

Research report

# An evaluation of the Statement of Fitness for Work: qualitative research with General Practitioners

by Beth Fylan, Fiona Fylan and Lauren Caveney

Department for Work and Pensions

Research Report No 780

# **An evaluation of the Statement of Fitness for Work: qualitative research with General Practitioners**

Beth Fylan, Fiona Fylan and Lauren Caveney

A report of research carried out by Brainbox Research on behalf of the Department for Work and Pensions

© Crown copyright 2011.

You may re-use this information (not including logos) free of charge in any format or medium, under the terms of the Open Government Licence.

To view this licence, visit <http://www.nationalarchives.gov.uk/doc/open-government-licence/> or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

This document/publication is also available on our website at:  
<http://research.dwp.gov.uk/asd/asd5/rrs-index.asp>

Any enquiries regarding this document/publication should be sent to us at:  
Department for Work and Pensions, Commercial Support and Knowledge Management Team,  
Upper Ground Floor, Steel City House, West Street, Sheffield S1 2GQ

First published 2011.

ISBN        978 1 908523 34 1

Views expressed in this report are not necessarily those of the Department for Work and Pensions or any other Government Department.

# Contents

Acknowledgements.....	vi
The Authors.....	vii
Abbreviations .....	viii
Glossary of terms .....	ix
Summary .....	1
1 Introduction .....	5
1.1 Research and policy objectives.....	5
1.2 Research context .....	5
1.2.1 <i>Approaches to managing sickness certification</i> .....	5
1.2.2 <i>GPs' views on their role in sickness certification</i> .....	6
1.2.3 <i>Patient characteristics</i> .....	6
1.2.4 <i>Impact of the fit note</i> .....	6
1.3 Method.....	6
1.4 Sample .....	7
1.5 Recruitment .....	7
1.6 Data collection .....	7
1.7 Data analysis .....	8
1.8 Introduction to the results .....	8
2 General Practitioner preparation.....	9
2.1 Perceptions of the extent of change .....	9
2.2 Perceptions of the policy change .....	12
2.2.1 <i>Positive views</i> .....	13
2.2.2 <i>Negative views</i> .....	15
2.2.3 <i>Potential future improvements</i> .....	16
2.3 GPs' information needs .....	17
3 Using the fit note in practice.....	20
3.1 Consultation tool .....	20
3.1.1 <i>Design of the form</i> .....	22

3.2	Outcome expectancies .....	22
3.2.1	<i>GPs' self-efficacy to complete the fit note</i> .....	22
3.2.2	<i>Perceived effect on the GP-patient relationship</i> .....	23
3.2.3	<i>Perceived benefits to the patient of returning to work</i> .....	24
3.2.4	<i>Influence of the patient's job characteristics and their position in the labour market</i> .....	25
3.2.5	<i>GPs' assumptions about employer responses</i> .....	27
3.3	A shift in focus.....	27
3.3.1	<i>A richer assessment of fitness for work</i> .....	27
3.3.2	<i>Consultation length</i> .....	29
3.4	Difficulties.....	30
3.4.1	<i>Poor administrative preparation</i> .....	30
3.4.2	<i>Confusion about dates</i> .....	30
3.4.3	<i>Distinguishing between return-to-work options</i> .....	30
3.4.4	<i>Section blindness</i> .....	31
3.4.5	<i>Other uncertainties about areas of the form</i> .....	31
3.4.6	<i>Providing limited detail</i> .....	31
3.4.7	<i>Employer practices</i> .....	32
3.4.8	<i>Language and literacy barriers</i> .....	32
4	Receptiveness.....	33
4.1	The patient agenda.....	33
4.1.1	<i>Patients who are motivated to return to work</i> .....	33
4.1.2	<i>Perceptions about patients' lack of motivation to return to work</i> .....	34
4.1.3	<i>Perceived effect of the patient's work ethic</i> .....	36
4.1.4	<i>Communicating via the patient</i> .....	38
4.1.5	<i>Patient tactics</i> .....	38
4.2	Pre-empting employer responses .....	39
4.3	The consequence vacuum.....	40

5	General Practitioner approaches to patient management.....	43
5.1	Facilitating a return to work .....	43
5.1.1	<i>GPs' perceptions of their role</i> .....	43
5.1.2	<i>The balance of responsibility</i> .....	46
5.1.3	<i>Accountability</i> .....	47
5.2	Extent of collaborative working.....	48
5.3	Roles for other agencies.....	50
6	Understanding the extent of their role.....	52
6.1	Role boundaries .....	52
6.1.1	<i>GP views about the purpose of their fit note advice</i> .....	54
6.2	Role conflict .....	55
7	Discussion and conclusion .....	57
8	Recommendations and implications for policy .....	60
Appendix A	Interview schedule.....	61
Appendix B	Sample structure .....	65
References	.....	66

# Acknowledgements

We would like to thank the General Practitioners (GPs) who took part in the evaluation along with practice staff and primary care organisation staff who helped with their advice in contacting GPs and in putting us in touch with potential research participants. We would also like to thank the staff at the Health, Work and Wellbeing Directorate of the Department for Work and Pensions (DWP), in particular Bola Akinwale, the evaluation steering committee and the other evaluation research partners.

# The Authors

**Beth Fylan** is a Director at Brainbox Research. She has extensive experience in social and health research and has worked on a range of studies for government departments, local authorities and Primary Care Organisations. Beth is a member of the Social Research Association and a Fellow of the Royal Statistical Society.

**Dr Fiona Fylan** is a Director at Brainbox Research. She is a practising Health Psychologist and a Chartered Member of the British Psychological Society. She has designed and led a wide range of nationally important research and has worked internationally in applying psychology to better understand behaviour and to develop and evaluate interventions to change behaviour.

**Lauren Caveney** is a researcher with a special interest in understanding people's health behaviours. She has worked on many research projects, including national evaluations of health-related interventions.

# Abbreviations

DWP	Department for Work and Pensions
ESA	Employment and Support Allowance
GP	General Practitioner
IMD	Index of Multiple Deprivation
ME	Myalgic Encephalopathy, sometimes referred to as Chronic Fatigue Syndrome
ONS	Office for National Statistics
RCGP	Royal College of General Practitioners

# Glossary of terms

Employment and Support Allowance	A Government benefit that provides financial help to people who are unable to work because of illness or disability and personalised support to those who are able to work.
eMed3	The electronic fit note due to be released in 2012.
Fit note	A colloquial name for the Statement of Fitness for Work.
Jobseeker's Allowance	A Government benefit for unemployed people of working age who are available for and actively seeking work.
Health Psychology	The branch of psychology that is concerned with understanding how biological, psychological, environmental and cultural factors affect health.
Illness perceptions	The beliefs that an individual has about their condition, such as its symptoms, causes, consequences, how long it is likely to persist and how successfully it can be treated.
Musculoskeletal conditions	Conditions that affect the affect nerves, tendons, ligaments, nerves and muscles.
Med 3	An alternative name for the Statement of Fitness for Work.
Occupational health	The branch of medicine concerned with the maintenance and promotion of health and wellbeing of being of workers in all occupations.
Pharmacological treatment	Treatment of a condition using drugs.
Primary Care Organisations	Bodies responsible for commissioning health-care and care services.
Self-efficacy	Belief in one's ability to perform a task competently.
Sick note	A colloquial name for the medical statement that was in use prior to April 2010.
Sick role	A health-related behaviour to demonstrate sickness and to maintain the benefits associated with being ill which, amongst other things, offers the patient exemptions for example from work or from other normal social roles.
Statement of Fitness for Work	The form issued by a General Practitioner (GP) to a patient whose health affects their ability to work. Introduced in April 2010.

# Summary

## Main messages

- The Statement of Fitness for Work (fit note) has become a consultation tool that General Practitioners (GPs) use to initiate and guide negotiations with patients about returning to or commencing work. GPs use the fit note to justify why they have initiated discussion about work and to prompt them through the process of questioning patients about their work-related capabilities.
- GPs who welcomed the introduction of the fit note did so because they believe work is beneficial and because they believed the previous certification system to be ineffective. GPs who held negative views of the policy did so because they were sceptical that it could change outcomes for patients and because it does not force GPs to change how they certify sickness absence.
- GPs perceive that the fit note is most effective for patients with conditions such as Myalgic Encephalopathy (ME), mild-to-moderate mental health conditions and musculoskeletal conditions.
- GPs are less confident in using particular options on the fit note, like the amended duties and workplace adaptations tick boxes. Some reported difficulty in understanding and distinguishing between the four return-to-work tick boxes and confusion over date fields. Not all GPs understand the level of detail they should include on the fit note.
- Prior to the introduction of the fit note, most GPs spent little time preparing for its use because they perceived the change to be straightforward. As a result, many GPs at first overlooked the fit note's potential to change patient outcomes. Some GPs acknowledged that over time they understood the fit note can be used in a richer way.
- Barriers to the successful use of the fit note include GPs' self-efficacy in dealing with conflict, their unwillingness to damage their relationship with their patients, the patient's age, and the local economic and labour market conditions. GPs are also less likely to drive for a return to work if they perceive the patient's job to contribute to their health condition.
- GPs' self-efficacy in using the fit note is reduced because they receive little feedback about the usefulness of their advice.
- Many GPs believe that motivating their patients to return to work is an integral part of their role and that the fit note has helped them to do this. It has also helped some GPs to adopt a stricter role with their patients.
- GPs who prioritise medical rehabilitation begin using the fit note later in the patient's recovery.

## Background

On 6 April 2010, the Government implemented a new Statement of Fitness for Work across England, Wales and Scotland to replace the 'sick note'. The new medical statement aims to:

- improve back-to-work advice for individuals on a period of sickness absence;
- improve communication between individuals, GPs, and employers on what a patient can do and how a patient's condition could be facilitated in work;

- reduce sickness absence;
- support people with health conditions to stay in work or return to work more quickly;
- contribute to creating new perspectives on the link between work and health and improve awareness and understanding of the importance of work for good health.

## Method

The evaluation explores the extent to which the fit note meets its policy objectives to improve assessments of sickness and how this is achieved in practice. It answers the following broad questions: what are GPs' experiences of using the fit note?; what role do GPs feel they play in giving return-to-work advice; and how has the fit note influenced their role perceptions? We conducted 45 in-depth, semi-structured interviews with a purposive sample of GPs in England, Scotland and Wales. Sampling variables included GP and practice characteristics. We conducted fieldwork between February and May 2011 and analysed data thematically.

## Results

### **GP preparation**

Most GPs interviewed spent very little time preparing to use the fit note prior to its introduction because they thought the change was straightforward. There was much complacency about the extent of change and many GPs initially overlooked the fit note's potential. Some GPs reported changing their view of the fit note over time, acknowledging its potential to be used in a richer way than the sick note. Some GPs thought that additional guidance about recommending workplace adaptations would help them use the fit note more effectively. Training in communicating and negotiating skills was considered key to effective use of the fit note.

GPs hold a range of views about the policy change. Positive views are informed by the belief that work is generally beneficial for health and reflect expectations that it would change patient, employer and GP behaviour. Negative views reflected a belief that the changes made to sickness certification were superficial and would therefore be ineffective. GPs widely believe that patients would benefit from more knowledge of the link between health and work and the impact of sickness absence on health.

### **Using the fit note in practice**

The fit note is used by GPs as a consultation tool to bring up the issue of returning to work with their patients, to guide the conversation about work, and as a buffer to justify initiating discussion about returning to work. For many GPs the fit note is now integral to the way they conduct consultations that involve work. The likelihood that they will use the fit note to introduce the issue of returning to work is influenced by their perceived ability to deal with conflict, their unwillingness to damage their relationship with their patients, the prospects of their patients ever working given their condition, the patient's age, and the local economic and labour market conditions. GPs perceive that patients with conditions such as ME, mild-to-moderate mental health conditions, and those with musculoskeletal conditions have experienced the most benefit from the fit note. GP opinion about whether consultation lengths had changed was mixed.

GPs are not equally confident in using all the options on the fit note, such as workplace adaptations and amended duties, and they have difficulty in understanding and differentiating between the return-to-work options.

## Receptiveness

GPs regard the patient's agenda for returning to work as a key determinant of the success of the fit note process. In turn, the patient's agenda is influenced by a range of factors including financial factors, their illness perceptions, and attitude to work. Recommendations for keeping patients in work or returning them to work may be hampered by patients who expect a negative response from their employers. GP self-efficacy in using the fit note is affected by a lack of feedback from employers about the value and feasibility of the advice they give on the fit note.

## GP approaches to patient management

GPs generally feel that their role now involves changing patient perceptions of their ability to work and in some cases GPs have been able to adopt a stricter role with their patients. GPs generally make decisions about returning to work in isolation from other clinicians. Co-location of other services, such as physiotherapy and counselling services, aids communication about the patient's ability to work, which may otherwise be communicated via the patient.

As patients face non-medical barriers to returning to work or moving off sickness-related benefits, GPs believe that referral to agencies to address non-medical barriers would be beneficial.

## Understanding the extent of their role

GPs without occupational health training believe that some aspects of the fit note, such as recommending amended duties and workplace adaptations, fall outside their area of expertise. They believe that giving advice to employers is an occupational health role, rather than the role of the GP. While some GPs can see a benefit to having contact with employers, most GPs are wary of doing so because of the time commitment it would involve and because their role is to be the patient's advocate.

GPs hold varying views on the purpose of their advice on the fit note: some believe it is guidance for the patient to discuss with their employer; some believe it is advice for the employer to consider and take action upon; and others believe it is an instruction to the employer. They still perceive a conflict in their role in sickness certification: they act in a statutory role while also acting as the patient's advocate and they worry that this may erode patients' trust in their GP.

## Conclusions, recommendations and implications for policy

Our findings suggest that the fit note is a useful consultation tool that GPs can use to keep their patients in work and to return them to work. We did, however, identify a range of barriers that GPs experience to returning patients to work using the fit note. These include: low GP self-efficacy to use the fit note; the patient's age; the local economic and labour market conditions; GP reluctance to damage their relationship with patients; and patient's own agenda, for example their motivation to return to work, and their illness perceptions.

The fit note has helped many GPs to motivate patients to return to work and has helped some GPs adopt a stricter role with patients. However, GPs believe that there is a role for other agencies in helping remove non-medical barriers to their patients working, such as lack of skills or problems with their employers. They do not see giving specific occupational health advice to employers as part of their role.

This research explores GPs' perceptions of the fit note, which may be different from the views of employers and individuals. The findings indicate that many factors influence how GPs use the fit note including their self-efficacy to do so, the patient's own agenda and the perceived value of using the fit note at all given the patient's condition. These and other factors may be at play and may influence employer and individual experiences of the fit note process.

Further training in communication and negotiation skills in the context of patient management would help GPs feel confident raising returning to work with their patients. GPs also need further guidance about what to write on the fit note to make it useful to patients and employers. Policy makers may consider ways to help GPs and employers share information without damaging the GP-patient relationship or adding to the GP's workload.

Greater public awareness of the health implications of long-term work incapacity would help to improve people's understanding of the importance of work and help GPs motivate people to return to work earlier.

# 1 Introduction

## 1.1 Research and policy objectives

The new Statement of Fitness for Work (fit note) was introduced on 6 April 2010 with the aim of improving individuals' and employers' access to timely information about when and how sick individuals might return to work. As General Practitioner (GPs) play a significant role in managing sickness absence, Department for Work and Pensions (DWP) commissioned this study to understand GPs' views on the fit note; their experiences of using it; and how the fit note has influenced their perceived role in giving back-to-work advice to patients. It is part of a wider programme of evaluation on the fit note including research with employers and statistical examination of fit note data. It addresses the following research questions:

1. How do GPs use the fit note and what factors influence how they use it?
2. How do GPs perceive their role in giving back-to-work advice? How has the fit note influenced their role perceptions?

The new fit note was developed to: improve back-to-work advice for individuals on a period of sickness absence; improve communication between individuals, GPs, and employers; reduce sickness absence and support people with health conditions to stay in work or return to work more quickly; contribute to creating new perspectives on the link between work and health; and improve awareness and understanding of the importance of work for good health. It includes a new option of 'maybe fit for work' and other changes so that GPs can record details of the functional effects of the patient's condition. Patients and their employers can consider changing the working environment, job role, working hours, or take other steps to help the patient return to work or to stay in work.

## 1.2 Research context

### 1.2.1 Approaches to managing sickness certification

Previous research has identified that GPs' views on the value of work in maintaining health influences their approach to patient management (Hiscock and Ritchie, 2001; Mowlam and Lewis, 2005). GPs ranged from those who believed work to be a crucial element of their patients' health to those who rarely took work issues into account as they believed the focus of their role to be the medical recovery of their patients (Mowlam and Lewis, 2005). GPs' perspectives on their role in sickness absence management may also influence their willingness to intervene in helping the patient return to work and they may make a distinction between those who are on sickness absence from work and those who are on sickness absence from job seeking (Hiscock and Ritchie 2001). Research conducted since the introduction of the fit note indicates that the vast majority of GPs believe that work is generally beneficial for health (Hann and Sibbald, 2011).

Three main approaches to managing patients' return to work have been identified in a previous study (Hiscock and Ritchie, 2001): firm negotiators who would be actively involved in the management of patients' return to work or job seeking; soft negotiators who would be more flexible and accommodating while being eager to encourage the patient back to work where possible; and non-interventionists who are influenced by patients' expectations and pace, willing to give advice but unlikely to give specific directions about returning to work. GPs were found to adopt each of

these different approaches in different circumstances. Further research explored how GPs work with patients to assist them back to work, GPs' perceptions of the extent of their remit as a facilitator, the factors that influence their approach and how they work with other specialists and organisations (Mowlam and Lewis, 2005).

### 1.2.2 GPs' views on their role in sickness certification

Research with GPs identified three perspectives to the GP role in sickness certification: those who prefer to have no role in certification; those who think that the responsibility should sit with the GP but think that role modifications would be beneficial; and those who value their role in sickness certification and believe that GPs are in a good position to hold that role (Hiscock and Ritchie, 2001). Role conflict has been identified as being a factor in GPs' approach to certification: the GP-patient relationship was found to be in conflict with the GP's role in certifying sickness (Hussey *et al.*, 2008).

### 1.2.3 Patient characteristics

Other studies have found that the patient's condition influences GP practices around sickness certification. Campbell and Ogden (2005) found that GPs were more likely to consider patients with psychological conditions as unfit for work than those with physical conditions. Norrmen *et al.* (2008) found that there is a higher risk of certification when the patient's condition is not physical. Those with mild and severe mental health conditions were found to be at risk of long-term work incapacity (Shiels *et al.* 2003; Shiels and Gabbay, 2007; Wynne Jones *et al.*, 2009). High rates of sickness certification were also found for musculoskeletal conditions (Wynne Jones *et al.*, 2009). Campbell and Ogden (2005) found that GPs were likely to issue sick notes to patients with physical conditions in order to maintain the relationship with the patient. Other risk factors for long-term work incapacity include age (Wynne Jones *et al.*, 2009; Shiels and Gabbay, 2007) and deprivation (Wynne Jones *et al.*, 2009).

### 1.2.4 Impact of the fit note

A pilot study of the fit note with over 500 GPs found that those using the trial medical statement were less likely to advise refraining from work and more likely to provide written fitness for work advice for patients than those using the Med 3 (sick note) (Sallis *et al.*, 2010). GPs used the date sections of the trial Med 3 inconsistently and that they were confused about the period for which their advice applied.

A survey of GPs conducted six months after the fit note was introduced indicated that the fit note has had a positive impact on the perceived quality of GP-patient consultations and on patient outcomes (Hann and Sibbald, 2011). GPs who reported a greater positive impact on the quality of their consultations and patient outcomes were also more likely to report higher levels of confidence in dealing with patient issues around returning to work, to report longer consultations and to have received recent training in health and work. Those who had received recent training in health and work tended to report generally higher levels of confidence in dealing with these issues.

## 1.3 Method

We designed the study to provide insight into the GPs' experiences, behaviours and beliefs surrounding sickness certification and sickness absence and as such used qualitative methods to gain an in-depth understanding of use of the new medical statement in a clinical setting. The study takes a Health Psychology approach to understanding GPs' experiences of sickness certification in which we have explored psychological predictors of behaviour such as behavioural, normative and control beliefs, that is to say, GPs' beliefs about the outcomes of how they manage patients, the factors affecting how they undertake certification, and how they perceive others view and manage certification.

## 1.4 Sample

We used a purposive sampling approach to ensure that the participants reflected central variables likely to influence GPs' approaches to assessing fitness for work and attitudes towards health, work and wellbeing. Our sampling structure included the following variables:

- GP characteristics, including GP age, gender, speciality and years of clinical experience.
- Practice size indicated by the number of partners.
- Characteristics of practice locations using indicators of deprivation (The Index of Multiple Deprivation, Index of Multiple Deprivation (IMD))<sup>1</sup>, urbanicity (The Office for National Statistics (ONS) Rural/Urban Local Authority classification)<sup>2</sup> and geographic location (Scotland and Wales, English Government Office Regions)<sup>3</sup>.

A total of 45 GPs were included in the sample. As the study uses a qualitative approach, we did not attempt to generate a statistically representative sample, but focused on constructing a sample with broad coverage of these key variables. The structure of the sampling variables included in the quota is shown in Appendix B. The designed sample was achieved during fieldwork.

## 1.5 Recruitment

GP practices and GPs were identified through working with Primary Care Organisations and through desk research. GPs were offered a £100 incentive in the form of cash or vouchers to encourage them to take part in the research. Once potential GP participants had been identified, we formally contacted individual GPs to discuss and confirm their participation, gain their consent and agree an appointment for interview.

## 1.6 Data collection

Data were collected through a series of face-to-face semi-structured interviews with GPs that explored their views about and experiences of the fit note. We constructed and piloted an interview schedule comprising interview questions and associated probes and prompts (included in Appendix A) which explored substantive areas in sickness certification and health, wellbeing and work. Fieldwork was conducted between February and May 2011. Interviews were conducted by three experienced researchers: one health psychologist; and two social researchers. Interviews lasted around one hour and were audio recorded with participants' written permission and transcribed verbatim. Researchers gained participants' informed consent and provided them with an information sheet explaining the aims of the research and how the interview data would be used. The information sheet also included the contact details of the researchers so that interviewees could contact us after the interview if they had any queries.

---

<sup>1</sup> The Index of Multiple Deprivation encompasses several indicators of deprivation such as employment levels, crime and health. Separate indices of deprivation are available for England (2007), Scotland (2009) and Wales (2008).

<sup>2</sup> ONS Rural/Urban Definition and LA Classification:  
<http://www.ons.gov.uk/ons/guide-method/geography/products/area-classifications/rural-urban-definition-and-la/rural-urban-local-authority--la--classification--england-/index.html>

<sup>3</sup> ONS Government Office Regions 1998:  
<http://www.ons.gov.uk/ons/guide-method/geography/beginner-s-guide/maps/english-government-office-regions.pdf>

### 1.7 Data analysis

We analysed the data using thematic analysis following the methods of Braun and Clarke (2006), in which text is broken down into units of meaning and grouped into themes that illustrate the experiences and perceptions of GPs regarding the new medical statement, work-related health and wellbeing, and the GP-patient dynamic in the context of the fit note.

### 1.8 Introduction to the results

We present the results of the thematic analysis in five chapters, each corresponding to a theme identified in the analysis. The first three chapters – *GP preparation*, *Using the fit note in practice*, and *Receptiveness* – are an in-depth exploration of GPs' experiences of using the fit note. The fourth and fifth chapters – *GP approaches to patient management*, and *Understanding the extent of their role* – explore GPs' perceptions of their role in giving return-to-work advice and how those perceptions have changed following the change in policy. Each chapter begins with a summary of the key findings and illustrative quotes from interviews with GPs are included in the text of the report in italics.

## 2 General Practitioner preparation

### Key findings:

- Prior to the introduction of the fit note, most General Practitioner (GPs) interviewed thought the change was straightforward so spent very little time preparing for its use. There was much complacency about the extent of change with many GPs initially overlooking the fit note's potential. Some GPs reported changing their view of the fit note, acknowledging its potential to be used in a richer way than the sick note.
- GPs hold a range of views about the policy change. Their positive views are informed by the belief that work is generally beneficial for health and reflect expectations that it would change patient, employer and GP behaviour. Those with negative views of the policy thought that the changes made to sickness certification were superficial and because it does not force GPs to change how they certify sickness absence.
- GPs widely believe that patients would benefit from more knowledge of the link between health and work and the impact of sickness absence on health.
- Additional guidance about recommending workplace adaptations and adaptations for specific conditions would help GPs use the fit note more effectively. Training in communication and negotiation skills is key to using the fit note successfully.

This chapter describes the ways that GPs use the fit note in consultations with patients. It is presented in the following subthemes: Perceptions of the extent of change; Policy perceptions; and GP information needs.

### 2.1 Perceptions of the extent of change

This subtheme describes how GPs and practices prepared for the introduction of the fit note. It explores how GPs' motivation to prepare for the introduction of the fit note varied with their perceptions of the importance of the change and the time they felt they had to prepare.

GPs were aware that there was going to be a change to sickness certification before the fit note's introduction. Some described a large amount of discussion in the GP community about the fit note before it was introduced. GPs with a special interest in occupational health were very aware of the new fit note and had kept up-to-date with work and wellbeing research. For GPs with no occupational health specialism, the amount of advance notice they recalled receiving affected how prepared they were for the fit note's introduction. Most GPs felt that they had had plenty of notice while some felt that the fit note had been introduced quickly and they had not prepared adequately.

*'No, I think we just did it [introduced the fit note] on the day that it was meant to switch over. We had the books available here and then we self-taught each other to exactly what needed to be done and we just quickly changed from one to the other. So I suppose the first few forms probably were not done as properly as it should be.'*

(GP 8: male, more than five years' experience, small practice, high deprivation)

In other circumstances, such as a GP returning from maternity leave just after the fit note was introduced, the GP was aware that the medical statement had changed but had little information about how to use it correctly.

GPs' self-efficacy to use the fit note influenced the amount of preparation they did. Most GPs felt confident that completing it would not be a difficult task. Their confidence was based on an appraisal of the form, which they felt to be sensible and straightforward. Confidence to use the fit note did not depend on the length of time GPs had been practicing: more experienced GPs described how their experience gave them confidence that they would be able to use the new medical statement easily while newer GPs felt that they were more adaptable to change than more experienced GPs so they would themselves be the most effective users of the fit note.

Because GPs were on the whole confident using the fit note, they spent little time thinking about how it might be used in practice and so they did not allocate time to learn how to use it. Most GPs recalled spending very little time preparing for the fit note and in most interviews they described a passive rather than active approach to their own preparation, which was largely informal and undertaken on an individual basis. Some described how time constraints meant they did not check the guidance information in advance. Some described how they had learnt to use the note in a live situation.

*'If I said to you we spent a grand total of ten to 15 minutes [preparing] that probably would have been about it.'*

(GP12: male, more than five years' experience, medium-sized practice, high deprivation)

*'So I very much just took it as 'Well it's introduced, start using it and see what happens.'*

(GP 30: male, more than five years' experience, medium-sized practice, low deprivation)

The apparent simplicity of the fit note and the clarity of the guidance led to GPs being complacent about the extent of the change and so most remained unaware of its potential uses and impact on how they manage their patients. They recalled how the format of the new medical statement had been similar to that of the old Med 3 and this had influenced their perceptions that it was a minor administrative change. To some GPs, the new medical statement seemed to be the old Med 3 with a few additions, rather than a significantly different form that would require planning to implement.

*'I thought it was going to be more, how can I explain it? Because to me that bit that says "You may be able to work given the following" is kind of like an add-on and to me it's more like the original sick note than I thought it was going to be.'*

(GP 21: female, mental health specialist, low deprivation)

GPs who perceived the fit note to be to be a minor administrative change discussed how they had not prioritised preparing for it as they often get new forms and therefore hadn't considered that they would need new skills to complete it. Some GPs held the view that the fit note was less important than other forms that GPs are required to complete, such as cremation certificates, and the implications of making a mistake less serious.

Some GPs considered the change to be significant, and in some instances described it as equally important as the introduction of a new drug. This group thought more about how they and their practices would prepare for the introduction of the fit note. However, when considered at a practice level, preparations for the change varied. In some practices GPs made individual decisions about how to use the fit note, in others GPs had informal discussions with colleagues about how to use it.

Some practices included the new fit note as an agenda item at a practice meeting. Informal preparation was more common, however, and GPs described this type of approach as more typical to the way that GPs and practices work. Informal preparation involved GPs discussing the fit note with colleagues during breaks or asking colleagues for advice. In some cases partners planned more formally how to use the fit note in practice meetings or in training meetings and they involved other practice staff in those sessions so that everyone was aware of the change.

*‘Within the practice, and it’s a small practice so there are two partners, so we discussed it as a pair but we also had a protected learning time. So every month we have a practice meeting and we do some learning with the whole practice, so that’s the practice nurse and the administrative staff. So I presented the changes because we wanted to have a different culture in the practice about calling it a fit note and we wanted to educate patients that they weren’t asking for a sick note, they were going to be asking for a fit note.’*

(GP 2: female, mental health specialist, high deprivation)

GPs in practices that train GP registrars were keen to follow best practice and to be knowledgeable enough about the new medical statement to cascade information to trainees. In most practices in the sample, however, formal practice-wide preparation was largely administrative and limited to removing the old sick notes from GP offices and issuing the new fit notes and guidance information.

*‘No we didn’t [prepare formally as a practice]. I think we had...we have a once a month meeting where on a first Monday of a month we look at all the stuff that comes in, for example the NICE guidelines, any new instructions, so it would have been flagged up for that, that the new sick note has arrived, and when to start using it and that would have been it, but it was very much we got a message from our Deputy Manager which is “I have now got the pads, I’m putting them all in your rooms and I’m confiscating your old ones” and that was it.’*

(GP 10: female, occupational health specialist, low deprivation)

One GP with a special interest in occupational health had prepared a presentation about the new policy for the practice team.

In larger practices GPs described how they work at different sites and have challenging time constraints so there was little opportunity to discuss the introduction of the fit note with their colleagues. In some cases GPs prepared in isolation with little discussion with peers about the fit note because practices are busy environments and it is usually left to the individual to prepare for changes.

*‘Obviously with the practice I was working at, at that time, I was partner there and I don’t think there was major preparation to change to be honest. There was just the one day we had a discussion “Okay, the fit notes are going to change” and then that’s it then, the next day we just got them and obviously it’s up to the individual GP to figure out what’s happening I think. We might have done it in a better way but obviously in the GP surgery there’s so many things going on I don’t think it becomes on the high priority list.’*

(GP 42: male, less than five years’ experience, medium-sized practice, high deprivation)

With hindsight some GPs reflected that because they didn’t think it was an important change they had not adequately prepared. Others felt that they had been cynical about the policy’s potential to effect change. Others had not realised the fit note’s potential. Some GPs acknowledged that over time they began to change their view of the fit note’s potential to be used in a different way to the old Med 3.

*‘So initially I treated them like old-style sick notes and ticked an awful lot of “You’re not fit to work” and used them as a kind of black and white thing and then gradually, over a period of time, I started thinking “Hold on, this is a bit richer and I could be using it a different way”.’*

(GP 8: male, more than five years’ experience, large practice, medium deprivation)

### 2.2 Perceptions of the policy change

This subtheme explores GPs’ understanding of why the policy was introduced and how much they accept and agree with it. GPs in the sample held a range of opinions about what had motivated the policy change and often identified multiple reasons for the change: some thought it was designed to reduce the financial burden of benefits payments, possibly for political reasons; others that it was to benefit employers for whom sickness absence is expensive; some thought its aim was to force employers to assume more responsibility for keeping people in the workplace; while others thought the policy aimed to prevent short-term absences developing into long-term absences through keeping people in work.

*‘Well they [the government]...my impression is that they felt sickness was very high in the UK compared to other European countries and that they felt that this could be decreased by trying to allow this to happen. What I think then the papers took on board is they wanted to cut benefits. I’m not sure exactly that, that actually is a direct cause of the sick note. I think the sick note in itself, and the fit note has very good intentions. I think it could go further and I think it could be a lot better used that way. I suspect for political reasons it didn’t but obviously there is a secondary bit in the back light when they’re [the Government] financially compromised at the moment and they want to cut down incapacity benefit and they need to do more assessments of people and that’s the feedback from a lot of patients, that they’re being refused that.’*

(GP 7: male, more than five years’ experience, large practice, medium deprivation)

*‘I think not from the medical point of view but just from a lay person’s point of view that this general sense that there are lots of people who are signed off sick for long periods of time who just do not get back into work and if they’ve been off for longer than, I don’t know, say a year or 18 months the chances of them going back is very low. So the idea of encouraging people back and the idea that just because you can’t do your job doesn’t mean that you couldn’t do a modified job or another job, and trying to get people looking at being off sick as not being signed off forever, as it being a very temporary thing and then to move them forward and encourage them to think about going back into the workplace. So I think obviously there’s huge cost savings and health implications. So I think that was why I thought that [the fit note] was being brought in.’*

(GP 20: female, mental health specialist, low deprivation)

### 2.2.1 Positive views

GPs' positive views about the fit note policy were mainly informed by two things: their perceptions that the previous system of sickness certification was not effective in encouraging people to work; and that work is beneficial to individuals, to their families and to society as a whole. For some GPs the policy change had led them to think more deeply about the issues related to sickness absence and they used the fit note as a springboard for culture change about sickness certification in the practice. GPs felt that the previous system of certification was abused by patients who did not want to work and that the whole area of sickness certification had a negative impact on GPs' morale. They described how the previous policy had made it easy for people not to work, which had resulted in them becoming de-skilled and de-motivated. They expressed the view that it had been left to GPs to resolve these problems because they were on the front line communicating with patients and in some cases they experienced intense pressure from patients to issue sick notes.

Changes introduced to the medical statement that enable people to return to work in some capacity made sense to the GPs we interviewed. They received the changes positively because they expected that the fit note will help change patient and employer behaviour: they offer new opportunities for patients to return to work and a basis for them to negotiate a return to work with their employer. Some GPs also welcomed the impact the fit note policy might have on their peers through its potential to change GPs' sickness certification practice: they feel that others have issued sick notes too easily and that GPs in general had attracted a reputation for leniency in sickness certification.

*'Yeah, I think GPs generally have had in the past a reputation for giving out sick notes too easily and I know there was the back pain, became stress, stress is the big thing, and I think if we can just keep pushing forward the ethos that work is important, it then helps people on the front line who have to get them back to work to have less arguments...'*

(GP 29: female, more than five years' experience, large practice, low deprivation)

Some GPs hoped that this new policy was part of a transition to a new way of thinking about sickness certification. Others took a wider view of the policy: they felt that patients who they could help return to work would be happier and healthier; and that happy, healthy patients use fewer practice resources. Indeed, they felt that most GPs would hold the same view.

*'I think most doctors would have the idea that it's really helpful getting patients back to work because they seem to be happier overall. It's a generalisation, and if they're happy it usually means they trouble us less, there's less workload for us really.'*

(GP 24: male, more than five years' experience, large practice, medium deprivation)

GPs believe that employment in its various forms – hobbies, paid or voluntary work, regular socialising – is good for people. The fit note policy reflects their own opinion about the relationship between employment and health and legitimises it, although one GP described how it is only since the introduction of the fit note that he fully believed that work is a good way to improve wellbeing. GPs understand work can have benefits for individuals, families, the economy and society in general. They discussed how work promotes a mutually reinforcing relationship between patients' physical and mental health and believed there were very few conditions where the patient would not benefit from some form of work while recovering. Some GPs also held the view that the financial benefits that work brings to people are as important as the psychological benefits to their general wellbeing. Many GPs felt that the previous system lacked the sophistication to be effective as they felt they needed to assess the patient as well or not well and therefore able or unable to work.

*‘Well I’ve always felt that just because you have a particular illness that doesn’t...I’ve always been surprised that it was an all-or-nothing policy before, you had an illness and, therefore, you couldn’t work ...I was always surprised that there was no flexibility that, say, if you broke your left hand and you’re right handed you couldn’t go into work and do some sort of work in some sort of capacity, and the same applies when we see children, parents say they’ve got a sore throat or an earache or they’ve hurt their eye or they’ve hurt their hand, can they go into school and I say “Well they can still sit in their lesson and listen”. So there has to be a system that is flexible and allows a person to, even if they’re not doing their normal job, attending work and doing something, or making some form of contribution. It’s not always possible. If you drive to work and you’ve broken your leg then that’s not feasible, but there are so many situations, as a GP, that previously you thought to yourself “Well there is no option on the form to say this person is probably okay to go back to work but not maybe do their normal job”.’*

(GP 9: male, orthopaedics specialist, low deprivation)

GPs expressed how the fit note has given them the opportunity to help patients get back to work sooner. They viewed it as having the potential to offer them more freedom to make suggestions to get people back to work and the opportunity for them to be creative in suggestions about returning patients to work. Encouraging a dialogue between patients and employers was also seen to be a positive outcome of the new policy. GPs discussed how the fit note was an opportunity for patients and employers to work together to build a solution that would enable them to return to the workplace; GP could then ratify that solution through their guidance on the new medical statement.

Some GPs believed the policy had finally caught up with their views and practice around sickness absence. Before the introduction of the new medical statement these GPs would amend the old Med 3 certificate with back-to-work advice for the patient to show their employer or with comments on the extent of the patient’s capabilities. GPs discussed how they were also now able to practice in accordance with their own beliefs: they described their own work ethic and their long-held belief that those who could work should work. They described how they had previously asked their patients about possibilities for amended duties and phased returns at their workplaces.

*‘I think maybe this is slightly a generational thing but I think, personally, even with the old system, I always suggested a lot of those things but the emphasis was then on the patient to relay that. I wouldn’t have given them a note to say “Take this to your employer” suggesting a phased return, I might suggest that to the patient saying “Have you spoken to your employer? Do you think they’d be happy if you went back part time for a few weeks?” So I would have always suggested those things if I thought they were relevant...but it makes it more formalised.’*

(GP 5: female, less than five years’ experience, small practice, high deprivation)

Another area in which GPs welcome policy change is in the ability to issue medical statements over the telephone. This change in policy was thought to be particularly useful in saving valuable consultation time and in negating the need for a patient, perhaps experiencing pain or discomfort, to travel to the surgery. Some GPs discussed how they had previously issued Med 3 certificates after a telephone consultation. GPs described this as taking a pragmatic approach and some expressed a feeling of relief that they were no longer breaking the rules by conducting telephone consultations.

GPs’ acceptance of the policy is also influenced by the belief that people have a responsibility to society to work or to contribute in some other way. Many GPs viewed themselves as hard-working, higher-rate taxpayers and felt that it was unjust that people were able to take from society without contributing to it in some way. Some GPs hold a passionate belief in the importance of work to a fair society.

*'I think, as a general population, doctors and people who work in the NHS are hard-working and have a strong work ethic themselves and so, therefore, we'd apply that to the patient population that they're seeing and try and encourage in the same way as we encourage healthy eating, healthy living and healthy lifestyle, a healthy attitude to work, so I suppose it has always been a part of that.'*

(GP 43: female, less than five years' experience, large practice, medium deprivation)

### 2.2.2 Negative views

GPs who expressed negative views about the policy did so because they perceived it to be a superficial change that would be ineffective in dealing with the problems in the sickness certification system. They felt that the policy did not go far enough in tackling the pervasive problem of sickness absence. They believed that patients who do not want to work are still abusing the benefits system. Some thought that, while the fit note is a good first step, it is not able to solve the problem of long-term absence from work, especially when the employer is reluctant to take the patient back into the workplace or the patient is reluctant to return. These GPs expected more fundamental changes that would involve assessments by occupational health specialists, particularly in cases where the patient is making a slower than expected recovery or the patient's condition is considered by the GP to be complicated. Some had expected that certification would be removed entirely from the GP's remit.

*'Well we knew all the stuff that the Government was talking about, taking away decisions from GPs and making it much more an employment-based thing and we were actually expecting the whole thing to be taken away from us, that was one of the discussions that we'd had as a group of partners, but we were expecting not to have to do this and it all to be going to occupational health type doctors, so when this change came in we all thought "Oh, okay".'*

(GP 34: female, more than five years' experience, medium-sized practice, medium deprivation)

In some cases GPs felt that more innovative changes are needed to alter the culture of patients asking for sick notes. They felt that it would take more than the new medical statement to challenge their patients, especially when it has been easy for them to get sick notes from other GPs.

Concern for patients also informed GPs' negative views of the fit note. One GP described how they believed that the new system is unfair to patients who are in receipt of sickness-related benefits, that the policy was introduced too swiftly, and that there is little support for people who are undergoing changes in their benefits status.

*'I think the whole thing is wrong, I don't quite know how the fit note is a move towards improving the fairness of the system and I also see people...what's happened in, well certainly since the credit crunch, is that lots of people are being just swiftly taken off benefits and then we see the aftermath of that because they come and go "What am I going to do now?" and the swiftness at which that is happening and the cut throat nature of which it is happening is amazing and it's obviously very powerful.'*

(GP 39: female, more than five years' experience, large practice, medium deprivation)

Additional reasons why GPs were negative about the fit note were: because it could easily be used as if it were the old Med 3 so GPs were not compelled to change their certification practices; cynicism that it was just another initiative that would not result in change; and the perception that the policy was politically motivated rather than having a medical basis. In some cases GPs reported that their colleagues had advised them to use the fit note as if it were its predecessor, a sick note. For example, in one practice in the sample a general decision had been made that all GPs should ignore the new options that the medical statement offered and to issue the fit note as if it were the old sick

note. Most GPs interviewed assumed that others in the profession held similar views to themselves but some were aware of colleagues who were either more or less positive about the fit note. Some GPs suspected that opinions about the fit note are polarised within the profession.

Some GPs were pleased that the policy change was not more fundamental and that it did not place too much onus on GPs themselves to drive the patient to return to work. Others, however, felt that it had not given them enough scope to help the patient return to work and expressed disappointment that the fit note had not had more impact on their practice and its patients. Some felt that it would need a culture change within the GP community for the policy to reach its full potential: they described how in the past GPs believed that by signing people off sick they were acting in their patients' interests.

*'I think there's probably been a long culture of [GPs] just being quite happy to sign people off and there hasn't been much resistance. We've had quite a long period of prosperity and so there hasn't been a lot of pressure from Government to change that until now, where we're now not having a period of prosperity, and obviously it's important to try and sort this out if it saves a general amount of money. But I think there is probably a culture amongst GPs that they've been quite soft, but not just because we haven't had pressure to change that and we could argue we've always been acting in the patient's best interests.'*

(GP 9: male, orthopaedics specialist, low deprivation)

### 2.2.3 Potential future improvements

GPs commonly felt that there is low general awareness of the benefits of work for health and the potential detrimental impact of long-term sickness absence or worklessness though patients would benefit from this knowledge.

*'I'm not convinced that patients or the public necessarily know that work is good for health. I don't think we've done enough of a good job saying "Do you know if you're on long-term sick you're likely to die 15 years earlier?" or "Do you know if you work consistent hours and have that routine your state's going to be better, you might not be asking me...?" and I think just telling... patients aren't stupid and I like having that discussion with them.'*

(GP 31: male, less than five years' experience, large practice, high deprivation)

For the most part GPs and patients have not changed the language they use to talk about medical statements. Overwhelmingly, GPs persist in using the term 'sick note' or 'line' in Scotland. In only one surgery where GPs in our sample worked had all staff been instructed to refer to the new medical statement as a fit note.

Some GPs suggested that the policy change could be implemented more effectively if the fit note were available in an electronic format. They believed that this would prevent duplicating paper copies and would make the fit note easier to re-issue if it were misplaced by the patient. This would save time for GPs as there would be no longer be any need to transfer patient notes from paper forms to computer records, which could allow more accurate records of sickness absence to be maintained. This group of GPs also felt that electronic notes would save time and inconvenience for GPs when their patient's absence is routine, such as after an operation, as they would not have to repeatedly see patients who need to collect paper fit notes.

*'Perhaps if [the fit note] was electronic the patients wouldn't have to come into the surgery and pick them up... it causes so much traffic, and so much inconvenience for us and the patient, especially when it's simple things like a patient's had a routine operation.'*

(GP 39: female, more than five years' experience, large practice, medium deprivation)

GPs also thought that it would be more difficult for people to make fraudulent alterations if the fit notes were issued electronically. One GP explained that patients said that they would buy a fake sick note if he didn't issue one. They thought electronic fit notes would be more difficult to forge. There were, however, a few GPs who prefer to have less reliance on IT and like completing the fit note on paper as it is quicker for them to complete it in this way.

### 2.3 GPs' information needs

This subtheme describes GPs' experiences of accessing the sources of information available to them about the fit note, the helpfulness of the information, and any gaps they identified in the information available.

GPs found out about the introduction of the new medical statement from several sources including GP-specific media, such as Pulse and GP Notebook, from national media such as television and newspapers, and from colleagues through formal and informal channels such as conversations, local GP forums and formal presentations within practices. GPs also used the websites of the British Medical Association, the Department of Health (DH), internet searching and they described accessing the electronic version of the Department for Work and Pensions (DWP) guidance. GP expressed a variety of preferences for channels through which to receive information and guidance about the fit note. Some GPs preferred to read the paper guidance and subsequently rely on the internet to access information for ongoing guidance. Others, including one GP who cited age as a reason for their preferences, wanted detailed paper information that they could keep and refer back to. In large practices where paper guidance was received and circulated by practice administrative teams, GPs explained how it can be difficult for information to be passed on to all GPs as information often gets stuck in the process of its circulation.

*'The problem with anything that goes to work is that you've got, how many, eight GPs in our practice and it's got to go round, if you get one copy it's got to go round them all and occasionally they get stuck and someone forgets to pass them on.'*

(GP 36: female, more than five years' experience, large practice, low deprivation)

GPs recalled receiving official guidance information about the new medical statement in advance of its implementation. Most who could recall reading the booklet *Statement of Fitness for Work – A Guide for General Practitioners and other Doctors* found it useful and easy to understand. As GPs felt under constant time pressure it was important to them that this information source was quick and easy to read and it was therefore considered to be a well-pitched document. They described how the guidance addressed their key information requirements and some GPs described how they had not felt that they needed any additional advance guidance to implement the fit note. Some GPs kept the booklet and referred back to it. GPs described how the DWP website was easy to access if they had queries, although some expressed disappointment that the content was similar in depth to that contained within the booklet. Other GPs described how they had felt confused by the guidance and they needed to seek out other information in order to implement the fit note properly and that guidance about the previous sick note had been superior. This group had residual questions after reading the guidance to which they could not find answers, which they suspect led them to make mistakes in their use of the fit note.

*'We couldn't find [information about back-dating] initially. It took about a month, I'd say, of actually using the fit notes and telling patients "No, we can't possibly backdate these, it needs to be done at the time" because that was the interpretation we made from the slip. So we probably were mishandling them for the first month.'*

(GP 34: female, more than five years' experience, medium-sized practice, medium deprivation)

Some GPs discussed there being a lack of specific information about how to use the fit note across a range of conditions and job roles. For these GPs the simplicity of the guidance was disappointing and it failed to cover the situations that might arise in their consultations. GPs generally described the information as adequate but not helpful in all circumstances. They expressed a need for more guidance on levels of fitness acceptable in different workplace situations and more guidance about occupational health. They also discussed how they required further guidance on workplace adaptations or specific adaptations for patients with specific conditions, for example musculoskeletal conditions, because they perceived that employers need specific guidance about the patient's capabilities.

*'So in my experience with musculoskeletal stuff, so let's say back pain which is an area I have a big interest in. I speak to employers, actually what they're really keen on is not "light duties" or reduced activity or anything vague like that, they like to have "Not to be sat for more than 30 minutes" or "Not to lift more than 5 kg", so you can be really specific about what you mean by it, because, you know, "Avoid lifting", what does that mean? Does it mean avoid lifting a cup? Does it mean lifting a cardboard box? Do you know what I mean? So I think that didn't come across very well on it [the guidance booklet]. So giving you some...it might have been there and I just didn't see it, but giving you some specific pointers would have helped.'*

(GP 15: male, orthopaedics specialist, medium deprivation)

Information was also felt to lack a local context for GPs who believed that the location of their practice had an impact on the type of conditions that their patients presented with, for example areas where there were large employers of manual workers.

Some GPs thought that information from health organisations such as Primary Care Organisations and the DH was lacking. They thought that GPs might view the change in policy more positively if they had received information from health-related sources because it would be seen as a change aimed at improving health and wellbeing rather than saving money or to fit a political agenda.

*'Having something that seemed to be from the NHS for the NHS would have tugged the emotional strings of GPs whose focus is an individual patient and trying to get a patient better rather than our broader responsibilities for an economically reliable society, which leaves us a bit cold really.'*

(GP 1: male, more than five years' experience, large practice, medium deprivation)

GPs discussed possible gaps in their professional skill set in the context of the new medical statement. Some recognised that communication and negotiating skills were key to a successful consultation using the fit note and believed that GPs who are not skilled in these areas would struggle to use it effectively. A series of RCGP National Education Programme workshops about health and work were available to ten per cent of GPs. In our sample, workshops appeared to be taken up more commonly by recently qualified GPs than by their more experienced peers, although many GPs were aware that the training was available. Some GPs were aware of the workshops but chose not to attend for a range of reasons: they did not perceive the subject matter to be important or interesting enough to warrant their attendance; they would prioritise other training above health and work training; they felt that they did not need additional training to implement the new medical statement which was perceived to be just form-filling; or their workload precluded their attendance.

*'No we're far too busy to go to workshops, unless they're of extreme importance and involve either paying us or involve sums of money that we might lose if we don't turn up. So yeah, [the fit note is] not that difficult to get your head around.'*

(GP 24: male, more than five years' experience, large practice, medium deprivation)

Those who had attended a workshop were enthusiastic about its value in two main areas: understanding the impact of worklessness on individual wellbeing; and gaining practical advice on how to implement the fit note including negotiating techniques, motivating patients to return to work and managing difficult patients. GPs felt they were able to embed the skills they had learned in the workshop directly into practice and communicate some of the headline facts they had been taught to their patients, such as the comparative damage to health caused by sickness absence and smoking.

*‘We did quite a lot of talking [at the workshop] about the link between time off work and ill health and the emotional and physical problems with not being at work, the sort of problems with peers and lack of relationships and that sort of thing, and we did some role playing about conversations, difficult conversations when people have been off a long time and you don’t really think they need to be off, and that sort of thing, and discussing work with people. It was useful and I still remember the things we did. I think it was good and it has helped me to talk to patients a bit more since and actually proactively say to them “How about we try this?”’*

(GP 36: female, more than five years’ experience, large practice, low deprivation)

GPs described how the workshop had given them the confidence to use the fit note properly. In some cases it had changed their views on the value of work to health and wellbeing and changed their usual practice of using the new medical statement as if it were the old sick note. In one case the training had provoked the GP to reflect on how she had in the past made value judgements about her patients’ occupations. She explained how she had previously been more inclined to give patients time off work if they were in jobs that she perceived to offer little job satisfaction. The training had made her realise that people get job satisfaction from many different occupations and professions and that allowing the patient to take time off might not be the best way to rehabilitate them.

GPs discussed how they would have welcomed additional training if it had been free of charge. In one case the GP had a negative view of the RCGP and did not want to attend their programmes. Others felt that completing the new statements is straightforward so they did not believe that there would be enough content for a full workshop.

A recurrent view was that positive case studies that outlined how the fit note had been used to return patients successfully with different conditions would also help GPs see how the fit note could be effective and valuable in re-introducing their patients to the workplace.

*‘I think we need little case scenarios of positive cases of the people with the mental illnesses and with the back pains of who managed, with chronic sick notes, to get back into something, because I’ve not got enough of them, not enough cases to know it’s worth all the effort.’*

(GP 28: female, more than five years’ experience, large practice, high deprivation)

GPs wanted to access more information in electronic formats, for example through podcasts and e-learning modules, which would be easy for GPs to access at times and places that are convenient to them.

*‘One of the recommendations I put on the feedback is that it would be easy to podcast them and have it as a resource online because that would cascade to many more GPs, then they’ll be able to spend an afternoon, or some other means of communicating those practical tips to GPs.’*

(GP 31: male, less than five years’ experience, large practice, high deprivation)

## 3 Using the fit note in practice

### Key findings

- The fit note has become a consultation tool that General Practitioners (GPs) use to bring up the issue of returning to work with their patients, to guide the conversation about work, and as a buffer to justify initiating discussion of returning to work. For many GPs the fit note is now integral to the way they manage consultations that involve work.
- GPs are less confident in using particular options on the fit note and they have difficulty in understanding and differentiating between the return-to-work options.
- GPs' likelihood of using the fit note to bring up returning to work is influenced by their self-efficacy in dealing with conflict, their unwillingness to damage their relationship with their patients, the prospects of their patients ever working given their condition, the patient's age, and the local economic and labour market conditions. They are also mindful of the potential negative effect of placing the patient under pressure to return to work and of the financial consequences for the patient of what they put on the fit note.
- GPs believe that patients with conditions such as Myalgic Encephalopathy (ME), mild-to-moderate mental health conditions, and those with musculoskeletal conditions have experienced the most benefit from the fit note.
- GPs' opinions about whether consultation lengths have changed were mixed.

This chapter describes how the fit note has been integrated into GP-patient consultations since its introduction. It also explores how the changes to the medical statement have led to a shift in the focus of the consultation, the factors that influence how and when GPs use it, as well as some of the practical difficulties that GPs face when using it. It comprises four subthemes: consultation tool; outcome expectancies; a shift in focus; and difficulties.

### 3.1 Consultation tool

This sub-theme describes how GPs use the new medical statement during consultations with patients. GPs described how they use the fit note as a tool to broach the topic of returning to work with their patients, particularly when they request a medical statement. GPs explained how they use the fit note to initiate a discussion about the patient's role to gain an understanding of the extent to which their illness may impact on their ability to work. GPs described how they use the fit note to document the discussion that they have had with their patient about their ability to return to work, which they have not formally noted in the past.

Many GPs described the fit note as having a protective function for them: it acts as a buffer between the GP and the patient, justifying their reasons for discussing fitness to work and helping to reduce any conflict that may arise when discussing the patient's ability to work during consultations. GPs reported that discussing the purpose of the new medical statement usually eases tension if a patient is unwilling to discuss the possibility of returning to work as they are able to stress the recent policy changes as the driver behind the discussion and assure patients that they are not being singled out.

*‘[I] say “Look, these are new guidelines. It’s not me as an individual kind of ostracising you. This is what we have to do”.’*

(GP 18: female, less than five years’ experience, large practice, high deprivation)

*‘[The fit note] has given us the ability to have that negotiation and have it backed up by evidence and by government policy, so we’re really positive about it.’*

(GP 2: female, mental health specialist, high deprivation)

Many GPs saw the fit note as a prompt that facilitates an in-depth discussion between them and the patient about the patient’s work-related capabilities. Some described showing the patient the fit note while talking through each aspect of it with them; they used it as a prop to direct the discussion, each section acting as a prompt to ask relevant questions, such as how many hours the patient works and what their role involves. GPs described using the fit note to gradually introduce the concept of returning to work because it can prime patients that a discussion will follow in a future consultation.

*‘[The fit note is] something you can talk about and you can bring it up at earlier consultations so that when they are ready to go back you can say, and I do often say to people, “Look, maybe next time we’ll put you back in [work] and write in here phased return”.’*

(GP 36: female, more than five years’ experience, large practice, low deprivation)

GP descriptions of the way that they use the fit note suggest that it is a tool that aids negotiation between GP and patient, allowing them to reach an agreement about which boxes are ticked on the form and when the most suitable time for a return to work might be. GPs explained that the structure and options on the fit note allowed patients to be specific about the type and amount of work they feel they would be able to manage with their current level of fitness, reducing concerns that they may have had about returning to work and reaching consensus.

*‘[The consultation is] very much a two-way process. I can sort of say to the patient what do you normally do, what do you feel you can manage, and what do you think about this one and this one, and we sort of come to some agreement.’*

(GP 29: female, more than five years’ experience, large practice, low deprivation)

A few GPs described using the fit note as a support tool for patients with mental health conditions to set regular achievement goals to encourage the patient to make progress towards recovery. In this way, GPs use the fit note to help patients resume the activities and routines that they had before they became ill including paid employment.

Some GPs discussed how they use the fit note during consultations as a tool to offer feedback to employers about their patient’s condition and the ways in which it might impact on the patient’s ability to carry out their day-to-day role. Some believe that the fit note is useful for encouraging employers to make workplace changes for people who may not be fully fit but are able to complete more basic tasks. They describe doing this by using the space on the fit note to demonstrate how work can affect particular health conditions, highlighting that some tasks may aggravate the patient’s condition. GPs also reported using the fit note to provide employers with information about their employees’ health conditions and that it can serve as a tool that patients themselves use to negotiate with their employer.

### 3.1.1 Design of the form

GPs generally thought that the fit note is simple, clear and easy to complete and so they felt confident using it as a consultation tool. They found that the tick box options make the form easier to complete during consultations and are useful in highlighting that the return-to-work options are an obvious next step after a sickness absence, making it easier to encourage patients to consider them. A few GPs reported that the size of the free text box is very useful in giving them space to write complex medical notes about multiple conditions if they need to. They also used this space for clarifying their reasons for marking tick boxes. Some reported that they attempt to exploit the full potential of the form by making sure that it is detailed and legible and therefore could be a useful tool for outside organisations such as employment assessors. This would also mean that they would be less likely to be contacted for information about that patient at a later date.

GPs described the options on the fit note that they frequently use during consultations. Some reported mostly selecting the amended duties and altered hours options for their patients, whereas others commonly negotiated a phased return to work with specified hours. GPs also reported using the fit note to suggest workplace adaptations for their patients, although less frequently, and many discussed selecting multiple options as they thought it necessary to make their advice as detailed as possible.

Despite the advantages that the fit note brings to GPs in allowing them to discuss patients' work-related health, a few explained that if they have marked the fit note to highlight that the patient is not fit for work at the current time, they consider the statement to be a sick note. Only if they consider the patient to be fit for some form of work do they make a mental distinction between the two types of note and think of the note as a fit note.

*'Rather than say "You are not fit" I say "You may be fit for work" and then I use this box here, then I suppose that, to me, is a fit note, otherwise it's a sick note.'*

(GP 16: Male, Less than five years' experience, Small practice, High deprivation)

## 3.2 Outcome expectancies

This subtheme describes the factors that influence why GPs choose to use the fit note in different ways. We consider how GPs' expectations of the outcomes of using the fit note influence their willingness to discuss return to work, work capabilities and workplace adaptations with patients.

### 3.2.1 GPs' self-efficacy to complete the fit note

Self-efficacy is a person's belief that they can perform a task well. GPs' self-efficacy in their ability to use the fit note was wide-ranging and influenced their intention to use the fit note to its full effect. Some GPs felt adequately confident in their ability to fill out the different parts of the fit note, and they know where to look for guidance on recommended absences from work for specific conditions. Less commonly, GPs, admitted to avoiding the amended duties and workplace adaptations options as they did not feel confident that they knew enough about specific aspects of their patients' jobs. This group was not necessarily less experienced. A few GPs, one with a special interest in occupational health, explained that their colleagues rarely use the fit note in its full capacity because they believe the patients should see a GP who has occupational health expertise.

*'I've got colleagues who won't put anything. They'll put the diagnosis and sign the box, which is what you used to do on the old forms, and say "You need an occupational health opinion, go and see an occupational health trained doctor".'*

(GP 11: male, occupational health specialist, medium deprivation)

Some GPs explained that they fill in the parts of the fit note that they feel more confident with and omit sections in which they have less confidence in completing appropriately. One GP mentioned that there are aspects of the fit note that are not very easy to complete but later reported that she felt confident completing the fit note: this apparent contradiction may indicate that GPs are uncomfortable admitting their lack of confidence or that they rarely think in an in-depth way about how the fit note could be used more effectively.

*‘Workplace adaptations, that’s the other thing I really don’t know, I haven’t seen, physically I haven’t seen the place, so it’s difficult for me to make the comment what workplace adaptations.’*

(GP 13: female, more than five years’ experience, medium-sized practice, low deprivation)

### 3.2.2 Perceived effect on the GP-patient relationship

Many GPs have experienced conflict and confrontation when bringing up the issue of returning to work with their patients. GPs’ confidence in their ability to deal with this type of situation impacts on their decision to suggest returning to work to other patients. For example, several GPs from highly deprived areas experienced outbursts of anger from patients denied a sick note. Some GPs described how early attempts to use the new functionality of the fit note with patients had not gone well so they were now reluctant to use it properly. Another GP was aware that negative feedback from disgruntled patients could affect his reputation and so could have a knock-on effect on his income or appraisals.

*‘There was an incident where a patient charged out of here very offended, using some very offensive language about me and my unwillingness to provide a sick note. It didn’t do anything [good] for my reputation... [When] the patient surveys are sent out that person may well give me bad marks, which may well count against me... It can have an effect on what people say about you and that has an effect on your income, on your list size and your reputation.’*

(GP 6: male, occupational health specialist, high deprivation)

GPs’ experiences of particular conditions and the length of the GP-patient relationship emerged as factors that explained GPs’ approaches to using the fit note. The longer the patient has been known to the GP, the more understanding they have about what the patient can and cannot do, and they use this knowledge to guide their assessment of patients’ fitness for work during consultations. Sometimes they would make assumptions about how long the patient would need to take off work based on their knowledge of the patient and their condition.

*‘I suppose once you’ve been in practice for 20 to 30 years you start to maybe make some assumptions, perhaps, about patients presenting and how long they will take or perhaps with that added experience you’re more realistic about how long it might take to get this patient back. Or perhaps you’ve known the patient for a lot longer and you know that ten years ago they had a similar thing and they needed three or four months so you may as well write them off for two or three months straightaway.’*

(GP 43: female, less than five years’ experience, large practice, medium deprivation)

There were a few GPs who perceived that the old Med 3 certificates made it difficult to challenge patients about their ability to work and they see challenging patients as less daunting now because there is an alternative to being fit or not fit for work. These GPs explained that if the patient believed that they needed time off but the GP did not agree, choosing not to offer them a sick note might have damaged the GP-patient relationship.

*'The binary nature of the old style sick notes, work or not work, was quite unhelpful and often led to people just saying that they were not fit to work. That's the way you deferred because you didn't want to undermine your therapeutic relationship with your patient, who you may have known for ten years.'*

(GP 1: male, more than five years' experience, large practice, medium deprivation)

### 3.2.3 Perceived benefits to the patient of returning to work

The expected benefit to the patient of exploring a return to work also influences how GPs use the fit note. As well as considering the environment that patients work in and the type of job that they do, GPs use other factors to assess benefits of return to work for the patient, such as the patient's health condition. If the GP perceives the illness to be acute and to have minimal impact on the patient's ability to work in the long-term then the GP may be less inclined to introduce the subject of returning to work. GPs also explained that there are some conditions that require a certain recovery time and the fit note is unable to expedite this process. These cases are usually acute and therefore finite and GPs believed there is limited risk that these patients will be away from work in the long term. For some conditions GPs devolve the decision about returning to the patient, believing that the patient is in the best position to judge when they feel sufficiently recovered to return. GPs identified back pain as being particularly difficult to manage as patients with long-term sickness absence can adopt a sick role that means they believe themselves to be incapable of work. However, if the patient's condition is more chronic then a return to work may be discussed, although GPs noted that patients with chronic conditions who had received long-term sick notes offered the most resistance to work-related consultations.

Many GPs discussed how patients with conditions such as myalgic encephalomyelitis or ME (often referred to as chronic fatigue syndrome), common mental health conditions and musculoskeletal problems had experienced the most benefit from the introduction of the new note. These conditions are perceived to be highly compatible with amended working hours, tasks and phased returns and the fit note can lead to positive health outcomes for these patients through having the opportunity to work. GPs are unlikely to issue patients with severe mental health conditions, such as severe depression, with a fit note, particularly if it is related to a workplace factor. Some psychiatric patients may never have worked and GPs may not expect them to be able to in the future.

*'Most of [the psychiatric patients around here] will have not worked for years and years and years...I couldn't even remember the last time I actually gave them a sick note because that's just long-term and yeah, there's never been any chance of some of them working anyway.'*

(GP 17: female, more than five years' experience, medium-sized practice, medium deprivation)

GPs reported seeing the benefit for patients with less severe mental health conditions of any type of work that they could do while exploring treatment options such as anti-depressants. GPs would be more willing to discuss work with this category of patient, however they explained how they might prefer to leave sufficient time for medication to take effect before they would raise the subject of work.

Substance abuse was discussed by GPs as a common condition that makes it difficult to return to work. They described how if a patient is addicted to drugs or alcohol it may be difficult to challenge their perceptions that they are unable to work and they may not attend the sessions to which they have been referred by their GP, so the chances of improvement in their condition may be reduced. Some also highlighted that these patients may also be unreliable in their work attendance, or could arrive at work drunk, and so the employer may not welcome their return. Some GPs may perceive that the support available to patients with addictions is not sufficient to help them recover to a point

where they are able to return to work, at least within a short time period. Again these outcome perceptions influence GPs' decisions, making them more likely judge them unfit for work than question patients about their ability to recover enough to work in some capacity.

*'Alcohol services locally are pretty rubbish so if you're doing a sick note because someone's alcoholic then they're never likely to be fit to work in the near future, if ever, and that's partly lack of services and lack of support and lack of real, what's the word, proactive approach by society to deal with these societal problems.'*

(GP 12: male, more than five years' experience, medium-sized practice, high deprivation)

Some GPs are inclined to certify alcohol and drug users not currently in employment as unfit for work as they believe that they will be unable to find work with their condition, if they are on methadone for example. Some GPs highlighted that the attitudes of their patients are difficult to challenge as most don't want to consider going back to work.

*'People who are on a methadone script do find it very hard to get employed and actually get work... Some of those patients they've been on the system a long time and they know how to say things and what to say and they're very resistant to change.'*

(GP 43: female, less than five years' experience, large practice, medium deprivation)

A small number of GPs described how some patients can be anxious at the prospect of returning to work. In this type of situation, the GP may assess the long-term gain of issuing a medical statement certifying the patient as not fit for work in the hope that they can build a relationship with the patient and eventually encourage them to return to work.

*'Sometimes you have to weigh up whether [issuing a statement] is in the patient's best interest in terms of the doctor/patient relationship... You're looking for the long-term as opposed to the short term gains by sending them back to work early. The long-term gains might be that the relationship actually benefits and you're able, at some point, to negotiate a return to work rather than a breakdown of relationship in which they go to another doctor who then just gives them a sick note.'*

(GP 24: male, more than five years' experience, large practice, medium deprivation)

GPs also generally believe that age affects people's ability to get back to work or stay in work. They explained how people approaching retirement age may be reluctant to discuss returning to work and that they may be less inclined to challenge these patients about their capability, believing the advantages of forcing them back to work for a short period of time before they retire do not outweigh the potential disadvantages, such as the patient's anxiety at returning to work.

*'I've got a teacher who's off at the moment waiting for retirement, and I think she's going to be off until she retires in the summer, because at the thought of going back she can't do it and actually she's making herself ill, petrified about going back to work.'*

(GP 36: female, more than five years' experience, large practice, low deprivation)

### **3.2.4 Influence of the patient's job characteristics and their position in the labour market**

GPs perceived that particular patient groups, such as older men working in manual jobs, are anxious about retraining for a return to work in a different role if they can no longer complete their full role. Some GPs described how they do not want to challenge this group about their abilities and believe that returning to work may have a negative impact on them, so certify them as not fit.

*'Men who have developed degenerative disease in manual work who are heading towards retirement, that is a particularly difficult group [to return] because they feel that they're too old to retrain but they're not fit enough to do the job they originally trained for and they then want to continue a sick note.'*

(GP 25: female, more than five years' experience, medium-sized practice, medium deprivation)

GPs also considered the impact of the patient's job on their condition: if they decided that a return to work could be harmful to the patient by causing a relapse or worsening of their symptoms then they were less likely to use the fit note in a return-to-work capacity. For example, if the relationship between the patient and their employer or their colleagues has broken down, or the patient has work-related stress then, in our sample, there was some suggestion that GPs may not believe that a return to work is the most beneficial option for the patient. In some cases GPs are aware that signing the patient off work may not be the best solution in this instance but feel they have limited options.

*'An example is...there's a relationship problem because of the way people treat each other [at work]...they often lead to people being sick but actually what they need is some fairly intensive workplace therapy of some description. They're undoubtedly distressed and they can't work but I don't think being away from work necessarily is the best answer.'*

(GP 6: male, occupational health specialist, high deprivation)

A recurrent issue among GPs we spoke to was the potential negative outcome of a patient returning to work before they can do their job properly. GPs expressed that patients may experience pressure and stress if they are unable to complete their job properly once back at work and so some GPs may choose to keep people off work until the patient feels that they have made a sufficient recovery to return.

The local labour market also influences how GPs use the fit note. If jobs are not widely available in the local area, or if it was felt that patients might have difficulty finding alternative work that is more suited to their physical ability, then GPs believed it is difficult to engage the patient in a discussion about work. GPs also explained how they feel more comfortable using the fit note with patients who are in work than with patients who receive benefits. GPs believed that the financial impact of a move from sickness-related benefits to Jobseeker's Allowance could have a negative impact on the patient's physical and mental health. GPs commonly thought that patients on income-replacement benefits would be worse off financially if the GP suggested that they were capable of doing some work.

*'It's always much easier when they have a job to go back to. It's really hard when they were on Jobseekers and they didn't have a job, or they have an informal job that because they've been off on sick they've lost, and then they've got nothing to go back to. [It's] really hard to try and make them go back to work...you're basically transferring them from one benefit to another and you feel mean doing that.'*

(GP 36: female, more than five years' experience, large practice, low deprivation)

GPs generally sympathised with unemployed patients and they believed there are few advantages to suggesting ways of working when patients would be unable to find employment. Some GPs tended to agree to their patients' requests for sick notes because of the limited employment options for people in the area, and because of the high volume of requests for medical statements they receive. Some, however, described regret at doing so. Many GPs chose to complete the fit note truthfully even if the expected outcome was somewhat detrimental to the patient's financial circumstances.

### 3.2.5 GPs' assumptions about employer responses

GPs use of the fit note is also commonly informed by their assumptions about employer responses to their advice. There were mixed opinions about employer responses to mental health conditions: some GPs perceive that employers are now more receptive to employees with mental health conditions and others thought that employers remain extremely cautious of staff with mental health conditions.

GPs considered casual and contract-workers to have difficulties in returning to work due to the nature of their role, often working on short-term contracts with specific tasks like lifting and building, before moving on to another job. GPs also believed that it is often unrealistic to advocate a change in duties for people who work in manual jobs due to the nature of the role and the limited flexibility in tasks that it allows. Other GPs held perceptions that only a minority of employers want their staff to return to work before they are able to complete their full duties, and that larger employers are likely to be somewhat flexible while smaller employers are less able to accommodate changes.

Some GPs thought that some employers do not take their employees' health seriously enough and may disregard the advice on the fit note and ask employees to complete tasks they aren't capable of doing. They also perceived, sometimes from experience, that employers are inflexible when the advice involved altered duties due to time and cost barriers. This could make GPs less likely to use the workplace adaptations options on the fit note, although one GP offered a specific example of how he continually issued fit notes even though he suspected that the patient's employer would not accept them because of an agenda to terminate the employment on medical grounds.

*'[The employer] wants to get rid of [the patient] on medical grounds. They want me to say that he's not medically fit to work, which I cannot because I know this gentleman has got those problems [diabetes and hypertension] but he's active; he's motivated to work.'*

(GP 19: male, more than five years' experience, small practice, high deprivation)

Others had sometimes experienced inflexible responses from employers who were unwilling to reduce work hours for their employees. They perceived that smaller companies may be limited in the number of alternative roles that they can offer employees during the course of a phased return. If GPs perceive that many smaller employers in the local area will not be able to accommodate role changes they are less likely to use this option.

*'I think where we live...a lot of people work for small companies; there aren't any large employers so there aren't roles for them to take.'*

(GP 21: female, mental health specialist, low deprivation)

## 3.3 A shift in focus

This sub-theme describes the changes in the focus of and manner in which consultation are conducted by GPs since the introduction of the fit note.

### 3.3.1 A richer assessment of fitness for work

Many GPs explained that the fit note is now integral to the way that consultations are conducted. Unlike the sick note, which was usually completed at the end of the consultation, GPs introduce the fit note much earlier. The GPs in our sample expressed that this change in consultation style has occurred across conditions and the consultation is often a joint discussion and agreement about what to include on the note. GPs explained how they can now assess patients according to the work that they might be able to do rather than assessing them only against the type of work that

they have previously done. Many GPs now highlight the positive aspects of a return to work and explain that long periods of time off work can make it more difficult for patients to make a return. Their focus has shifted from what patients are unable to do to what they are able to do at work, and work can become part of their treatment course. Some GPs described how they have a more holistic attitude towards the advice that they give; they advocate work as part of a healthy lifestyle, alongside other factors such as diet.

GPs explained how the shift in focus of consultations that involve work allows them to gain greater insight into the patient's job role and understand more about the practical aspects of their work and the interactions that they have with others on a day-to-day basis. Many GPs feel that now they can consider alternatives to signing people off sick.

*'I think probably more of what you said before, about discussing the employment a bit more, because before it was very black and white, you either worked or you didn't, so with this you do have to, you know, "Well could you?" So I think it has probably allowed us to at least ask more and possibly get people back to work more.'*

(GP 17: female, more than five years' experience, medium-sized practice, medium deprivation)

Some GPs with specialisms in occupational health and orthopaedics chose to explore their patients' job roles in more detail.

*'Personally I take a more detailed occupational history, so I want to know exactly what parts of the [local forestry work] process they're involved in, whether they're chain-sawing, whether they're working in machines, whether they are organisers for the contractors, so I want to know exactly what their job involves.'*

(GP 35: male, orthopaedics specialist, high deprivation)

Some GPs also mentioned exploring other concurrent non-medical issues with patients, such as motivation or problems with relationships at work, which may be acting as a barrier to staying in work or returning to work. In some cases GPs would counsel the patient in ways to resolve their work issues, such as talking to their employer, but would not issue a fit note because the patient's problem is non-medical. In other situations the GP would use the fit note to give the patient time away from work to help them cope with their non-medical work-related problems.

*'I suppose there's an example, just yesterday there was someone came in who was working in a nursing home and been getting a bit of back pain because of heavy lifting and he's supposed to be getting leave but he's not being allowed leave and the nursing home's under investigation and there're all sorts of issues going on there and it was clear that the back pain was a side issue and he was asking "Can I be getting this investigation, that investigation?", "These investigations aren't going to tell you anything", and we managed to come to an agreement. He agreed that actually the main issue was that there were other issues going on at work and unless those were resolved me signing him off for a week or two weeks because of back pain wasn't going to do anything to change those things but it would give him what he was needing, i.e. leave which they weren't allowing him to have, and I was trying to say "You've got employment rights, by me signing you off and turning this into a medical issue when actually it's not a medical issue, it's an issue between you and your employment", so I did it eventually.'*

(GP 30: male, more than five years' experience, medium-sized practice, low deprivation)

All GPs we spoke to described how they address the patient's medical condition in the consultation before they bring up the issue of return to work, unless the patient initiates discussion of certification or returning to work. Discussion about returning to work is introduced at varying stages of the

consultation, however many GPs explained that they make it clear to the patient early on what they expect from them in regard to returning to work. GPs consult the patient about their strategies around returning and they use consultation time to explain, agree and justify to the patient what they have written on the note. They described how they now probe further than they did using the sick note for an understanding of what the patient feels that they can do at work and act as a problem-solver to discover what duties are compatible with their condition. They also highlighted the importance of exploring patients' confidence around a return to work as well as their desire to do so.

*'So we have to ask two questions: how much would you like to start work?...and...how confident are you that you could start work?...So if they're not confident that's where they need to be trained. That's where you work on the psychology. And those two questions are very, very, useful to be able to judge and evaluate whether it's worth trying to take them off the sick.'*

(GP 28: female, more than five years' experience, large practice, high deprivation)

There were of course some GPs who felt that they had always emphasised the importance of work in improving their patients' wellbeing and discussed the possibility of amended duties; and therefore had not changed their interaction with patients since the introduction of the fit note. A few GPs chose only to adapt their consultation style to focus on work capability when they perceived that the patient's condition was in a 'grey area' or for example, they were stressed, and there may be some scope for suggesting amendments.

GPs who had not changed their consultation style in response to the fit note realised that because of this the fit note had not achieved much in helping their patients return to work.

*'We haven't really changed [patient] behaviour as much as we had hoped. [It] involves not changing a piece of paper but a much richer change to a consultation...At the moment it's a different piece of paper rather than a different way of doing things.'*

(GP 1: male, more than five years' experience, large practice, medium deprivation)

The consultation style has also not changed over time for GPs who continue to use the fit note as a 'sick note', signing people off for a set time-period at the initial consultation.

### 3.3.2 Consultation length

GPs differed in their opinions about whether the length of patient consultations have changed since the introduction of the fit note. Some GPs believe that consultations have slightly increased in length due to them asking more in-depth questions of the patient and documenting information more accurately, particularly at the initial consultation. Some of these GPs however, believe that these consultations are now more meaningful because as they can do more for their patients, such as exploring different options to return to work. They believe that the note can save consultation time in the long-term and reduce the number of notes issued as a consequence of patients returning to work earlier.

*'In the long run patients don't come back or usually they don't come back to ask for more sick notes because usually they understand that I do want them to work if they can with their ability. So in the long-term I think it save consultation time. In the short-term, that consultation, I do spend longer.'*

(GP 40: female, less than five years' experience, large practice, high deprivation)

Others do not believe that consultations have become significantly longer with the fit note but many suggest that the main difference is the focus, as conversations and questions now have greater focus on work. In contrast to this a ten-minute appointment was sometimes considered too short to allow a comprehensive discussion about the patient's job role and challenge their perceptions of their inability to work. A number of GPs described having many more consultations with their long-term sick patients than they would have had previously, meaning that they could more closely document their progress and work capability.

### 3.4 Difficulties

This sub-theme explains some of the practical difficulties experienced by GPs when they prepared to use the fit note, during and after the consultation.

#### 3.4.1 Poor administrative preparation

While some GPs had the opportunity to look over the fit note before using it in a consultation, a few GPs found that pads of fit notes had not been in place in the practice in time. They described how insufficient supplies of fit note pads made it difficult for the change to be implemented in their practices and these GPs were forced to continue using the old sick notes. In other cases while GPs were aware that change was being introduced the switchover had been poorly managed by the practice and this meant that they did not have the opportunity to prepare.

*'I think people had perhaps got the original message that they were changing and then had just forgotten about it and then some practices had them, the new notes, they'd been put somewhere else and nobody had actually switched them over, so people were still using the old ones and hadn't realised the changeover had gone on and then some people just denied all knowledge of it full stop so I think that was a problem.'*

(GP 20: female, mental health specialist, low deprivation)

#### 3.4.2 Confusion about dates

While the fit note is described in many cases as well designed for its purpose, there were a few difficulties reported with the numerous date fields on the form. For example, if the date of assessment and date of statement duplicated each other, then some GPs are confused about which date field is required. Some GPs suggested that alternative wording at the top of the form would make it clearer if only one of the two date fields needs to be completed. GPs often feel under time pressure and would often choose not to calculate future dates in order to complete the fit note, instead preferring to write the number of weeks or month that the fit note is valid for. There was also an issue with GPs being unaware, particularly in the early stages of the fit note's introduction, about whether it could be back-dated, as the statement about the date on which the patient is assessed is unclear. Even now, a few GPs remain uncertain about the guidance for back-dating notes. An example offered by one GP was uncertainty about whether issuing one backdated note is sufficient when the patient has been unable to visit the practice for some time for a review, or whether two notes need to be issued to cover both a time-period that has passed and the future sickness period.

#### 3.4.3 Distinguishing between return-to-work options

Although GPs feel confident using the fit note, they reported problems understanding and differentiating between the return-to-work options. One experienced orthopaedic specialist described such a difficulty with the 'amended duties' and 'phased return' tick-box options, as they considered the categories to be broad and overlapping explanations of workplace changes.

Other GPs felt comfortable with the phased returns, amended duties and altered hours options, however they felt less confident specifying workplace adaptations because they don't have a good understanding of the patient's workplace.

*'I would say phased return is quite straightforward, self-explanatory. I'll say "Two hours a day for one week, then three hours a day for the next four weeks and then review". Altered hours: similar. Amended duty: usually I'll say "Avoid certain things", so, for example, catering, waitress or something like that with wrist problems I'll say "Avoid lifting with the left hand, avoid usual lifting" and just that so they can do. Workplace adaptation: I hardly tick that box because I don't understand the workplace really.'*

(GP 40: female, less than five years' experience, large practice, high deprivation)

### 3.4.4 Section blindness

Others experienced section-blindness and completely failed to notice entire sections of the fit note, meaning that they regularly left parts blank. These sections included the name field, the future assessment field and the signature space at the bottom. Some GPs explained that it may be useful to highlight some of the sections, particularly those that are mandatory, to prevent them being overlooked. Some suggested colour coding the fit note to flag those sections that are compulsory.

### 3.4.5 Other uncertainties about areas of the form

More confusion arose over specific sections, for example the 'I will/will not need to assess your fitness for work again at the end of this period' option. Many GPs were unsure as to whether this section was mandatory as they assumed that a patient did not usually need to be reassessed after the specified time period of sickness. In some cases they were unsure as to whether they would need to see the patient again at the end of the specified sickness period and so did not know how to complete the form. To resolve the confusion, many tended to score out or omit this section completely.

*'At first I did start to either score or score it off but then I got confused as to exactly when I should and shouldn't be using it. I must admit I tend hardly ever to fill that in because I thought the default position was that you don't need anything and that you don't need to state that.'*

(GP 30: male, more than five years' experience, medium-sized practice, low deprivation)

One GP noted that if the option were a tick box rather than a deletion option, then it would be easier for them to complete.

Some GPs thought it would be useful to have additional space at the base of the form for the practice information or stamp. GPs discussed their thoughts on the design of the fit note; a small number of GPs discussed difficulties with the layout that didn't allow them an allocated space to specify a time-period for the fit note such as, 'three weeks', and thought that additional space would be an advantage.

### 3.4.6 Providing limited detail

Some GPs annotate the fit note with instructions to use it as a continuation of a previous note, or amend the wording to allow more personalised patient notes as they do not believe that the fit note always suits their purposes. However, time constraints can limit the amount of detail that they incorporate, which means that the patient's employer is potentially left without sufficient detail about the tasks that may be able to carry out. For example, the GP may specify an option such as amended duties but not clearly relate it to the tasks that the patient performs in their role.

*'Lack of time, so sometimes I don't put all the details because I'm running late. I put "amended duties" and I don't put anything about the job that I know that person does and I'll just put "back pain means they can't lift" or something like that.'*

(GP 2: female, more than five years' experience, small practice, high deprivation)

### 3.4.7 Employer practices

In some instances, GPs described how employers appear to misunderstand the process involved in sickness certification using the new medical statement. They explained that some employers are yet to understand that the fit note allows changes to the patient's role and the employers have asked for more information. They sometimes send their employee back to the GP for a 'sign-on' note or an old-style sick note in order to protect themselves from taking on the responsibility for the employee going back to work before they are fully fit.

*'They haven't got a clue what the new note's about. I've been getting employers ringing us up and saying, "Can you provide a medical report, can you elaborate on what you're putting?"...They regularly send a patient back for a return-to-work note, so if you put in that a patient's fit for all duties but heavy lifting they will send the patient back and ask for a proper sick note.'*

(GP 4: male, more than five years' experience, small practice, medium deprivation)

GPs also described situations where employers have put employees under pressure to ask for a fit note to return to work even when they are not fit enough to work because they don't want employees having too many days absent. They may feel that if the employee is able to do some work, they can push to get them to do more rather than amend their duties. When patients are eventually well enough for a full return to work, employers may sometimes request a fit note as proof of this. This presents a practical difficulty for GPs, as employers do not understand that this is not necessary and GPs have to alter the note to state that the patient is fully fit for work as there is no tick-box option to cover this. Some GPs were confused as to why this has been removed from the design of the fit note. One GP proposed that an option that described the patient as completely fit for work would help them overcome this difficulty.

*'I don't find this note as easy to say that you are 100 per cent fit for work. There should almost be a third option that says "You are completely fit for work".'*

(GP 41: male, less than five years' experience, large practice, medium deprivation)

### 3.4.8 Language and literacy barriers

Language barriers can present a great difficulty for GPs in discussing work with their patient and being sure that they have fully informed them about what has been written on the fit note. Less experienced GPs in particular may worry about this issue. There could also be practical difficulties in directing patients to the information on the back of the fit note; not all patients are literate, rendering the information of little use to some. A few GPs suggested that simplified instructions for patients would be useful in this case, including sources of additional advice and support that patients can access if they have any further questions.

## 4 Receptiveness

### Key findings

- General Practitioners (GPs) regard the patient's agenda for returning to work as a key determinant of the success of the fit note process. In turn, the patient's agenda is influenced by financial factors, their illness perceptions, and attitude to work.
- Recommendations for keeping patients in work or returning them to work may be hampered by patients who predict a negative response from their employers.
- GP self-efficacy in using the fit note is affected by a lack of feedback about the value and feasibility of the advice they give on the note. Any feedback they get about the content of the fit note comes via the patient.

This chapter describes how the patient's own agenda can influence the effectiveness of the fit note in facilitating a return to work. It also explores how a patient's anticipation of their employer's response to the fit note and the absence of any observable outcomes or feedback for GPs from employers can impact on the use of the fit note. It comprises the following subthemes: patient agenda; pre-empting employer responses and consequence vacuum.

### 4.1 The patient agenda

This subtheme describes a commonly held perception among GPs in our sample that the patient's agenda for employment is key to the effectiveness of the fit note in helping people return to work. GPs identified three main factors that governed the patient's receptiveness to the fit note process: financial factors; the patient's illness perceptions; and the patient's attitude towards work.

#### 4.1.1 Patients who are motivated to return to work

Where patients want to return to work, because of their work ethic, job satisfaction, financial concerns, or concerns about losing their job, GPs felt that the fit note could enable them to resume work sooner than the sick note might have done. In such cases, GPs felt the fit note could form a basis for the employee and the employer to begin negotiating about return to work and described the fit note as empowering for the patient, who could use the GP's guidance as a bargaining chip with their employer.

*'Well, again, it took a few weeks for them [patients] to understand what they were getting but I think on the whole they like it [the fit note] because they equally like the ability to have this dialogue with their employer because the patients that like it want to work and often they're stopped and they may not be getting a sick scheme from their employer and they financially need to get back into the workplace.'*

(Female, more than five years' experience, medium-sized practice, medium deprivation)

*'I think so [patients are returning sooner] but I think what's probably quite fortuitous for this is that because of the economic climate at the moment people are more scared for their jobs so I think they appreciate that effort to get them back to work quicker, yeah.'*

(GP 15: male, orthopaedics specialist, medium deprivation)

Some GPs felt that motivated patients had always returned to work as soon as possible so the fit note had not made a big difference to the speed with which they now return. Self-employed patients were thought by GPs to be less likely to take time away from work than their employed counterparts because they would lose earnings. GPs expressed their frustration that they could not persuade these patients to take time off to recover from illness or injury and were concerned that the patient could exacerbate their condition if they resumed work too early.

*‘Self-employed people you have to persuade to take time off work, in general. So the guys around here are all farmers, they’re all self-employed, they probably haven’t got insurance and it’s very, very hard to get them off work, even when they’ve had operations or heart attacks or broken bones, it’s very difficult to say “You shouldn’t be at work” because they don’t claim benefits, they don’t get insurance so they won’t rest.’*

(GP 4: male, more than five years’ experience, small practice, medium deprivation)

Similarly in deprived communities where there is a lot of competition for work and the jobs available are low-skilled manual or service industry jobs such as hotel work, GPs perceive that patients are keen not to take time off work. GPs felt that patients are concerned that they don’t receive sick pay from their employer and that their job might not be there for them on their return. GPs described their frustration that patients who really needed time off to recover would not take that time. GPs thought that patients who have concerns about losing their jobs welcome the opportunity to be assisted to return to work and for these patients the fit note was successful in assisting them to do so. Conversely, if the patient is in a low-paid job and receiving statutory sick pay while off work, GPs believed the patient to be less motivated to return and therefore less receptive to back-to-work discussions using the fit note. GPs perceived the financial impact of being away from work as not prohibitive for these patients.

### 4.1.2 Perceptions about patients’ lack of motivation to return to work

GPs described how employer sick-pay packages can influence the timing of patients’ return to work and in some cases patients time their return to coincide with the end of their period of sick pay.

*‘Finance is a big thing, often people have sick pay packages for six months and then it goes down to SSP and they go “Oh, well I’ll go back to work now”.’*

(GP 7: male, more than five years’ experience, large practice, medium deprivation)

GPs described how some patients view getting employer sick pay as a right and in some cases view sick leave as part of their annual leave entitlement, so some patients resist returning to work until then.

GPs discussed how patient beliefs about their illness are influential in their willingness to consider returning to work before they are fully recovered. Some patients believe that their recovery will be more effective at home than at work and that returning to work might hinder their recovery. GPs believe that employer practices are also influential. For example, some employers now adopt strict sickness absence policies and take disciplinary action against employees who have sometimes just two or three individual sickness absence episodes. Patients can be reluctant to return to work before they are fully recovered in case they can’t manage their return and have a further period of sickness absence. GPs also found that there was a disparity between patient and GP perceptions of the level of fitness they would need in order to work in some capacity. Patients who had adopted a long-term sick role and those who had perhaps never worked felt that they would need to have a much-improved level of fitness in order to be able to work in some capacity. The patient was likely to think they were incapable of any work while the GP often felt that there was something they could do. GPs described how some patients on long-term sickness-related benefits are surprised when their

GP raises the issue of work. Similarly, GPs felt that patients are unwilling or feel unable to consider re-training for a different role if they think they are unfit for their current role.

*'The other category is this one, these people like...again, I saw a patient recently diagnosed with diabetes, "Oh I have got diabetes, I can't go to work, give me a sick note", I tell them "I have diabetes myself, I come to work here every day. Just having diabetes does not make you unfit to work".'*

(GP 19: male, more than five years' experience, small practice, high deprivation)

*'I've got people who have been off work for such a long time that actually they're quite shocked when I say "Actually I think it would be good for you". I can think of one young man who's been off work probably for about 12 years and I was aware about...so we've gone beyond certification, but I am aware that actually the Government are going to start reviewing people on long-term sickness benefit and actually starting to chuck people off it and that is causing problems, and I suggested to him that he start to think about whether he could be employed, his condition's very stable, he's got his car, his disability car, and he moves around and I suggested we put him in contact with [an agency] who do some sort of employment support work and looking at jobs and things, and he was just gobsmacked that I even suggested it.'*

(GP 10: female, occupational health specialist, low deprivation)

Some GPs provided examples of patients who have ulterior motives for not working, for example if they are involved in an injury compensation claim. These patients would have a weaker case if their injury has improved and therefore are unwilling to admit that they may have recovered to the extent that they can return to work.

*'So if somebody comes in with this back pain they're "Oh I've had two years and no-one can get it better", I'll say "Oh, are you involved in suing?" and they'll say "Yes", and I'm saying "Oh right, okay, well I know you're not going to get better", do you see, I know they're not going to get better because it's sorted and they've got their money they're not going to say they're not in pain.'*

(GP 10: female, occupational health specialist, low deprivation)

GPs described finding it more difficult to facilitate a return to work using the fit note in cases where, given the patient's subjective experience of their condition, the GP cannot easily gauge the effect the condition has on the patient's ability to work. Some GPs also believed that patients could feign these conditions because symptoms are not well defined.

*'I think if I am going to be filling it out as the GP it's difficult to think a form would actually change what I do because I've got to be on the patient's side really, not completely, if I think they completely don't have one [an illness] then I tell them they don't have one, but if they're telling me "Yes I need one, I need one" then I think "Well perhaps you do but I'm not quite sure" and I push them a little bit and they still insist they need one then I feel obliged to give them one [a note], even though the gut feeling is perhaps they're swinging the lead. Things like stress are really difficult to judge and back ache.'*

(GP 44: female, more than five years' experience, small practice, high deprivation)

One GP regretted that his professional peers were very quick to refer patients to specialists as he felt this could legitimise the patient's assessment of themselves as sick. Some GPs believed that having a long-term relationship with the patient made it easier to judge whether the condition was genuine while others felt this was difficult regardless of the patient relationship.

Patients sometimes do not want to disclose their condition to their employer or colleagues. This may be because they do not want others to know about their condition at all or because they do not want others to know how their condition affects their ability to work. This can be motivated by fear of losing their job.

*'I think there's often peer pressure within their jobs and they're worried that if they can't do the same as everyone else at work then they find that more stressful and they'd rather not have to go in and they don't always want people to know why they've got maybe special conditions. So sometimes they would rather just be off until they're better rather than having to go in and explain it and so I think sometimes it's just the person's perception of what other people are going to think, and also I think worrying at the moment in this climate is about their job and if they're not seen to be working absolutely 120 per cent then they're probably dead wood and they'll be on the next pile to go.'*

(GP 20: female, mental health specialist, low deprivation)

GPs held a perception that some patients did not want to return to work. They described how the outcome of the consultation might depend on the strength of the patient's argument. GPs described how some patients have even presented with new conditions to avoid returning once the GP had deemed them fit to work in some capacity. In some cases GPs perceived there to be little point in arguing because it is difficult to disagree with the patient if they do not want to work. As GPs perceived that people generally don't understand the likely benefits of work to their health, GPs' use of the fit note to act in the patient's best interests is not the outcome that the patient expected or wanted from the consultation.

*'So it's been helpful for patients for you to be able to be an advocate for them to get back to work, but the flipside is some folk who are clearly just not wanting to work at all for various reasons... For example, there was a patient who had developed seizures, which he was claiming were due to epilepsy, they were almost certainly due to drug misuse, and he said "I need signing off from my work because I've got these seizures, I work up ladders at the local supermarket and if I have a fit on top of the ladder I'm going to fall off and that would be disastrous", I said "Well that doesn't mean to say you're not fit for work, it maybe means you can't work up ladders", so I said "I'll put a note saying you may be fit for work taking into the following advice: may be prone to seizures, cannot go up ladders, or shouldn't be working at heights" and he wasn't very happy about that but I felt that was a valid thing to do for him.'*

(GP 30: male, more than five years' experience, medium-sized practice, low deprivation)

### 4.1.3 Perceived effect of the patient's work ethic

GPs explained that some patients already know about the fit note when they come into the surgery and want to use it to get back to work. It was felt that this group of patients respond well to return-to-work conversations if they enjoy their jobs. In some cases GPs have been surprised by the receptiveness of patients to the fit note, even if they had expected to be signed off work when they attended the consultation.

*'You might imagine that people would come in wanting a sick note because they want time off work and they still get people that you think actually a one- or two-week break and there's no way you're going to use a fit note because actually they need it, and that's fine, so you just write "Not fit for work", but most of the time I've suggested that actually they might be fit with adaptations, or whatever, they're quite open to it, which has surprised me a bit actually, yeah.'*

(GP 15: male, orthopaedics specialist, medium deprivation)

Other patients have a sense of duty towards their employers or their colleagues not to prolong their period of absence, or they perceive their workload to be a demanding one, and so they are keen to return to the workplace as soon as they can.

*'Then you also have the opposite end where people have high-powered jobs who feel they can't leave the job to anyone else and the company can't cope without them, and they sometimes rush back as well.'*

(GP 32: female, more than five years' experience, medium-sized practice, low deprivation)

In some cases GPs report attempting to stall patients who are keen to go back too soon if the GP believes the return may damage their recovery.

Patient characteristics that GPs thought affect willingness to return to work are age and socio-economic position. Some patients will raise certification with their GP early on in the consultation because work is important to them and often they have already communicated with their employer and established the basis on which their return is possible. GPs who described their patient lists as being predominately middle-class professionals felt that they enjoyed their jobs more, identified with work and would want to return to work quickly and so they had trust in their patients' accounts of their condition and their job role.

*'Where I worked in has got two premises, one is more middle class I would say, the other is more with population would take benefits...Let's put it this way, and they actually...quite a few of them [in the former area] do want to go back to work, yes, and so I use a lot of the altered hours or phased return so they are still working while they're off sick, while the other one where the population get used to taking benefit they find it very difficult, well quite challenging consultation. When I try to explain to them about they're fit to work or do certain duty they will come up with many different things.'*

(GP 40: female, less than five years' experience, large practice, high deprivation)

*'Different socio-economic groups, professionals, I know that they will probably be returning to work because it's the job that they work for and it's part of their identity, but people who are just doing a job just to get the money in, they don't enjoy it.'*

(GP 45: female, less than five years' experience, large practice, medium deprivation)

GPs think the effectiveness of the fit note is diminished in situations where patients on benefits have no intention to work. GPs perceive the patients to have many reasons for this including the people around them – peers and family members – who may not work and so the patient lives in a culture where people don't expect to work.

*'You've got a whole generation now who've got parents who probably didn't work, who haven't had a work ethic in school to create the education they need in order to get up the ladder, who are then going into this idea that you don't work and you're supported, and it's just going on and on and on and on and trying to lift somebody out of that, where do you start?'*

(GP 25: female, more than five years' experience, medium-sized practice, medium deprivation)

#### **4.1.4 Communicating via the patient**

A further difficulty described by GPs was when information from other clinicians involved in the patient's treatment is relayed through the patient. GPs suspected that what they are told by the patient does not always accurately reflect the situation, for example their physiotherapist's views on the progress made.

*'Well if you just think of a straightforward thing like somebody having back pain or having surgery or whatever, you won't get, in good time, a report from the physio. What you'll get is a report from the patient of what the physio has said, "The physio's really pleased with me and they say I'm doing fine and I should be okay to do this, this and this", which actually is really quite good as long as the patient's motivated. If the patient isn't motivated and wants to stay off for a few weeks longer they'll say "Well the physio says that it's going slowly".'*

(GP 10: female, occupational health specialist, low deprivation)

#### **4.1.5 Patient tactics**

In GPs' view, patients can manipulate both their GP consultation and their Department for Work and Pensions (DWP) assessment in order to be judged not fit for work. They believe that the benefits appeal process encourages false sickness claims and patients are able to invent new medical conditions in order to remain on sickness-related benefit. GPs felt that these patients had adapted to the new system and had developed tactics to remain in receipt of their benefits.

GPs believe that patients who do not want to work will always find a medical reason why they cannot work and so the new policy is ineffective in encouraging this group back to work. In some cases patients returned to their GP for a new medical statement when they had been declared fit by the DWP Work Capability Assessment.

Patients also employ tactics, according to GPs, to ensure they achieve their desired certification outcome. GPs describe patients who GP-hop in order to find a GP who is willing to sign them off rather than insist on a return-to-work plan. They either do this within the practice or across practices so they will change surgeries in order to secure a preferred outcome. GPs do not perceive that the fit note has addressed this practice; however some practices, both large and small, had adopted a co-ordinated approach to sickness certification to avoid disparity between the certification habits of GPs. Keeping good patient notes detailing what their long-term management plan was for the patient also helped prevent patients manipulating a new GP. Some GPs noted on the patient's record that they must return to work after the expiry of their current period of certification. That notwithstanding, GPs have experience of patients presenting with new symptoms to a different GP in order to be judged as not fit for work.

*'If I find someone is not off sick, you may be fit, they shop around, so I've got a practice of ten, however because you've got to use your list they can do that less, will go and see someone else and say can you sign me off sick, you know, I've now got this new problem, so that's interesting you didn't say that to the other doctor the other day, perhaps I forgot, you know it's my headaches, they're terrible, I can't get out of bed and no way could I work...'*

(GP 28: female, more than five years' experience, large practice, high deprivation)

## 4.2 Pre-empting employer responses

GPs reported that patients commonly explain that their employer will be inflexible when advised that they can return with certain conditions.

GPs explained how they rely almost entirely on the patient's account of their role and their employer's willingness to make adaptations or accept phased returns, altered hours or amended duties. GPs described how patients often report that their employer would be highly unlikely to accept modifications. GPs are conscious during the consultation that they only have the patient's account of what is possible in that workplace. Some GPs suspect that patients who do not want to return to work will present the GP with a negative picture of the prospect of returning to work before they are fully fit.

*'Yeah, they don't want to go back and they definitely don't want to go back on amended duties, so if there's a chance that you can sign them fit for amended duties and they're thinking "No, I don't want to do that" they'll come back and say "No my employer didn't let me".'*

(GP 34: female, more than five years' experience, medium-sized practice, medium deprivation)

GPs described their different tactics for managing these situations. Many GPs concede to the patient's view because they feel that trust between GP and patient is central to their ongoing relationship and so they are reluctant to argue or disagree with the patient. This often results in them declaring the patient unfit for work.

*'Well if the employer won't make a change to the workplace environment, or give the phased return, or whatever, you end up having to give that patient a sick note.'*

(GP 38: female, more than five years' experience, small practice, low deprivation)

Other GPs stand by their guidance and explained that it is up to employers to decide the extent to which they follow that advice. One GP explained that he changed how he deals with these situations during the year following the introduction of the new medical statement. At first he had declared the patient not fit for work, but with time he had developed more understanding of the fit note policy and had realised that the employer is not compelled to follow the GP's guidance so now stands by his guidance regardless of the patient's views on what the employer will find acceptable.

*'Now my understanding is they [employers] don't have to follow that so I say "I'm not changing my advice, that is still my advice, it's up to your employer whether they follow that [my advice] but I'm not changing it." I still would say "You maybe fit for work", whereas before they used to come in and say "I need a new sick note" and you'd always just comply with the request, but now I've stopped doing that.'*

(GP 41: male, less than five years' experience, large practice, medium deprivation)

GPs describe having sympathy with the patient view that their employer will not accept them back unless they are fully fit, especially if the employer does not offer sick pay, the patient's job role is low skilled and the employer can easily find a replacement staff member. GPs also rely on the patient for information about the availability of alternative roles within the organisation and this influences their decision to make suggestions about returning using the fit note.

### 4.3 The consequence vacuum

GPs receive very little or no feedback from employers about how useful or feasible their guidance is or the extent to which their recommendations have been implemented.

GPs identified two main reasons for this consequence vacuum: employers and GPs have very little contact; and in most cases of acute injury or illness the patient will not need to return to the GP. As a result GPs have no knowledge of the pathway the fit note follows once it leaves the surgery, of who reads it, who may act on the guidance that they give, and whether it has been successful in effecting an earlier return.

There is, therefore, little opportunity for informed reflection on the type and depth of advice that GPs give to employers about accommodating return to work. GPs described how they would feel happier about giving back-to-work advice if they were to receive some feedback about the usefulness of the recommendations that they currently give. This lack of feedback affects GPs' confidence that they are using the fit note correctly – some GPs assume because they hear nothing that the advice they give is effective and this increases their confidence that they are using it well, while for others the lack of feedback results in uncertainty. GPs also explained that as far as they are aware there has been little publicity about the effect the fit note is having which makes them less confident in using it.

*'I'm sure it would be good to have feedback from them about the specifics that they would like us to be giving and if there were specific queries that they have, obviously within the limits that we have being outside of the working environment. We're not trained occupational health physicians with diplomas in that sort of line, we're just general practitioners who are doing what we think is best and making our own judgment on what the patient's told us about their day-to-day activities and balancing the two really. So I think, yeah, there would be advantages of greater communication. I'm sure if there were specific things they wanted to know it would be helpful to know what they are rather than us just making very broad, sweeping statements about what we think is appropriate.'*

(GP 43: female, less than five years' experience, large practice, medium deprivation)

*'I would say my problem is I'm never very...I'm confident...You could write "You may be fit for work" ticking absolutely everything really and you could tick all of that for everything and then you could write a whole spiel down but nobody's ever come back and discussed it with me and I'm not very confident that the employers are paying any attention to it.'*

(GP 21: female, mental health specialist, low deprivation)

Some GPs are unsure about how specific to be about what the patient can or cannot do and feedback from the employer would help them decide on the appropriate level of detail. Employers had told one GP – with a special interest in orthopaedics – that specific information about what the patient should or should not do in the workplace was more useful than general advice, such as undertaking light duties.

The majority of the information that GPs receive about employer responses is either via the patient or anecdotally from colleagues and friends. GPs described that while they have found it easy to use the fit note to suggest a return to work they don't know how successful that has been. They perceive that most employers would be able to adapt to the fit note yet they don't know in practice if this is being done or how much assistance employers provide to the patient who wants to return to work. In some cases GPs are pessimistic that their advice is followed.

*'Aye, well often you do hear from patients, "Oh yeah, I was allowed to phase back into work or alter my hours" and things like that, that's good but yeah, sometimes you write things out and think "No-one's going to pay any attention to that".'*

(GP 30: male, more than five years' experience, medium-sized practice, low deprivation)

The lack of feedback from employers led GPs to draw their own conclusions about employers' willingness or ability to make modifications to the patient's job. GPs assumed this would depend on the size of the organisation and on the nature of the patient's role. Larger employers were felt to offer the most flexibility because the impact on the business is less and sufficient staff are available to compensate for the aspects of the patient's role that couldn't be fulfilled. GPs also assumed that large employers have better access to occupational health services that could assist the patient's return to work, and have administrative processes to organise modifications. Nonetheless, GPs cited examples of large public sector employers who were reluctant to accommodate any change to the patient's job. The patient's role was also thought by GPs to influence the employer's attitude to return, with high-value employees enjoying more flexibility. GPs also accepted that many employees do not have the skills to be able to fill alternative roles within an organisation while they recover and so therefore the employer might prefer them to refrain from working completely until they are able to fulfill their usual role.

Some GPs expressed scepticism about the extent to which employers understand the new certification system and GPs believe that employers pay very little attention to the fit note advice they receive. They suspect that the business imperative of the employer means that they don't have the best interest of the patient at heart and may have an agenda to manage patients who have chronic illnesses out of the business. Others assume that employers are keen to get people back into work and so will do their best to follow the GP's guidance. Usually, however, GPs are left frustrated that there is no dialogue with the employer about flexible options for their patients. In some situations a lack of feedback or requests for clarifications might result in the GP issuing a not fit for work medical statement when the patient might easily have stayed in work.

*'Yeah, because usually the employers, the vast majority that I've seen...I had a gentleman, his wife was really, really ill, perhaps dying, I can't remember who it was but they were understanding. I had actually written out a sick note with amended duties because he had to kind of help with this horrible time, so it could be modified, and he did work from home. So I was trying to negotiate that he did perhaps one or two hours and do it that way. They were totally unreasonable, I was forced to actually give him a full time off because I felt it was just no feedback, no questions raised, whereas the Police Force, when I do that, I say "Well I always get a reply back saying why, we've done this, I've found that", from the one or two, but the major other companies, you never get anything, nobody seems to even call us up or if they have an occu health in their department, absolutely nothing.'*

(GP 13: female, more than five years' experience, medium-sized practice, low deprivation)

GPs appreciate that the quality of their advice can have an impact on the employer and on the patient. They perceive that the depth of detail they provide must be sufficient for it to be useful, however because of a lack of contact they are unable to make an evidence-based assessment on the depth of detail that would make the note useful and actionable.

On the rare occasions when employers had contacted GPs in our sample, it was usually to clarify the guidance the GP had given. However, in most cases contact was made via the patient who was asked by their employer to seek further guidance. GPs suspected that the patient may not always represent the employers' perspective accurately. GPs also described how being the conduit of information can be burdensome for the patient, especially when they are ill or injured and have

concerns about their job security or finances. GPs believe that the fit note works best if the patient and the employer have already had a conversation about what is possible. GPs described how after they issue an initial fit note stating that the employee is not fit for work they instruct the patient to have a conversation with their employer to explore options for return. In this way the GP can tailor the advice given on the second fit note to what the patient and the employer have agreed. This situation however also relies on the patient effectively relaying information between their GP and their employer.

*'An odd phone call [happens with an employer] but I mean it's usually through the patients, "My employer says this". There's always going to be a degree of that and there's always going to be a degree of "Well did they really say that? Is the patient lying or have they misrepresented what the employer said?" But in terms of direct conversations, none.'*

(GP 37: male, more than five years' experience, medium-sized practice, medium deprivation)

# 5 General Practitioner approaches to patient management

## Key findings:

- The fit note can empower General Practitioners (GPs) to facilitate patients' return to work and retention in work while they recover. GPs generally feel that their role now involves changing patient perceptions of their ability to work and in some cases GPs have been able to adopt a stricter role with their patients.
- GPs believe that patients with conditions that are compatible with phased returns can return to work sooner than they could have done under the previous certification system.
- GPs who focus primarily on medical rehabilitation use the fit note at a later stage in the patient's recovery than GPs who view work as part of the patient's recovery.
- GPs generally make decisions about returning to work in isolation from other clinicians. Co-location of other services, such as physiotherapy and counselling services, aids communication about the patient's ability to work, which may otherwise be communicated via the patient.
- As patients face non-medical barriers to returning to work or moving off sickness-related benefits, GPs believe that referral to agencies to address non-medical barriers would be beneficial.

This chapter describes GPs' perceptions of their role in helping patients return to work and how this has changed with the introduction of the fit note. It is presented in the subthemes of: facilitating a return to work; extent of collaborative working; and roles for other agencies.

## 5.1 Facilitating a return to work

This subtheme explores the effect of the fit note on GPs' perceptions of their role and GPs' views about the balance of responsibility between the patient and the GP.

### 5.1.1 GPs' perceptions of their role

GPs have differing views of their role in facilitating return to work. Many GPs believe that motivating people to get back to work as soon as possible after their illness or injury is an integral part of their role. They have found the fit note helpful because they can offer the patient an alternative to being able or unable to work and they can now influence changes to the patient's working environment to help them return to work. In particular, patients with musculoskeletal conditions, mental health conditions, fatigue, and stress-related conditions were described to have returned to work sooner than they might have done under the previous certification system. GPs consider the fit note to be particularly valuable for managing these conditions for which a phased return, for example two or three days a week, can be used to build patient confidence and eventually enable a full return. The fit note has enabled GPs to return patients to work before they are 100 per cent fit and in a few cases GPs have been able to help their patients avoid taking any time off work whatsoever, empowering their role as a facilitator. Although GPs may have tried to partially fulfill this role in the past, the fit note has given them belief that their role now does officially incorporate a responsibility to facilitate patient working where possible.

*'You think by the fact that you've been given this note where you're allowed to put these things on there [i.e. amended workplace options] that you are being given a little bit of responsibility to say things which before, perhaps, you would try and do but you never really knew if it was official.'*

(GP 20: female, mental health specialist, low deprivation)

Some GPs, however, already considered themselves to be facilitators of return to work and getting patients back to work has always been a key therapeutic goal for them. The fit note brought them a sense of professional validation of their role.

*'I remember feeling pleased that [the note] was here because I felt that it was validating what I was already doing.'*

(GP 38: female, more than five years' experience, small practice, low deprivation)

Some GPs, even those that were already fairly experienced in patient consultation, explained that the fit note has enabled them to adopt a stricter role with patients and they will try to encourage alternative strategies to taking time off work and emphasise that if patients do get a fit note to take time off work it is only short-term solution. For some patients the impact of a period of illness or injury has become short-term rather than long-term because the GP will now consider a return prior to a complete recovery. GPs now perceive that they play a role in protecting patients' future wellbeing by encouraging and enabling work.

*'When people are off work for too long it can often be hard to get back to work and I think if you enable people to get back to work quickly [they're] then less likely to be off sick in the long-term.'*

(GP 9: male, orthopaedics specialist, low deprivation)

The greater focus on the relationship between work and wellbeing has resulted in some GPs paying more attention to long-term outcomes rather than concentrating on the central medical condition.

GPs recognised that the fit note has given them a slightly different role in specifying when the patient should return to work and part of that role involves changing people's own perceptions of when they are able to work, motivating and encouraging them, particularly when they have clear incentives to stay out of work. These GPs consider part of their role to be educating their patients about a holistic recovery; however, the approach was managed on an individual basis as opposed to being governed by the condition that the patient has. They chose to explore with patients the idea that working is a way of improving fitness and aiding recovery.

GPs discussed their role as facilitators of more productive lifestyles and how helping people restore the balance of lives is key to successfully managing their patients. There was an awareness that working in some capacity keeps patients motivated, increases self-esteem and improves wellbeing.

*'I think [work] improves their health and wellbeing if they're in a job that's giving them job satisfaction and income, you know, a routine in their day, getting them out of the house and I think it can be for most people very beneficial to be going back to work.'*

(GP 27: male, less than five years' experience, small practice, low deprivation)

As a means of helping patients to recover, GPs have used the fit note to build patient confidence by emphasising that long periods off work can affect confidence about returning. GPs talked about the practicalities around their new role advocating work to patients. Many believed that advocating the importance of work in improving health and wellbeing involved learning new skills such as ways of

communicating this information to patients and employers, about why it was no longer ideal to just sign people off work instead of exploring their capability. They felt this change put emphasis on the social aspects of the GP's role rather than the medical.

*'[It] is a transition because you do have to learn new skills to do it and the first thing is kind of get the awareness actually yes, work is useful and that's actually really detrimental if I'm just signing people off, and then you're looking at more sophisticated ways you can liaise with patients, employers and patients.'*

(GP 15: male, orthopaedics specialist, medium deprivation)

GPs also explored how important it is to highlight the importance of work at the outset of consultations and not to become a facilitator of the patient's sick role. Many GPs feel that they have a clear obligation not to allow the patient to become dependent on sick leave or sickness benefit, which they believe will make them unhealthier in the long-term. In these situations the fit note can be used to allow patients to continue in a working situation while managing or recovering from their condition. Some GPs explained that as they have become more experienced in their role, they have been better able to comprehend that most people will be fit for some work even if they are currently on sickness-related benefits and it is important that GPs don't encourage dependency on sickness.

*'So you tend to present [a return to work] right at the outset about what you want the end game to be otherwise there's a real danger of creating dependency behaviours by just giving people sick notes and pushing them into a world in which they are passive, victims, ill, recipients of care as opposed to people who are active problem solvers who are looking for solutions. So I'm quite conscious of that.'*

(GP 1: male, more than five years' experience, large practice, medium deprivation)

In some cases GPs explained that their practice had agreed a general approach of promoting the benefits of work to patients. Some GPs described how they discuss difficult cases in the practice with their colleagues to ensure that they are providing a consistent approach or choose to document pointers in patient case notes so that if the patient moves to another GP in the practice, then they are aware of the failed attempts to get them back to work. However, when a GP has been issuing sick notes for a long period of time, it becomes very difficult for other GPs to attempt to approach a discussion about return to work with unwilling patients. In this situation, GPs' perceptions of their role as a facilitator may shift, and they no longer see it as their responsibility to repair the actions of another GP.

*'Initially I tried to encourage a few of the long-term sick ones that this was a move towards getting them back to work. Well it didn't go down very well but I've not even bothered broaching that very recently, I just acquiesce. If somebody comes in wanting a sick note, there's no point in arguing with them, if that's the first thing they say to you and they've been on one for months off another doctor I'm not suddenly going to challenge them.'*

(GP 39: female, more than five years' experience, large practice, medium deprivation)

Younger GPs described how they feel that they are more comfortable getting people back to work using a method of regular consultation, for short and long-term health conditions, even if this contradicts what their more experienced colleagues may be doing.

*'I suppose some of the more experienced GPs and some of the more senior partners I know do longer periods of absence on their sick notes, as they were called, whereas I probably am still very inclined to see people more regularly and to keep assessing things, even if that might be construed to the practice, perhaps, as a wasted consultation because you're not necessarily achieving much.'*

(GP 43: female, less than five years' experience, large practice, medium deprivation)

A few GPs noted that trainees are aware of the need to be proactive when dealing with patients and work but think that GP training fails to embed the skills required to facilitate a return to work, including conflict management, negotiation and motivation skills. GPs talked about how they develop these skills as they gain experience of communicating with patients.

*'I don't think [helping people to return to work] is well taught in medical schools or in GP training, no. I mean you do learn about the rules around sick notes and there's always questions in the exams about very factual information, but the actual skill of negotiating with someone and setting boundaries...that's not something that's really touched upon, in my experience anyway.'*

(GP 16: male, less than five years' experience, small practice, high deprivation)

In general, they do, however, believe that true change to GPs attitudes and GP-patient communication will come with time. Other GPs described how they get a good deal of professional satisfaction from having enabled a patient to return to the workplace. They offered real-life examples of how they had used the note to expedite patients' return. They noted that they now regularly attempted to help those with chronic conditions, such back pain, back into work and they also reported a heightened awareness of the pattern of long-term sickness and attempted to tackle it.

*'I feel pleased that the patient's gone out with a fit note that they are fit to work with amended duties.'*

(GP 2: female, mental health specialist, high deprivation)

*'I signed a guy recently back to [company name omitted] and I signed him back to two hours for the first week, three hours a day for the second week, but he was really happy with that.'*

(GP 39: female, more than five years' experience, large practice, medium deprivation)

*[The patient's] not going to the full capacity of her work as a child-minder, she's going to do the administrative work... I was able to write on here, you know, awaiting surgery, still needs to remain within the workforce but on a less frontline level.*

(GP 29: female, more than five years' experience, large practice, low deprivation)

### 5.1.2 The balance of responsibility

A small number of GPs thought they would be expected to take on more responsibility in getting people back to work, but the introduction of the fit note has not changed their perception that their role in returning patients to work is voluntary.

*'I felt that they were going to ask more of us in persuading patients to get back to work. I thought the burden of responsibility would be passed to us and it hasn't, so it's very similar to the sick note but it's called the fit for work note and there's an opportunity to encourage patients back to work in there, which is nice, but certainly there's no implied responsibility to get the patient back to work.'*

(GP 4: male, more than five years' experience, small practice, medium deprivation)

Other GPs felt that while they have a role in returning to patients to work, medical rehabilitation is their priority. This approach influences attitudes to certification because these GPs are more likely to use the fit note at a later stage in the patient's recovery as they believe general health to be more important than an ability to work. These GPs emphasise the importance of the patient's opinion about when they should return to work rather than giving their own opinion about when that return

should be, though they will often choose to make suggestions or put across their point of view. If a patient is keen to return to work then the GP will assist them to do so but they continue to view their role as achieving medical recovery. GPs do not aim to be morally instructive towards their patients, instead trusting the individual's perceptions about their illness and guiding them towards taking responsibility for a return to work.

*'My job's to return them to health and it's their responsibility to seek to know whether they're fit to work.'*

(GP 4: male, more than five years' experience, small practice, medium deprivation)

*'If they are really keen to get back to work and that's their main aim then it moves up my list, but if that isn't really a concern of theirs, it isn't a major concern of mine, I don't feel that I should...with everything else we have to do I don't feel it's really my role to try and get people back into work, unless I think it's going to be good for them medically.'*

(GP 21: female, mental health specialist, low deprivation)

Some GPs, including those with occupational health training, expressed their surprise at discovering the passive approach to sickness certification adopted by other GPs who do not feel that it is within their remit to get patients back in to work.

*'A couple of [GPs] said, 'If my patient comes to me and says they're not fit for work I just sign the sick note, I don't question that, I don't negotiate, I don't challenge in any way', and I was just amazed about that because I would be completely different.'*

(GP 10: female, occupational health specialist, low deprivation)

### 5.1.3 Accountability

GPs did not believe that their role as a facilitator meant that they should be held accountable for any negative outcomes or deterioration of health in their patient while working. Although their role is to be an advocate of patients, acting in the interest of their patients' physical and mental health, it is also to aid their patients' return to the workplace. One GP explained that her colleagues had been worried at first about being accountable for the advice they give, however other GPs discussed having professional responsibility for and frequently making decisions that affect people's health so were not particularly concerned about accountability in the context of the fit note. One GP, however, did suggest that he was unwilling to make suggestions about what tasks people could perform at work in case the patient sustained an injury while following their advice. Other GPs were not worried about being held accountable because the advice they give on the fit note is a negotiated agreement between themselves and the patient, or because the patient has already negotiated the adaptation with their employer, or because the employer is not bound to follow their advice.

*'So what you often tend to get from employers, if you say, for argument's sake, someone's got back pain and you say "Well okay, you prefer to have amended...", you tick the amended duties section, let's say they do a very manual job, you then want them to do a less manual job or a clerical job sitting at a desk, employers will then always ask you for "Well okay, where's the limit, what can they do, can they lift a...?", so frequently get "Can they lift a 5lb box, can they lift a 10lb box?" Now, at the end of the day, I'm not an occupational health doctor and I don't know the answer to that and that makes me feel slightly flattened, medically, legally as well if I was to get the answer to that question wrong. So I think that, again, is another...it's okay to hear amended duties or ticking or making some comment about light duties, for example, in the example of someone with back pain or any sort of musculoskeletal pain but you'll then be asked to draw*

*limits to say what is acceptable, and that is a very difficult question to answer for a normal GP whilst being medically legally...well whilst feeling medically, legally secure.'*

(GP 16: male, less than five years' experience, small practice, high deprivation)

*'I think you're doing the best that you can at the time you're saying it, and I think if you're doing it with the patient with you, you're making that sort of joint decision about what you think is suitable or not, and as long as they're on-board with that I think at the time you just have to do what you can and what you think is best.'*

(GP 3: female, more than five years' experience, medium-sized practice, medium deprivation)

## 5.2 Extent of collaborative working

This subtheme describes the extent to which GPs work collaboratively with other practitioners to facilitate a return to work and GPs' varying levels of isolation in the management of their patients

GPs discussed how they are the sole managers of the patient's recovery: they are willing to ask others for an opinion about the patient's condition but they perceive themselves alone to have the responsibility for patient management. They appreciate other clinicians' skills in dealing with specific conditions, however they perceive that, with the exception of occupational health clinicians, GPs alone have the training to make decisions about the patient in the context of work. GPs also think that it might be confusing for their patients to get conflicting opinions about when they are able to return to work from their different healthcare professionals.

*'I think somebody has to take responsibility for it at the end of the day and I think if you start to get too many people involved conflicting opinions will cause confusion within patients and will actually just lead to dissatisfaction I think.'*

(GP 16: male, less than five years' experience, small practice, high deprivation)

*'I'm not sure whether a psychiatrist or a community psychiatric nurse is in any better position to make a judgment about whether someone works than I am, although maybe an occupational physician might.'*

(GP 9: male, orthopaedics specialist, low deprivation)

The fit note has not changed the way that most GPs work with other healthcare professionals in order to get patients back to work and the focus of the care that other professionals give is on recovery rather than on returning to work.

GPs have limited means of or interest in joint decision-making with other health and social care professionals to facilitate patients' return to the workplace and while they are happy to refer patients on and get progress reports, the focus of that correspondence is rarely related to work resumption. GPs describe frustration with waiting times for specialist health services such as physiotherapy as lack of treatment can inhibit consideration of returning to work.

*'Counsellors, the wait is phenomenal, it's four, five months, something like that. So for your patient with back pain that's pretty much going to be three months off while they're awaiting their physio. The patient with depression who needs some form of talking therapy, you're looking at four months, that's a long time.'*

(GP 16: male, less than five years' experience, small practice, high deprivation)

Occasionally some GPs make a note in the referral documents that they feel that getting back to work would be good for the patient. A few GPs observed that referral forms now ask whether the patient is away from work as a result of their condition and one GP suspected that patients are seen earlier if they are away from work or if it is a new condition rather than one that is already long-term.

*'On the physio referral form one of the questions is 'Is the person out of work because of this?' and I think they do see them quicker. So if it's a new problem and their employment is being affected they will see them quicker than if someone's had something for six months, yeah so they do take that into consideration.'*

(GP 3: female, more than five years' experience, medium-sized practice, medium deprivation)

Where other clinicians, such as physiotherapists or counsellors, are co-located with the GP practice, GPs considered informal communication to be effective in informing how they help patients get back to work.

*'Where I work at the moment we're in one of the big health centres and we have in-house physio, so we can work quite closely with those, that's absolutely fine, and they often will in as much as we're using the same building you can either discuss it in person or over the telephone, or whatever, and that's often very helpful.'*

(GP 43: female, less than five years' experience, large practice, medium deprivation)

GPs also experience frustration when patients who have received hospital treatment are referred to the GP to obtain a medical statement, believing that there is the opportunity for a much greater role for hospital physicians in completing fit notes or advising about them. GPs explained that hospital doctors and sometimes other healthcare professionals such as physiotherapists may have a better understanding of the limitations of the condition, and the likely recovery time. Additionally, GPs often need to issue the medical statement in advance of receiving any information from the hospital about the patient's condition and their recovery. On the other hand, GPs felt that if the fit note is completed in hospital then the patient will be automatically signed off because they don't think hospital doctors understand the fit note.

*'I think hospitals have a role and what happens is they say go to your GP and sometimes we... you the hospital have diagnosed them something...it would be really helpful for the hospital who may know a bit more about their prognosis than me, to say 'I feel this person could have four weeks off work. However, after that [they] should be able to go back to their employers, or be able to do some kind of work that they used to do' and I think it's almost like they're [hospital doctors] exempt from being involved in this and yet the majority of these people are under the hospital as well. Let's empower the hospital to have fit notes or sick notes too, we get them coming straight out of hospital after their bypass operation needing a sick note because the hospital haven't done it, let's get them on board as well and let's say it's a shared responsibility rather than just the GP.'*

(GP 28: female, more than five years' experience, large practice, high deprivation)

One GP described changing the focus and the frequency with which she communicates with other healthcare professionals since the introduction of the fit note. She now has more dialogue with physiotherapists about the patient's recovery and how improvements could be targeted to enable the patient to get back to work, and more conversations with hospital staff focused on what the patient is capable of doing.

*'I think the only time that I've noticed it [a change in the focus of working with others since the introduction of the fit note] probably has been people who are under the care of physiotherapy and I've asked the physios "Do you think this person is progressing to the extent that we can look at getting them back into work?" or "Can you work on stuff so that they can do things?" So I think that's probably changed and, what other situations? I think...and I also occasionally I think when people are under specialists at the hospital, I have asked "Do you think this person can go back to work with this?" because I may not know enough about the conditions, "Can this person actually work with this?", because the patient may be telling you that they can't and then a consultant will say "Oh actually there's no reason why they can't". So I do think we have more conversations about that than before.'*

(GP 20: female, mental health specialist, low deprivation)

### 5.3 Roles for other agencies

GPs described how non-medical barriers prevent patients returning to or seeking work yet they experience pressure to sign patients off for these non-medical reasons. Barriers include patients' lack of confidence, work-based bullying or dysfunctional workplaces, patients' lack of work-related skills, and patients' fear or confusion about the benefits system. GPs described how facing these barriers can have psychological effects so a non-medical barrier can become a real medical one. GPs felt it would be useful to make referrals to other agencies in order to deal specifically with these non-medical issues. In some situations GPs encourage their patients to contact other agencies in order to explore alternative work options where the GP thinks that work may be contributing to their condition.

*'For me anything like that would have been...where I can just write that "This person is physically fit but she's not capable of getting any job or doing any job because of language, culture, and lack of skill".'*

(GP 19: male, more than five years' experience, small practice, high deprivation)

Some GPs felt that an independent occupational health resource should be available to assess patients for other types of work if, for medical reasons, they are no longer able to do their most recent job. An independent assessment could take into account aspects of the patient's condition and their skill set that the GP may not be aware of. This they felt would also be useful for patients who have not worked for some time who may need additional support to prepare them for an alternative career.

GPs described encouraging patients to contact organisations that could help them develop their employability although they think their knowledge of Jobcentre Plus services could be improved.

Some GPs felt that there was a role for an advice service which both employers and employees could access to help them implement GP advice. Some GPs gave specific examples where they have been able to refer to Fit for Work Service pilots and the Healthy Working Lives service in Scotland. These GPs described how they value these services because they have trained staff who can adopt the position of negotiator on behalf of the employee which negates the GP's need to do so.

*'If we're having difficulties or a patient, especially, is having difficulties getting back to work with these scenarios, or there's bullying in the workplace, or whatever, then I refer to the Fit for Work pilot and they have trained therapists and social workers and doctors and all sorts in the pilot study, and they will negotiate with the employer on the patient's behalf. That's really good actually, yeah.'*

(GP 38: female, more than five years' experience, small practice, low deprivation)

Though GPs with experience of the Fit for Work Service held generally very positive views of it, one GP thought a drawback of the service was that it is only available to patients in employment rather than those who are unemployed or self-employed. GPs thought the complex work issues that some patients face is beyond the scope of their consultation time and the Fit for Work Service helped when GPs had reached an impasse with the patient. GPs who had used the service felt it was quick, helpful and did not patronise patients. GPs also thought employers took the advice given by the Fit for Work service more seriously than the GP's advice.

*'I think they [the Fit for Work service] work because they 1) have the experience and the time, so when they see a patient they'll sit down for an hour, an hour and a half, to find out exactly what's going on, what their job entails and it's all very fit and well but I haven't got an hour and a half to sit with a patient and find out why. So they've got the time, they've got the expertise, they've got the...I think they've got the resources available to them to help them do that and because they come under the sort of umbrella they're almost...I think an employer would take them more seriously than they would a GP personally, I would.'*

(GP 41: male, less than five years' experience, large practice, medium deprivation)

GPs in Scotland thought that Healthy Working Lives was an excellent yet under-used service that could help keep patients in work, give them options for re-training, and help them access other services, such as therapy. It was felt that many GPs in Scotland either didn't use Healthy Working Lives or were not aware of it and its benefits.

One GP felt there is no pro-active working between healthcare professionals, employment services and social services to facilitate the patient back to work or into work; however, others have experience of working in practices where non-medical services are offered. For example, one GP's practice accommodated benefits agency staff on-site through charitable funding and the GP could refer patients to that specialist benefits adviser to talk about their concerns without having to visit Jobcentre Plus. Another practice had an occupational health advisor for people with mental health conditions and a Citizens Advice Bureau adviser on-site. Co-location of facilitates aids communication between the GP and other service provider and helps reduce barriers to accessing advice.

# 6 Understanding the extent of their role

## Key findings

- General Practitioner (GPs) without occupational health training believe that some aspects of the fit note, especially amended duties and workplace adaptations, fall outside their area of expertise.
- While some GPs can see a benefit to having contact with employers, most GPs are wary of doing so because of the time commitment it would involve and because of their role as the patient advocate. GPs believe that employer advice is an occupational health role, rather than the role of the GP.
- GPs hold varying views on the purpose of their advice on the fit note: some believe it is guidance for the patient to discuss with their employer; some believe it is advice for the employer to consider and take action upon; and others believe it is an instruction to the employer.
- GPs still perceive a conflict in their role in sickness certification: they act in a statutory role while also acting as the patient's advocate. They worry that this may erode patients' trust in their GP.
- All GPs experience some pressure to declare patients unfit for work and most GPs have very little understanding of the benefits system so struggle to be objective in the face of emotional pressure from their patients.

This chapter describes GPs' perceptions of the extent of their role in sickness certification and offering back-to-work advice and how their views of their role have changed since the introduction of the new medical statement. It is divided into the subthemes of: role boundaries; and role conflicts.

## 6.1 Role boundaries

This subtheme explores GPs' perceptions of the extent to which they can give back-to-work advice and their concerns about the overlap between the role of GP and of occupational health services. It also includes GPs' opinions about the purpose of the advice they give on the medical statement.

GPs discussed the extent of their occupational health knowledge and how aspects of the fit note, such as the option for workplace adaptations, fall outside most GPs' expertise. This means they are not always able to justify the guidance they give, such as altered hours or specific workplace adaptations. They sometimes find issuing fit notes difficult because they do not know enough about their patients' jobs. One occupational health specialist felt that GPs don't know the specifics of the patient's role, workplace and the other roles in the organisation so they cannot make specific recommendations to the employer. Another felt that all GPs should have some level of expertise in occupational health.

Many GPs felt that an option on the fit note to request an occupational health assessment would be a useful catalyst to the patient's return to work. Some GPs felt that their lack of occupational health knowledge limited their use of the fit note in advising phased returns, amended duties and altered hours, rather than suggesting workplace adaptations which they saw as outside their area of understanding. One GP suggested that there was role duplication between the employer's occupational health team and the GP when assessing the patient to complete the fit note.

*'So at the moment I think there's a lot of duplication because the occupational health doctor is trying to assess the patient for return to work, we're trying to assess the patient for a return to work, there's duplication there without communication.'*

(GP 34: female, more than five years' experience, medium-sized practice, medium deprivation)

*'I think we always have a difficulty because we're not occupationally trained. So if somebody... we've got a lot of people who work in factories and I don't specifically know what they're doing, I don't really care what they do to a certain degree, but we can't give specific advice because if they then injure themselves then we're in trouble, but the other side of it is we can't just sign everyone off work because we don't know. So obviously we make a judgment call and I think some people would make more of a judgment call than others, and that's always going to be an issue, but we can't all be all things.'*

(GP 37: male, more than five years' experience, medium-sized practice, medium deprivation)

Some GPs believe they only need to give limited guidance on the fit note and are therefore able to complete it with a basic level of information about the patient's job. These GPs do not perceive the fit note as expanding their role and expressed surprised at their colleagues' response to it because it does not require specialist knowledge.

*'I do slightly raise my eyebrows a little bit and my colleagues have clearly had some issues about the fit note saying "We've had no training in this". It's not rocket science. You don't need to be an occupational health consultant to make a suggestion that if you've been off work for two months that actually going back to work, starting mid-week and perhaps starting on half days, perhaps having a return to work interview, having a structured return and making some minor amendments on the issues that they think are the issue with their job going back to work. It didn't strike me as being rocket science to be honest.'*

(GP 11: male, occupational health specialist, medium deprivation)

One GP thought that the training she attended about the fit note made the level of detail needed clear but, as some of her colleagues had not attended, they remained uncertain about what to write.

*'Well I know...oh, that's why one of my partner's got very huffy about that, she was saying "How can I say this, I don't know what it is?", and actually if she'd gone to the evening meeting it was very clear that you're not accountable, you're just asking the employer to consider, you're not... and actually saying to us 'Please write it in very general terms. Do not write "should work 9 'til 2 or and avoid this, that and the other" and just write in very general terms', so, again, that was covered in the training.'*

(GP 10: female, occupational health specialist, low deprivation)

GPs discussed their role in providing guidance to employers and considered how much they are prepared to have contact with employers to explain the guidance or intervene on behalf of the patient. Most GPs described having limited contact with employers, contact typically being formal, written and instigated by the employer as part of an occupational health assessment. Some GPs are prepared to have minor contact with employers, for example a telephone call. On the other hand, one occupational health GP was prepared to give detailed written guidance to employers. Most GPs however suspect employer contact would be too time consuming and so resist this becoming a greater part of their role.

*‘See it’s still going to generate more work, isn’t it, for us, it’s never ending. If there was a problem where they could be sorted out between the employer and the employee it would be great, if they had a sense of understanding, if they had their own occu health, so it’s not tackling into my time and if they could perhaps...or even amended duties and stuff, if they had their own in-house they could modify according, that would be more helpful.’*

(GP 13: female, more than five years’ experience, medium-sized practice, low deprivation)

One GP suspected that employers would try to use GPs as a free occupational health service. Another suggested that they would welcome employer contact if they could see a business benefit to it: if the GP helped the patient to get back to work and therefore recover sooner, they would make fewer trips to the surgery and use fewer appointment slots.

*‘I guess if we knew that it [contacting employers] was worthwhile we might find the time to do it because if it meant that I didn’t see Joe Blogs so often then it would be in my interest to do it. If I know that I’ve got so many appointments in a week or I’ve got so much money to run the surgery and Joe Blogs is going to come back five times for his sick note, but if I actually speak to his employer he may only come back three or four times, that tiny reduction, well it’s quite a decent percentage reduction, would be worthwhile. I mean I know you need that actually for the five per cent or ten per cent improvement for it to be, in terms of business sense, worth me doing, and it does the patient, definitely worth doing.’*

(GP 12: male, more than five years’ experience, medium-sized practice, high deprivation)

Other GPs perceived the need for a formal process for employer contact should it become a greater part of their role. They felt they would need guidance about when it is appropriate to make contact to ensure patients are treated fairly and consistently.

*‘Well actually it’s something you’d be very wary about doing unless there were standard procedures because you could have your favourite patients who you went head over heels to try and help and then you could have patients who are actually really needy but actually not so likeable or easy and you wouldn’t be bothered to do it. So actually you need to have a standard thing for it.’*

(GP 10: female, occupational health specialist, low deprivation)

Many GPs resist the role of intermediary between patient and employer. They believe that employer advice is a role for occupational health practitioners and it should be a business expense for the employer. Some GPs felt that once a condition had become chronic then the GP’s role in certification should come to an end. The responsibility for assessment should then pass to a specialist or enhanced service provided by GPs. The prospect of increased employer contact provoked concerns about the additional time it would take and the conflict it would bring to their role as the patient’s advocate. They thought the patient would need to consent to contact between their GP and employer and GPs felt that patients were often nervous about their employer and their GP discussing their health.

### 6.1.1 GP views about the purpose of their fit note advice

GPs held varying views about the purpose of the advice they give on the fit note. Some GPs felt that advice was aimed at the patient providing confirmation that the patient can work which can be used to negotiate a return to work with their employer. In this way, the advice is to support the patient in taking responsibility for returning to work. Other GPs believed the fit note is advice for the employer to consider and use to take action. Employers can use the advice to consider whether it is possible for the patient to return. A few GPs perceived that the advice they give on the fit note is an

instruction that the employer has a duty to follow. These GPs were surprised that employers aren't obliged to follow their advice.

*'I was surprised to read in that leaflet when we first got it that employers are not bound to do what we say and the patients do, and I think employers do, take it as a rule that if you said six weeks off they'll give them six weeks off, whereas actually it's just advice from us.'*

(GP 32: female, more than five years' experience, medium-sized practice, low deprivation)

## 6.2 Role conflict

GPs discussed the conflict they experience in performing a statutory role for government certifying sickness while acting in the best interests of the patient. Some GPs felt that they were best placed to make assessments about their patients' fitness for work because they know their patients, their medical history and the history of their current condition.

*'They [GPs] are at the frontline. Absolutely right, and some GPs absolutely hate this issue, but then I'm thinking "But if we don't deal with this and we know these patients, we know these people, we see them and we have a very good idea of what they're like and what they are capable of doing, who is going to assess them?" and then you've got to employ a whole new strata or department, or whatever, and they don't know these people.'*

(GP 38: female, more than five years' experience, small practice, low deprivation)

In contrast, some GPs felt that sickness certification is a social not a medical issue and their role in it is a waste of their expertise and time.

*'Well I guess, as doctors, we try and prevent illness and we're sort of scientists really and to have to get involved in the whole social issue of people taking time off work and people feeling that they're not fit for work, especially in the area where I'm from, it is just something that I never, ever planned on being involved in. When I was a student we had no teaching on it at all as an undergraduate, this is we're talking in the '80s and early '90s now, but also as a hospital doctor my involvement was very little. I did hospital medicine for four years, and so you just dealt with proper illness and then you got into general practice and you see so much less illness and then you end up being...I feel sometimes like I'm a social worker and my training is partially wasted.'*

(GP 39: female, more than five years' experience, large practice, medium deprivation)

Many GPs, especially those in areas of high deprivation, believe patients expect their GP to help them maximise their benefits. GPs reported that patients blame them if they lose money through what the GP writes on the fit note. GPs in all areas experience some pressure to declare patients unfit for work and most GPs described how they have very little understanding of the benefits system.

One GP thought that independent assessments for both those in and not in work would be a good way of resolving differences of opinion about fitness for work between GPs and patients without damaging their relationship and breaching trust. In this way they welcomed the Department for Work and Pensions (DWP) Work Capability Assessments because they are based solely on medical conditions and their functional effects.

Some GPs expressed concern that challenging the patient might affect the GP-patient relationship. Others felt that patients believe the GP is now under the direction of the DWP rather than acting as a care provider. One GP felt that the change in policy has led to their role becoming police-like and that there was a risk that patients would try different GPs or stop going to the surgery altogether should the GP's approach to certification become too strict.

*'So am I accountable to the patient and you can get some very angry patients and you know I've probably lost a couple of patients by saying you are not sick and they go and see someone else and they hate me. So, it's very difficult when you've got your usual list and but you don't want to be the soft touch either. I mean knowing it's for the good of the patient but they don't see it that way sometimes.'*

(GP 28: female, more than five years' experience, large practice, high deprivation)

*'When you have those individual discussions about 'Tell me about the job you do' I think they just think...I think they think that we're being paid by DWP to keep people in work and off of benefits rather than it's actually good for your health and that's why I think public education and employer education I think would add more weight to that message, because, as I say, patients aren't stupid.'*

(GP 31: male, less than five years' experience, large practice, high deprivation)

Some GPs would like a means of alerting DWP when they do not believe the patient is medically incapable of work to trigger an independent assessment. They believe that this would help them merge the roles of patient advocate and medical assessor. In situations where GPs suspect the patient's condition is spurious a few felt they should be open with the patient and write that they had concerns on the fit note itself, while others regretted the fact that they could no longer write an RM7 certificate to request an independent assessment.

*'I certainly find, for a small number of patients, that I had concerns about their fitness. If I sent the old RM7 form off... 'These are my professional concerns' and I'd give it to another professional. The ideal is to have open, frank discussions with all your patients, it doesn't always work like that, patients have different agendas. Not all my patients want to work. I regard that as quite a useful back channel in a sense....and the new system doesn't appear to have that.'*

(GP 11: male, occupational health specialist deprivation)

# 7 Discussion and conclusion

In addressing our original research questions, we found a range of practice in use of the fit note and diversity in General Practitioners' (GPs') opinions about their role in provision of return to work advice.

## What are GPs' experiences of using the fit note?

- GPs use the fit note as a consultation tool to initiate and guide negotiations with patients through the options for returning to work. The GP-patient consultation has shifted focus to involve a richer discussion about the patient's work role and capabilities.
- GPs use the fit note to keep people in work and return people to work in a variety of ways for a range of conditions. They report the fit note to be most useful in facilitating a return to work for those patients with mild-to-moderate mental health conditions and musculoskeletal conditions.
- GPs are less likely to use the fit note to help patients return to work if the patient's job contributes to their condition. They are also unwilling to damage their relationship with their patients. Other barriers to effective the fit note include the patient's age and local economic and labour market conditions.
- Many GPs did not at first recognise the potential of the fit note to help their patients remain in work or return sooner and so did not put thought into how it might be used in practice. Not all GPs are confident in the level of detail required on the fit note, they can find it difficult understanding and distinguishing between the back-to-work options, such as workplace adaptations and altered duties, and they can be confused about how to complete the date fields on the fit note.

## What role do GPs feel they play in giving return-to-work advice? How has the fit note influenced their role perceptions?

- Many GPs believe that motivating people back to work is an integral part of their role and that the fit note has helped GPs do this. Some GPs give medical rehabilitation a much higher priority than returning to work and they begin using the fit note later in the patient's recovery.
- Generally, GPs feel that their role now involves changing patient perceptions of their ability to work and the fit note has allowed some GPs to adopt a stricter role with their patients. GPs believe that there is a role for other agencies in helping remove non-medical barriers to their patients working, such as lack of skills or problems with their employers. GPs don't see giving employers advice to be a part of their role.

The results add valuable insight into some of the previously reported findings on sickness certification. Most of the findings correspond with those of previous research but there are some key differences, and the breadth and depth of the current research enables us to understand why these differences have arisen.

As identified in the work by Sallis *et al.* (2010) on the trial Med 3, the fit note's use results in GPs being less likely to advise patients that they are unfit for work, and more likely to provide recommendations on how they could return to work. Our research shows that this is because the fit note has become a tool that GPs use as a prompt to facilitate a discussion on a return to work and also makes it easier for them to do so because it is 'the system' and not them raising what might be an unwelcome topic to some patients.

The change in policy has also led to a change in GPs' perceptions of their role. While medical rehabilitation is still viewed as their primary role, many now see occupational rehabilitation as an important part and it has made them more aware of the link between work and wellbeing. Like Sallis *et al.* (2010), we have found that GPs view the fit note as being particularly valuable in enabling patients with back pain to return to the workplace. In contrast, we have found that GPs also view it as being effective when used with patients who have depression. GPs in our research drew a distinction between depression associated with workplace-related stress and depression arising from other reasons.

Like Hiscock and Ritchie (2001) we found that GPs adopt different approaches to sickness certification and do not always base their assessment solely on their medical condition. Like Mowlam and Lewis (2005) we found that some GPs prefer to focus primarily on the patient's medical condition. In our study these GPs introduce the fit note into consultations later than GPs who consider work as part of the patient's recovery.

As found by Hann and Sibbald (2011) most GPs do not have a clear understanding of the benefits system. They are influenced by a patient's distress at the prospect of being moved from one benefit to another. GPs also tend to take a longer-term perspective on how their refusal to certify a patient as unfit for work will impact on their relationship with the patient. When GPs believe that a patient will be unlikely to successfully return to or find work, even when this is not due to a medical problem, they are less willing to risk their relationship with the patient by certifying patients as fit for work.

Many GPs recognised the lack of support for their patients who they believed lack the skills to work. GPs in the current study believed that the new policy still does not do enough to address the complex social problems that their patients face.

We did not find any consistent differences in the approaches undertaken by GPs with different levels of experience or within different sizes of practice. Instead, the greatest influencing non-medical factor has emerged as the levels of deprivation in the area and therefore the availability of paid employment. Indeed, Shiels and Gabbay (2007) found that only 3.4 per cent of the variance in their model of the likelihood of long-term incapacity was explained by GP effects. They found, as did we, that the diagnosis is the greatest predictor of long-term sickness certification. Our research revealed various modifying factors such as whether the patient is nearing retirement, whether they would need to undertake a different type of job, and the patient's own motivation to return to work.

Our findings illustrate that GP self-efficacy in using the note to help patients return to work has a major effect on their use of the Med 3. GPs can have low self-efficacy because of negative, and sometimes aggressive, responses from patients or because they lack expertise in occupational medicine and so are unsure of what workplace adaptations could be made. Attending an RCGP workshop increased confidence in both of these areas.

GPs have varying opinions about their role as facilitators of a return to work. Many believe that motivating people back to work is an integral part of their role and that the fit note has helped GPs do this. It has also helped them in their role of preventing patients from taking any time off at all. Most GPs also believe their role is to protect their patient's future wellbeing through encouraging and enabling work and through preventing their patients from developing a sick role. GPs do, however, believe that there is a role for other agencies in upskilling their patients, building their confidence and offering occupational advice and representation. Some give medical rehabilitation much higher priority than returning to work and these GPs would begin using the fit note later in the patient's recovery.

The boundary between advice given by GPs and specific occupational health advice is an area where GP opinion is mixed. GPs perceive their role as facilitators of return to work to fall short of giving specific occupational health advice, although those GPs with an occupational health specialism felt more comfortable giving more specific advice. There were varying views on the level of advice that GPs should give with little consensus amongst GPs. GPs still believe that there is conflict in their role in sickness certification that arises from their duty to society on one hand and their duty to be the patient's advocate on the other. GPs in deprived areas are more likely to feel frustrated by their role in certification and feel that there are fewer reasons to help patients consider work because there are fewer opportunities for them.

The research explores GPs' perceptions of the fit note, which may be different from the views of employers and individuals. The findings indicate that many factors influence how GPs use the fit note including their self-efficacy to do so, the patient's own agenda and the perceived value of using the fit note at all given the patient's condition. These and other factors may be at play and may influence employer and individual experiences of the fit note process.

The major strength of the research is that it explores the experiences and perceptions of a broad range of GPs. The sampling structure ensured that GPs with different characteristics were included in the study and the £100 incentive also ensured that the achieved sample did not comprise only GPs who held strong opinions about the fit note. As the research is qualitative it does not aim to generalise the findings, rather present the range of experiences and views that GPs hold.

## 8 Recommendations and implications for policy

We have made the following recommendations based on the main findings of the research and the strength of the evidence available.

- Offering training in communication and negotiation skills in the context of patient management would help those General Practitioners (GPs) who don't feel confident raising returning to work with their patients. A renewed round of workshops or e-learning modules would help raise GPs' confidence to use the fit note to its full potential and encourage patients to think about work. If GPs realise the training is about improving the health of their patients through preventing long-term sickness absence, rather than about filling in forms, they will be more motivated to attend.
- Reviewing the date fields on the fit note, the guidance about how to complete the date fields and the guidance on back-dating fit notes would help GPs better understand how to complete them.
- GPs need more guidance about what they should write on the fit note so that it is useful to patients and employers. There is at present uncertainty about how specific the guidance should be and variation in the depth of advice that GPs give. Positive case studies, including those with difficult patients, would help provide context to its use.
- Because GPs are confused by the benefits system they find it difficult to be objective with their patients if the patient brings emotional pressure to bear on the GP. A simple guide to the benefits system would help GPs gain an objective understanding of the consequences of certifying the patient as fit for work.
- Greater public awareness of the health implications of long-term incapacity would help to improve people's understanding of the importance of work and may motivate people to return to work earlier. GPs who attended Royal College of General Practitioners (RCGP) workshops found headline facts comparing the risks of sickness absence to smoking easy to remember and communicate. Messages like this may be effective in helping people realise the risks.
- Professional bodies in the medical profession and commissioners might look at ways of enhancing communication between medical professionals in order to share information about the impact of procedures and conditions on patients' ability to work.
- Policy makers may consider the need to address the consequence vacuum that GPs experience after using the fit note. This might involve bringing employers and GPs closer together to share information without damaging the GP-patient relationship or adding to the GP's workload.

# Appendix A

## Interview schedule

### DWP fit note evaluation: interview guide

#### **Briefing and informed consent**

First of all I want to talk about how the fit note was introduced.

1. Were you aware that there were going to be changes to the medical statement before the fit note was introduced?
  - How did you hear about the changes?
  - How did you expect the new medical statement to be different from the sick note?
  - What did you know about why the changes were being made?
2. Were you aware of any information or guidance for GPs around the changes to the medical statement?
  - Did you receive any written guidance, e.g. DWP ‘Statement of fitness for work: A Guide for General Practitioners’? IF YES, how useful did you find it?
  - Did you look at any websites? E.g. [healthyworkinguk.co.uk](http://healthyworkinguk.co.uk) website or DWP fit note pages where GP guidance can be downloaded? How useful did you find them?
  - How easy or difficult was the guidance to follow? Why?
  - Did you attend one of the workshops run by the Royal College of General Practitioners which supports GPs to increase their knowledge and skills to deal with clinical issues relating to work and health? IF NO, were you aware that the workshops were taking place? IF YES, how helpful was it?
  - Did you look at any other guidance/information? What/Where? How useful was it?
3. How did you prepare for implementing the fit note in your practice?
  - Was there a coordinated formal approach to prepare for the changes? In-practice presentation or training? Informal preparations e.g. talking to colleagues? Was this different from when the sick note was implemented? How?
  - How much time did you spend on preparing for the changes?
  - How confident did you feel that you would be able to use it?
  - What do you think about the level of support and guidance to help you implement the fit note in practice?
  - What additional guidance and training would you have liked? From the practice? From other sources?

Now I want to talk about how you manage patients whose health affects their fitness for work, and whether the fit note has made any difference.

4. Have your patient consultations changed since you started using the fit note? In what ways?
  - Are patient consultations more or less in-depth since the introduction of the fit note?
  - Length - longer or shorter? More or less time to complete the new form?
  - Have you used the fit note during telephone consultations? How have you found consultations over the phone? Advantages and disadvantages?
5. Has the fit note made a difference to how you communicate with patients about a return to work? What has changed?
  - When is the topic of returning to work raised? Who usually raises it?
  - What about the extent to which you discuss the nature of the patient's work and work-related or other reasons for absence?
  - Is a return to work more of a focus in the management of sickness absences since the fit note?
  - Is there anything that makes it difficult for you to discuss a return to work?
  - How does your approach to discussing a return to work differ for different types of patients? By condition and by social/work circumstances?
  - How does your approach differ from other GPs that you know? (including differences any speciality makes) Is there a consistent practice approach? Do you discuss your approach with colleagues?
6. Has the advice you give patients changed since using the fit note? How?
  - What level of understanding do you need to have about a patients' job to provide advice on their fitness for work, and whether they could return to work?
7. Do you think the fit note has made a difference to the length of patients' sickness absences?
  - Differences between conditions and types of patients? Are patients' returning to work sooner?
  - Any difference in requests for repeat statements? In what type of cases?
8. Do you view facilitating a return to work as an important aspect of treating patients whose health affects their fitness for work? How important is it?
  - Why or why not? How does this compare to the importance of medical rehabilitation?
  - Have your views on your role in facilitating a return to work changed since the introduction of the fit note?
  - Is it any easier for you to facilitate a return to work since the introduction of the fit note? Why or why not?

Next let's talk about your patients and their employers, and their reactions to the fit note.

9. How have patients responded to discussing a return to work using the fit note?
  - Are there any changes in patients' responses compared to when you used the sick note?
  - How do different types of patients (with different conditions) respond differently to discussions about a return to work?
  - How much do you think patients understand the reasons for the changes to the medical statement?
  - What barriers do you think patients face in returning to work?
  - Overall, what do you think that the patients think about the changes? Any difficulties explaining the changes to patients?

10. What is your impression of how employers have reacted to the changes?
- What barriers do you think they face in enabling patients to return to work?
  - What's your impression of how flexible employers are being in making adjustments in workplaces? Do you think the advice you provide to patients on workplace adjustments is often implemented by employers? What are the implications for a patients' treatment if workplace adjustments aren't made?
11. Has your communication with employers changed since the fit note was introduced? How?
- More or less contact with employers since the fit note? Who usually initiates contact? What sort of things do you tend to communicate about?
  - Do you think that communicating with employers is an important part of your job in managing patients whose health affects their fitness for work?
  - What are the advantages and disadvantages of communicating with employers? For patients, GPs and employers? Are any changes needed to improve communication with employers?
12. How do you work with other healthcare professionals or service providers to help manage a patients' return to work?
- Who do you work with? Occupational health services, hospital physicians (any increase in their use of Med 3?), employment services, counsellors, physiotherapists, mental health advisors, health and safety advisors, drug and alcohol counsellors?
  - In what circumstances would you work with them?
  - How has the way you work with other healthcare professionals and service providers changed since the introduction of the fit note? More or less interaction? Better information?

Next, I want to talk about the relationship between work and health.

13. What do you think about the effect of work on patients' health and wellbeing?
- Has your opinion changed since the implementation of the fit note?
  - In what circumstances do you think that a return to work would or wouldn't have therapeutic benefits for patients?
  - Has your opinion about what level of fitness is required for a patient to return to work changed since the fit note?
  - Have you looked at any of the research literature on the relationship between work and wellbeing? What do you know about it?

Finally, I want to talk about your overall satisfaction with the fit note and the impact that you think it has had on sickness absences.

14. Overall, how confident do you feel using the fit note?
- How easy or difficult have you found the fit note to use? Why?
  - Did you or will you, have to acquire new skills to complete the fit note?
  - What do you think a well completed/poorly completed form should look like?
  - What impact do you think a well completed/poorly completed form would have on: patients, employers, DWP?

- How important is it to you to complete the form as well as you can?
  - What stops you from providing a well completed form every time? What would make it easier for you to complete the form?
  - Do you worry about accountability when providing advice to patients and employers using the fit note?
15. What do you think of the changes made to sickness certification and the Med 3 form?
- Why do you think the policy was changed? How much do you agree or disagree with the reasons for the change in policy? Did you think the policy needed to be changed?
  - Are there any aspects of the new fit note do you like/don't like? E.g. the option to recommend that a patient 'may be fit for work'? Space to provide advice on changes to a patients' work environment or job role which could help them return to work sooner? The option to indicate that you do not need to see the patient again to assess their fitness for work? Work solutions tick boxes? The ability to soon issue Med 3 forms electronically and print them off in the practice?
  - Do you have any suggestions about how the fit note form and/or guidance could be improved?
16. Is there any additional training or support that you would like to help you to manage issues around sickness absence and patients' return to work?

Do you have any other comments that you would like to make?

# Appendix B

## Sample structure

A total of 45 GPs were included in the research sample. The sample GP and practice characteristics are detailed below:

### **GP characteristics**

GP age: 15 GPs younger than 35; 20 GPs aged 35–50; ten GPs older than 50.

GP gender: 22 male GPs; 23 female GPs.

Speciality: four occupational health specialists; four mental health specialists; four orthopaedics specialists; 33 GPs with no specialism or another specialism.

Clinical experience: ten GPs with less than five years' experience; 35 GPs with more than five years' experience.

### **Practice characteristics**

Size of practice: 15 GPs from small practices; 15 GPs from medium-sized practices; 15 GPs from large.

Area density: ten GPs practising in urban/inner city areas; 25 GPs practising in suburban areas; ten GPs practising in rural areas.

Geographic location: five GPs practising in Northwest England; six GPs practising in Northeast England (including Yorkshire and Humberside); five GPs practising in West Midlands; five GPs practising in East Midlands; five GPs practising in Southwest England; seven GPs practising in Southeast England (including East of England and London); six GPs practising in Wales; six GPs practising in Scotland.

Level of deprivation: 15 GPs practising in areas of low deprivation; 15 GPs practising in areas of medium deprivation; 15 GPs practising in areas of high deprivation.

# References

- Black, C. (2008). *Working for a healthier tomorrow: Dame Carol Black's Review of the health of Britain's working age population*, TSO.
- Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2): 77-101.
- Campbell, A. and Ogden, J. (2006). Why do doctors issue sick notes? An experimental questionnaire study in primary care. *Family Practice*. 23: 125-130.
- Haldorsen, E.M.H., Brage, S., Stremme Johannesen, T., Tellnes, G. and Ursin, H. (1996). Musculoskeletal Pain: Concepts of Disease, Illness and Sickness Certification in Health Professionals in Norway. *Scandinavian Journal of Rheumatology*. 25: 224-232.
- Hann, M. and Sibbald, B. (2011). General Practitioners' attitudes towards patients' health and work. Final Report for Health Work and Well-being Delivery Unit.
- Hussey, L., Turner, S., Thorley, K., McNamnee, R. and Agius, R. (2008). Work-related ill health in general practice, as reported to a UK-wide surveillance scheme. *British Journal of General Practice*. 58: 637-640.
- Hiscock J. and Ritchie J. (2001). *The role of GPs in sickness certification*. DWP Research Report No 148.
- Mowlam, A. and Lewis, J. (2005). *Exploring how General Practitioners work with patients on sick leave*. DWP Research Report No 257.
- Norrmén, G., Svardsudd, K. and Andersson, D.K.G. (2008). How primary health care physicians make sick listing decisions: The impact of medical factors and functioning. *BMC Family Practice*. 9:3. doi:10.1186/1471-2296-9-3.
- Sallis, A., Birkin, R. and Munir, F. (2010). Working towards a 'fit note': an experimental vignette survey of GPs, *British Journal of General Practice*, 60: 245-250.
- Shiels, C. and Gabbay, M.B. (2006). The influence of GP and patient gender interaction on the duration of certified sickness absence, *Family Practice*, 23: 246-252.
- Shiels, C., Gabbay, M.B., and Ford, F.M. (2004). Patient factors associated with duration of certified sickness absence and transition to long-term incapacity. *British Journal of General Practice*, 54: 86-91.
- Shiels, C. and Gabbay, M.B. (2007). Patient, clinician, and general practice factors in long-term certified sickness. *Scandinavian Journal of Public Health*, 35: 250-256.
- Wynne-Jones, G., Mallen, C.D., Mottram, S., Main, C.J. and Dunn, K.M. (2009). Identification of UK sickness certification rates, standardised for age and sex. *British Journal of General Practice*, 59: 510-516.

This report forms part of a programme of evaluation gathering evidence on the use of the Statement of Fitness for Work (fit note). On 6 April 2010, the Government implemented the fit note across England, Wales and Scotland with the aim of giving individuals and employers access to timely information about when and how sick individuals might return to work.

The research is based on 45 in-depth semi-structured interviews with General Practitioners (GPs) between February and May 2011. The report explores GPs' views of the change in policy, how they prepared to use the fit note and use it during consultations with patients, and their views on their role in sickness certification.

If you would like to know more about DWP research, please contact:  
Kate Callow, Commercial Support and Knowledge Management Team,  
Upper Ground Floor, Steel City House, West Street, Sheffield, S1 2GQ.  
<http://research.dwp.gov.uk/asd/asd5/rrs-index.asp>

**DWP** Department for  
Work and Pensions

---

Published by the  
Department for Work and Pensions  
November 2011  
[www.dwp.gov.uk](http://www.dwp.gov.uk)  
Research report no. 780  
ISBN 978 1 908523 34 1