arrangements.

3 **Redeployment** – enabling the retention of staff unable to do their own job through ill health or injury as an alternative to ill health retirement or termination. Staff should be made aware of the provisions within the NHS pension scheme to assist this process through “step down and wind down” arrangements. These are available on the NHS Pensions website at [http://www.nhsbsa.nhs.uk/pensions](http://www.nhsbsa.nhs.uk/pensions)

Rapid access is an approach which can be used alongside each of the above interventions. It is a proactive response by the organisation to the issue of sickness absence and recognises the importance of facilitating a rapid return to work for the benefit of the patient, the organisation and the health of the individual. By implementing rapid access, the organisation selects a series of interventions that it will offer to staff, for example access to physiotherapy services or counselling services. The selection of the services offered will depend on the assessed health needs in the organisation.

### IMPLEMENTATION MODELS FOR RAPID ACCESS

There are three common rapid access models in operation:

1. Providing access to bought-in rehabilitation services which will return frontline staff to work sooner than waiting for appointments in-house.

2. Expanding or investing in rehabilitation services within occupational health units to provide dedicated services for staff when the need is identified by the employee’s GP or by referral to the occupational health service or by NHS staff referring themselves.

3. GP makes a referral to the trust and rapid access is applied to both outpatient appointments and hospital admissions for treatment. This does not necessarily entitle staff to preferential appointments or include private facilities and treatment.

Implementation of rapid access for staff will depend upon which model is chosen but all plans should begin with agreement of an organisational approach at board level and the development of a policy to reflect this.

### WHO TO INVOLVE IN DEVELOPING THE POLICY

Boards should involve staff side in the development of the rapid access policy to ensure staff engagement and involvement from the start. Those involved in implementing a rapid access approach should also be included at this stage. Representation and input should be sought from line managers, occupational health, human resources and where possible GPs.

1. Best Practice in rehabilitating employees following absence due to work related stress (2003), IES/HSE research report 138.
POLICY

Developing a rapid access policy is a vital first step in the implementation phase. Research carried out by HSE\(^1\) sets out current good practice that can be applied to every stage of an employee’s rehabilitation and return to work following illness:

— Early contact with the employee
— Early health assessment
— Quality of the health assessment
— Development of an agreed rehabilitation plan
— Availability of therapeutic intervention
— Flexible return to work options
— Work adaptations and adjustments.

All these should be considered when developing the policy.

Examples of rapid access policies can be found on the [NHSE website](http://www.nhse.co.uk), however as a minimum, the policy should include the following areas:

— How and when rapid access should be considered
— Referral routes
— Roles and responsibilities of those involved in the process
— Development of a case plan that reflects the needs and responsibilities of all concerned including:
  — line manager
  — employee
  — occupational health
  — human resources.
— Processes available to facilitate return to work, including:
  — rehabilitation
  — redeployment.

Research collated as part of the Dame Carol Black’s review suggests that successful rapid access scheme policies set out what the principle is for adopting this approach and may include statements such as:

— Staff health is an organisational priority
— It is one of the ways in which the organisation is working to ensure it has a workforce that is fit and able to meet the challenge of delivering healthcare to patients
— This approach may include employees gaining more immediate access to health services provided by the trust and being facilitated back more quickly. This in turn will benefit the staff, the organisation and patients.

Once the policy has been agreed, those involved in its implementation should be made aware of their responsibilities and a communications plan developed to ensure that all staff are aware of the policy.
IMPLEMENTING THE POLICY

Roles involved in implementation
Occupational health will most probably take the lead in implementing this process and providing links to all of the others involved in developing the care plan and taking it forward.

They should develop a good working relationship with the employee’s GP to ensure that they are kept up to date with what is happening to their patient. The same applies to the relationship with the line manager who will have an important role to play in the rehabilitation. The human resources team needs to be aware of progress and should provide advice on any HR policies that may impact on the process.

Where an employee is on paid absence from work through illness, it is important that reasonable contact with the trust is maintained, via the line manager, and that the employee is contactable and able to keep any reasonable appointments offered. A decision about the frequency of this contact will be dependent on the individual case and should take into account the views of the individual and the needs of organisation.

Policies and care plans need to reflect these responsibilities and all parties need to be aware of the expectations placed upon them.

Referral
Employees may refer themselves (self referral), or be referred by their manager or GP. There is demonstrable evidence that the facility to self refer, for example to physiotherapy, is the quickest and most effective way to support employees back to work and in some cases avoid staff absence altogether.

Decisions about rapid access should be made by the receiving healthcare professional, as set out in the policy. This decision should be made after an assessment of the individual case by the healthcare professional. Examples of assessment processes and criteria are available on www.nhsemployers.org. Consideration should to be given to whether the employee is absent from work due to the illness or injury, and how contact will be maintained with them throughout the process.

All parties involved should be clear that the process does not necessarily mean immediate access to services but is intended to produce a care plan that will bring about a speedier return to work.

Following referral and assessment, if the case is viewed as appropriate for rapid access a care plan should be developed.

Developing the care plan
The care plan should be developed with input from all parties. It is a tool that records the outcome of the care planning discussion between the employee and their healthcare professional. This plan contains all the information needed to manage the care of the employee.

It is particularly important that line managers are engaged early in the process. They need to understand and respect the need for the employee to return to work as soon as practical and that this may mean that adjustments need to be made in working patterns or in the work itself.
Human resources teams may need to consider how they manage issues such as pay when employees are being rehabilitated back into work. More information about this can be found in the return to work section below.

The healthcare practitioner is most likely to facilitate the development of the care plans. They should facilitate the planning with support, guidance and resources.

A plan would contain information on the individuals concerns, their well-being needs, actions, goals, any support organisations and any specific needs they may have.

Developing a care plan involves discussion, negotiation, decision-making, and review.

More information on care planning can be found on the [NHS Employers website](https://www.nhsemployers.org).

**Case Studies**

**Southampton University Hospitals**

The occupational health and human resources teams at Southampton University Hospitals NHS Trust won an award for *Excellence in improving employee health and wellbeing* at the Health Care People Management Association for their Return2Health (R2H) scheme which offers employees a tailored package of care from treatment and personal consultation through to follow-up and continued support.

The project has helped to minimise the adverse effects of long-term sickness absence on both staff health and wellbeing and on finances. It creates a personal service where employees feel cared for, with realistic personal goals. In receiving dedicated support and advice, employees feel empowered to overcome the hurdles in front of them to recover quickly and return to work sooner.

Benefits to the organisation can be seen in the reduction of the overall absence rate, from 4.1% to 3.1%, and in the reduction in agency costs by 26%. Alongside this improved staff satisfaction, as reported in the NHS Annual Staff Survey, and a similar improvement in patient satisfaction, indicated by the patient survey.

**West Suffolk Hospital**

In December 2009, West Suffolk Hospital occupational health service was successful in achieving approval for part-time (0.6 WRE) physiotherapist dedicated to providing a service for members of staff only. The physiotherapist treats referrals from GPs and out patients department as well as the occupational health department.

Referrals have risen from 96 in the first year to 279 in the year ending 31 March 2011, whilst days lost have fallen from 2051 to 944, and the service is now preparing a business case to increase the physiotherapy post to full time. The business case will use data on the reduction in sickness absence due to musculoskeletal issues.

<table>
<thead>
<tr>
<th>Days lost to musculoskeletal-related sickness absence</th>
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<tr>
<td>1 April 2010 – 30 June 2010</td>
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<td>2051</td>
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Colchester Hospital University NHS Foundation Trust has introduced a triage system to look at supporting staff that are off sick which has also reduced sickness absence. When an individual reports as sick, their line manager contacts the Occupational Health & Wellbeing Department with details of the absence. The Health and Well-being team conduct a five to ten minute telephone call with the member of staff to establish any support that is required and signpost to relevant resources. This has resulted in mental health and musculoskeletal conditions being identified on day one enabling early support and intervention to support staff.

Following the phased roll out to all areas the findings for the last six months are shown below:

**Mental Health Issues**
- 71.66% returned to work within 4 weeks
- 21.66% returned to work within 8 weeks
- 6.66% remain absent.

**Musculoskeletal Disorders**
There has been a 100% increase in referrals to physiotherapy with the following results:
- 53.3% remained at work
- 21.7% return to work within 8 days
- 15% return to work between 9 - 14 days
- 7.5% return to work between 15 - 21 days
- 2.5% return to work between 30 days

This has contributed to a reduction in agency spend £586,000 over the six month period.

**East Lancashire Hospitals NHS Trust**
Within East Lancashire Hospitals NHS Trust (ELHT) MSDs have been consistently reported as the number one reason for sickness absence over the last twelve months.

In August 2010, a new health and well being initiative was devised in partnership with key stakeholders within the trust to specifically address MSDs within the organisation.

Following consultation with key stakeholders, a rapid access system for fast physiotherapy was introduced.

Fast Physio is a dedicated in house service delivered by ELHT specialist physiotherapists specifically for employees.

The service is free, confidential and is available to all ELHT employees.

The services ‘Fast Physio’ offers include:
- Open access to physiotherapy on a self referral and management referral basis to all employees of the organisation.
- Rapid access physiotherapy to provide appropriate and timely management and advice of MSDs.
- Telephone and email advice to enable employees to self manage their injury more effectively.
— Access to ‘Fast Physio’ webpage and self-management resources.
— Recommendations of workplace adjustments were appropriate.
— Advice and support during return to work for managers and employees.

In the first four months following the introduction of Fast Physio musculoskeletal (MSK) sickness rates significantly reduced from 14.09% to 12.31%.

Musculoskeletal sickness rates dramatically reduced following the provision of the service.

Bank and agency expenditure significantly reduced following the provision of the service demonstrating a clear financial return on investment of £367,000 in four months on temporary staffing cover alone.

Return to work

The main aim of rapid access intervention is to facilitate a quicker return to work than would be expected without the intervention. Consideration should be give to the way in which the individual returns to work especially if a return to normal duties is not immediately advisable. There are a number of options available including rehabilitation and redeployment.

Where rehabilitation is considered possible, the occupational health service and human resources team will manage the return in the manner considered best for the individual. In most cases this is likely to be phased, with a change of duties if necessary.

Many trusts using rehabilitation as part of their sickness absence management policies have found that it is not always possible to rehabilitate staff back into their original post in the short term. This may be due to job loading or to the nature of their illness. For instance, musculoskeletal problems need time to heal without the risk of further damage. In these circumstances a widely used alternative is redeployment.

Redeployment is seen as an important mechanism that can assist in the retention of experienced and skilled staff in the NHS. An effective redeployment policy can help to help retain staff unable to do their job through ill health or injury.

This can be used in the short term while an employee is recovering or permanently for staff who have no likelihood of returning to their original role.

In some cases redeployment will require re-training and it is good practice for this to be provided as part of a package devised and managed by the occupational health service and human resources. The level and length of re-training should be carefully considered to ensure that is it appropriate and proportionate.

Data collection: creating your own evidence base

A great deal of work has gone into collecting the data to make a business case for rapid access. It is essential that NHS organisations that already or intend to use rapid access schemes collect data to show the effectiveness of their strategy. The collection of data prior to implementation is vital to achieve a base line with which to benchmark progress. The NHS Employers’ document Planning and developing your occupational health services provides information on the type of data to collect. It is helpful in making regular reports to the board and in making the case – if necessary – to expand the service. The Future Forum advised that the board should review staff health and well-being progress against plan at least annually.
Working with human resources, occupational health and finance colleagues will allow those implementing the policy to collect data about patients, sickness absence, reductions in associated costs and most importantly the reduction in length of absence that is facilitated by the rapid access process.

CONCLUSION

Sickness absence costs are currently in excess of £1.6 billion a year. Rapid access schemes will assist NHS organisations in meeting the Government’s quality innovation productivity and prevention (QIPP) challenge of reducing staff sickness absence by one third, saving the NHS £555 million by March 2013. They will also contribute to meeting the health and wellbeing pledge in the NHS Constitution, which states that: “The NHS commits to provide support and opportunities for staff to maintain their health, wellbeing and safety”, and to the health and well being recommendations in the Operating Framework 2012/13 and Future Forum report. Most importantly, reducing sickness absence will help towards an improvement in patient care.
NHS Employers

The NHS Employers organisation is the voice of employers in the NHS, supporting them to put patients first. Our vision is to be the authoritative voice of workforce leaders, experts in HR, negotiating fairly to get the best deal for patients.

We help employers make sense of current and emerging healthcare issues to ensure that their voice is front and centre of health policy and practice. We keep them up to date with the latest workforce thinking and expert opinion, providing practical advice and information, and generating opportunities to network and share knowledge and best practice.

We work with employers in the NHS to reflect their views and act on their behalf in four priority areas:

- pay and negotiations
- recruitment and planning the workforce
- healthy and productive workplaces
- employment policy and practice.

The NHS Employers organisation is part of the NHS Confederation.

Contact us

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