Research report

GPs' perceptions of potential services to help employees on sick leave return to work

by Fiona Fylan, Beth Fylan Gwynn and Lauren Caveney

DWP Department for Work and Pensions

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Glossary of terms

Atos Healthcare	The organisation that carries out Work Capability Assessments for individuals claiming Employment and Support Allowance.
Citizens Advice Bureau	A charitable community-based organisation that provides free impartial advice for people.
Clinical Commissioning Groups	Groups of GPs that are responsible for designing and commissioning healthcare services in their area. They are in the process of taking this role over from Primary Care Trusts.
Counselling	A form of psychological therapy that involves a trained counsellor listening to a client talking about the problems they face.
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.
Fit note	A colloquial name for the Statement of Fitness for Work. Also referred to as the medical statement.
Jobseeker's Allowance	A Government benefit for unemployed people of working age who are available for, and actively seeking, work.
Health and Safety Executive	The national independent watchdog for work-related health, safety and illness.
Health Psychology	The branch of psychology that is concerned with understanding how biological, psychological, environmental and cultural factors affect health.
Musculoskeletal conditions	Conditions that affect the nerves, tendons, ligaments 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 workers in all occupations.
NHS Direct	A telephone and website advice service that gives people access to clinical information, and confidential advice about their health.
Primary Care Trusts	Bodies responsible for commissioning healthcare and care services.
Psychological therapies	A range of talking therapies, such as Cognitive Behavioural Therapy, delivered by a psychologist or a trained therapist.
Self-efficacy	Belief in one's ability to perform a task competently.

Sick note	A colloquial name for the medical certificate that was in use prior to April 2010.
Small- and medium-sized enterprise	A legal definition of an organisation based on its size, turnover and balance sheet. The UK definition is fewer than 250 employees with a turnover of less than £26 million and a balance sheet of less than £13 million.
Statement of Fitness for Work (referred to as the 'fit note')	The form issued by a GP to a patient whose health affects their ability to work. Introduced in April 2010.

List of abbreviations

DWP	Department for Work and Pensions
ESA	Employment and Support Allowance
GP	General Practitioner
IAS	Independent Assessment Service
ONS	Office for National Statistics
RCGP	Royal College of General Practitioners
SME	Small- and medium-sized enterprise

Summary

This report presents the results of a series of six focus groups with General Practitioners (GPs) to explore their views on a possible new support service to help employed people who are off sick from work to return quickly and prevent them from falling out of paid work. The Government's *Independent Review of Sickness Absence* (Black and Frost, 2011) recommended that such a service be developed and the research presented here aims to inform the Department for Work and Pension's (DWP's) consideration of the nature and organisation of a potential Independent Assessment Service (IAS).

Method

GPs were recruited from different locations and had a range of practice experiences. Participants included GP partners, GPs in their first five years of practice, GPs practising in rural and urban areas, and GPs with a special interest in a wide range of professional areas. This variety in the sample provides confidence that the results can be generalised beyond those GPs who participated and will resonate with the wider population of GPs. Focus groups took place in August and September 2012 and a total of 39 GPs took part.

During the focus groups GPs were presented with four different possible models for an IAS and asked to discuss their views on each of them. Option A would be based on the current sickness certification process with enhanced guidance available for GPs when they are completing the fit note. In Option B, GPs would be able to refer patients to an independent occupational health expert, who would assess their capability to work and offer advice on adjustments that could be made to facilitate their return to work. Option C would offer a more holistic case-managed service which provides patients with support individually tailored to meet their return-to-work goals. The support options extend beyond their medical needs and can include workplace mediation and financial advice. Finally, it would be possible to combine these different models into a staged approach in which patients can progress through the levels of the service or be referred directly to the level that best suits their needs.

We explored GPs' perceptions of each of these four possible IAS options, their perceptions of the nature and scale of need for an IAS and how patients should access it, as well as how it should be organised. We also explored GPs' views on the benefits of the proposed service and any influence it might have on how they view their role.

Key findings

We found that GPs support the idea of an IAS and would be happy to engage with one. They recognise the benefits of work to patient wellbeing and view the services within an IAS as supporting and complementing their role.

GPs' perceptions of possible models for an IAS

GPs recognise the value in each of the tiers of support, however, there was a widespread preference for a staged model in which the level of support is tailored to the individual needs of the patient.

Option A would help GPs to develop appropriate recommendations for the fit note and employers to implement them. GPs believe that smaller employers are most likely to use this option as they are less likely to have access to their own occupational health service. It does not, however, overcome

the problem that GPs can experience when their role as patient advocate makes it difficult for them to challenge the patient's account of their condition.

Another challenge that GPs can face is their lack of occupational health expertise which limits the extent to which they can make detailed recommendations about workplace adaptations. They, therefore, welcome the ability to refer patients for an expert occupational health assessment as in Option B.

GPs believed that patients who would benefit most from Option B are those with clearly defined and non-complex conditions such as musculoskeletal conditions that would respond well to more specific or complex workplace adaptations than they are able to suggest.

Most GPs, however, would prefer this option to include the ability to refer patients for a face-to-face assessment rather than one conducted over the telephone, which is the model proposed for Option B. They believe that patients who are reluctant to return to work could more readily misrepresent their condition over the phone than they could do during a face-to-face consultation.

GPs believed that employers who had been reluctant to implement workplace adaptations they had suggested on the fit note may feel more obliged to do so when faced with a more detailed report and recommendations made by an independent occupational health expert.

Of all the possible models of an IAS, GPs believe that Option C would provide the highest level of support for the patient and its holistic nature makes it particularly beneficial for patients with complex conditions that include both medical and social aspects and for patients with mental health conditions. GPs highlighted that even with this holistic service the patient must be willing to return to work, even if they need support to increase their motivation or confidence to return. However, they are aware of the potential cost of Option C and believe that relatively few of their employed patients would need this level of support to return to work.

For that reason their preferred model is the staged approach in which patients would progress through Option A, to B and then to C, although with the flexibility to allow GPs to refer patients directly to B or C where they believe this is more appropriate. GPs stressed that the referral process should be straightforward and should not add to their administrative burden.

GPs' views on the nature and scale of an IAS

While GPs' estimates of the numbers of patients that they would refer to an IAS are low, when scaled up, this could amount to a large volume of service users nationally. They believe that most of their employed patients are keen to return to work as quickly as possible and can do so under the current system of sickness certification but there are some who would benefit from additional support. They estimate that each full-time GP would use Option A for around ten to 15 patients per month, they would refer four to six patients to Option B and one to two per month to Option C.

GPs highlighted that most of the patients they write long-term medical statements for are on sickness benefits and only around ten per cent are for people who are in employment. They believed the holistic approach and sustained support available in Option C would help patients who could potentially work move from sickness or other benefits into paid employment.

GPs identified the services that they would like patients to be able to access through the proposed IAS, most commonly counselling, psychological therapies, physiotherapy, workplace occupational health visits, and workplace mediation. Careers advice, addiction services, general and lifestyle advice, occupational therapy, work skills, pain management, acupuncture and deep tissue massage were also identified as being important to offer, albeit for a smaller number of patients.

GPs anticipated that an IAS would need to be a national service encompassing a wide range of support and offering personalised expert help. While GPs would prefer it to have national guidelines and procedures, they also thought it should be able to take into account local issues and make use of, rather than duplicate, existing local services.

GPs' views on the benefits of an IAS and any influence on their own role

We found that GPs believe that an IAS would have both economic and social benefits. All the GPs who took part believed that there would be potential for patients to benefit tremendously, both psychologically and financially from a support service that facilitates them to return to work sooner than they would otherwise have been able to.

GPs felt that employers would benefit financially from reducing their costs arising from sickness absence, and that small employers would particularly benefit as they are less likely to have access to their own occupational health support.

Benefits to society were also highlighted by GPs. By preventing people from moving from paid work into unemployment or sickness benefits, GPs thought that an IAS has the potential to save money, and as such would be a good investment.

GPs also felt they themselves would benefit because, in the few cases where they suspect that patients are reluctant to return and so are exaggerating their symptoms, they could refer the patient to an independent service without compromising their relationship with the patient.

We found that GPs already recognise the importance of work for health and wellbeing and so the proposed IAS would not change this perception of their role, rather, they would welcome the expansion of their role to be a gatekeeper to services, such as advising patients on changing their employer or their occupation.

Policy considerations

The findings raise a number of issues for consideration when developing policy. This section outlines our interpretation of the key findings from the study which have implications for the design of any future services.

Clear but flexible guidelines

While GPs want clear guidelines about who to refer and when to do so, they also want the referral process to be flexible so that they are able to use their knowledge of the patient when considering the level and timing of support. For this reason they preferred a staged model but with the additional facility to refer their patients for a face-to-face assessment rather than a telephone assessment.

Defining the target group

While GPs recognised the value of an IAS for helping people remain in work, they believed that far greater numbers of their patients who are not in employment could benefit from the support offered by such a scheme.

Ensuring occupational health expertise

As GPs often felt that they lacked occupational health expertise, they wanted any services to be a source of authoritative back-to-work advice for patients and their employers. Staffing any future services in this area with people who have occupational health expertise is likely to promote GPs' trust and of use of them.

Minimising the administrative burden

To promote take-up, any new service would need to place as little additional administrative pressure on GPs as possible.

Complementing existing provision

GPs believed that to avoid a 'postcode lottery' the IAS should be a national organisation with national policies but the support accessed through the IAS should integrate with, and make best use of, existing local provision rather than duplicate services. They supported fast-tracking to assessment or treatment providing it is based on purchasing additional services rather than existing NHS provision.

Developing clear messages about the purpose of an IAS

Messages to GPs and patients about the purpose of an IAS should clarify that the service would exist to assist patients to return to work. GPs were concerned that patients would be apprehensive about being assessed and feel suspicious that its purpose is a Work Capability Assessment. Messages could usefully incorporate evidence on the effectiveness of the IAS, as the evidence base is developed.

Funding

GPs believe that the IAS should be organised and funded separately from the NHS and that funding should, at least in part, come from employers.

1 Background

The DWP is developing a series of policy initiatives as part of the Government's response to the *Independent Review of Sickness Absence* (Black and Frost, 2011). The review aimed to identify ways of reducing the number of people who fall out of work due to ill health and to improve the system used to manage sickness absence for people in employment. The report drew attention to the benefits of work to physical and mental wellbeing and the harmful effects of long-term unemployment and prolonged sickness absence. It highlighted that people with a health condition who could be facilitated in work are often on sickness absence or do not work at all and that much more could be done to make working the norm for people with relatively mild chronic health conditions. The authors made a series of recommendations to improve the sickness absence system. The first of these was that the Government should fund a new IAS to provide support to help employed people who are off sick from work to return to work quickly and prevent them from falling out of paid work. The IAS, as recommended in the report, should combine an assessment of an individual's physical and/or mental function with advice about how an individual could be supported to remain in, or return to, work following a period of sickness absence. It was suggested that the service should usually be accessed when an individual has been absent from work for four weeks.

Following publication of the review the DWP has been considering the potential characteristics of an IAS. The current system provides advice to employers and GPs and this could be extended to provide a system for referral to an independent occupational health expert. A more extensive model could be based on an holistic service that provides a wide variety of support services tailored to the individual. Alternatively, a staged model could be set up in which GPs can refer to all three of the different support levels depending on the needs of the individual patient. These models are described in more detail in Section 1.1.

As GPs are likely to be a key referral route to this possible service and would influence service-user volumes, it is important to understand their perceptions of different possible models for an IAS and how they would interact with them. Brainbox Research was commissioned to undertake a piece of deliberative research with GPs to explore their responses to the different service models, the way in which they would use them, and the type and number of patients they would be likely to refer. This took place in a focus group environment: focus groups are an ideal way of exploring a range of views and to understand how and why GPs would work with an IAS in different ways. Focus groups enable complex issues to be explored in depth and allow GPs to discuss aspects of the IAS that would be important to them and their patients.

1.1 Models for the IAS

The four models for the IAS we discussed with GPs are based on three different levels of support for GPs, employers and employees plus a staged option in which GPs can refer to the different levels depending on the needs of individual patients.

1.1.1 Option A

The first option would offer a similar level of advice and support to that currently available. Advice for small- and medium-sized enterprises (SMEs) would continue to be available via the free Health for Work Advice Line (see Section 1.2.2). This provides advice both on getting employees back to work after a period of sickness absence and managing health conditions whilst employees remain in work. The existing Healthy Working UK service would also continue to be available for GPs and additional advice to help them develop fit note recommendations could be implemented.

1.1.2 Option B

Option B would extend the support beyond that which is currently available. It would be based on GPs referring patients to an independent occupational health expert who would assess the patient's capability to work and give advice on reasonable adjustments that could be made to support their return to work. It is anticipated that the assessment would probably take place by phone. This would identify appropriate return-to-work goals which could be to the same role, to a different role with the same employer, or to a different employer, as recommended by Black and Frost (2011). The report produced by the occupational health expert would be shared with the GP, the patient and the employer. They would also signpost the employee or their employer to relevant professional specialist advice and services.

1.1.3 Option C

This option would provide an holistic service. GPs would be able to refer patients to a longer-term, more holistic service to support them back to work. Once the referral has been made the patient would be allocated a case manager who would work with them until after they have returned to work. Potentially, this service could be used to help patients access services, for example physiotherapy, more rapidly than they would using the normal referral routes. The intended benefit of this is that patients return to work faster and so they are on sick pay for shorter periods. The support does not stop when they are fit to return to work; it continues for a specified time afterwards. In addition to support and advice on the specific health problem the patient has, they could also get help with workplace issues such as the relationship with their line manager, bullying, workplace stress and so on. There could also be help with non-work-related matters such as debt advice for a patient whose money worries were contributing to their stress.

1.1.4 Staged model

The staged model would combine the previous three options so that patients could receive the most appropriate support at the most appropriate time during their return-to-work journey. There are two ways in which this could be delivered: Employees could progress through the service so that they first receive Option A, then those who have not returned to work progress to B, and then C. Alternatively, GPs could make a direct referral to the level of service they believe to be most appropriate at any point in the patient's period of ill health. This approach would be to provide patients with the appropriate amount of support in a timely fashion so it is anticipated that relatively few people would need Option C.

1.2 Current health and work policy initiatives

Over the past few years there has been increasing recognition that a medical condition, either acute or chronic, does not necessarily preclude work. Accordingly, a series of policy initiatives has been developed (the fit note, the Occupational Health Advice Service; and the Fit For Work Service (FFWS) pilot programme), aimed at enabling patients with a health condition to stay at work while managing their condition, or to return to work sooner than they would previously have done. These are described in the next sections.

1.2.1 The Statement of Fitness for Work (the 'fit note')

The fit note was introduced in April 2010 and helps GPs, patients and employers focus on what the patient can do rather than what they cannot. The major difference between the fit note and the old medical statement (the sick note) is the addition of a 'may be fit for work' option that GPs can use to indicate that the patient may be able to work if certain changes are made. They can

then give advice about the impact of the patient's condition on their fitness for work, and make recommendations under four options: a phased return to work; altered hours; amended duties; and workplace adaptations. By providing more flexibility for GPs to tailor their advice about fitness for work, it is hoped that GPs will be less likely to advise that the patient is not fit for work and more likely to provide written advice on how the patient could return to work. There is a growing evidence base that the fit note is achieving this aim (e.g. Sallis, Birkin and Munir, 2010; Wainright, Wainright, Keough and Eccleston, 2011). A further aim of the fit note is to improve communications between employees on sick leave and their employer, and there is some evidence that progress is being made towards this goal (Lalani *et al*., 2012).

However, GPs can lack confidence in using the fit note to its full potential as they believe they lack specialist occupational health knowledge (Fylan, Fylan and Caveney, 2011; Wainright *et al*., 2011) and tend to rely on just two of the options available to them: phased return and altered hours (Fylan *et al*., 2011). The fit note does not necessarily address the conflict perceived by many GPs between their role as patient advocate and their role in sickness certification (Money, Hussey, Thorley, Turner and Agius, 2010; Wainright *et al*., 2011; Wynn-Jones, Mallen, Main and Dunn, 2010). GPs recognise that patients, particularly those with mental health conditions, can have complex difficulties that would benefit from a more holistic approach than they are able to provide under the current sickness certification system (Macdonald *et al*., 2012).

1.2.2 The Occupational Health Advice Service

The Occupational Health Advice Service was set up in 2009 as a response to Dame Carol Black's review of the health of Britain's working age population (DWP, 2008). The review highlighted that SMEs have little access to occupational health services to help them manage sickness absence or employee health issues at work. The service aims to provide SMEs with early and easy access to high quality, professional advice tailored to their needs, in response to individual employee occupational health issues. It was initially established as a pilot programme running from December 2009 to March 2011 and has been extended to run until March 2013. Employers can use the service to get information on health conditions which should help them put into place appropriate support to either keep the patient in work or to enable them to return to work. They can also seek advice on implementing recommendations made by their employee's GP on the fit note. In addition to the advice line a web portal was established: the Healthy Working UK service. The website (www.health4work.nhs.uk) contains information and resources for employers on managing health and work.

The pilot evaluation (Sinclair, Martin and Tyers, 2012) showed that the volume of calls received from SMEs was lower than anticipated, although nearly all of the employers who participated in the evaluation found the service useful, and most were able to act on the advice received.

Following the launch of the fit note both the telephone advice line and the website (http://www.healthyworkinguk.co.uk) were extended to GPs. The site contains information on the fit note and background information on a wide range of topics related to the health and work agenda. It also contains a search facility to help GPs identify local services that they could refer or signpost patients to. They can use the advice line to get advice on patient health and work issues.

1.2.3 Fit for Work Service programme of pilots

A service similar to the one proposed in Option C, offering holistic, case-managed support to help employees on sick leave to return to work – the FFWS – was piloted in 11 different areas (starting in March 2010). The initial project was funded for one year, and of the 11 pilots, seven were continued for a further two-year period. It aims primarily to help employees return to work after a period of sickness absence but is also able to help those who are managing their health condition in work

to remain in work rather than taking sickness absence. Each area is run independently and so has different characteristics, although all have a common case-managed approach and access to a range of holistic services to address health-, social- and work-related difficulties.

The first year evaluation of the pilots (Hillage, 2012) contains several findings that are useful when considering the possible development of an IAS.

The clients referred to the service were primarily ones with complex healthcare needs, often combining a health condition with social problems and relationship difficulties at work. Social difficulties included poor housing, relationship difficulties and financial problems. Workplace difficulties included harassment and bullying, lack of work support and concerns over workload.

All the FFWS sites found it difficult to engage with employers, particularly small employers. They also experienced considerable difficulties in communicating with GPs about the service, both due to accessing GPs and also maintaining the visibility of the service beyond the initial contact. GPs explained that they receive a lot of emails and it is difficult to get their attention using this method of communication and that they have so many demands on their time they tend to quickly forget about things that are not perceived as being immediately relevant. GPs who were interviewed as part of the evaluation and who did not make use of the service had a limited understanding of the service and its eligibility criteria. Very few did not use the service because they did not believe discussing work with patients to be part of their role.

Clients were positive about the service and believed that it had supported them in returning to, or staying in, work. GPs appreciated the holistic approach taken to help their patients, the expert workplace assessments that could be undertaken, and that the service freed up some of the GP's own resources.

While the first-year evaluation is based primarily on perceptions of effectiveness rather than data that can be used to build a predictive model of successful return to work, the evaluation team identified key features of a successful approach. An initial assessment needs to be undertaken rapidly following referral, a return-to-work goal needs to be set and worked towards and the case manager needs to identify any latent concerns about work that the client might have. Further services such as psychotherapy and physiotherapy need to be accessed rapidly and clients should receive advice to manage and improve their condition. Finally, communication between the employer and the employee should be facilitated and advice given about the changes that could be implemented to return the patient to work.

2 Methods

We used a deliberative approach in which GPs were asked to discuss their response to the possible IAS options during a focus group. We undertook six focus groups with GPs which allowed us to explore their views and experiences of supporting patients back to work and their perceptions of the different IAS options. At the start of the group the four different options were outlined by the facilitator and GPs had the opportunity to ask any questions to clarify the difference between the options but more detailed discussion waited until later in the group. It was stressed that these proposals are only for people who are in work and not for those who are on benefits.

We developed a focus group topic guide comprising a series of questions and associated probes and prompts (see the Appendix) to explore the following main research questions:

- What are GPs' perceptions of each of the IAS options?
- What is the nature and scale of need for an IAS?
- How do GPs think patients should access the service and what should the eligibility criteria be? How should it be organised?
- What do GPs think the benefits of the proposed service will be?
- How would the IAS influence how GPs view their role in supporting their patients in returning to work?

The focus groups included four different patient vignettes that were used to explore GPs' perceptions of the options and the benefits to different groups of patients and conditions. Each group lasted at least 90 minutes. With participants' written permission they were audio recorded and transcribed verbatim.

2.1 Recruitment

Our strategy was to recruit GPs from different practices for each focus group rather than base each focus group at a particular practice. We also wanted to recruit GPs with a range of different experiences and with varying degrees of engagement with the health and work agenda. To achieve this we communicated with GPs via Practice Managers rather than directly as we anticipated that GPs with a particular interest in health and work would dominate the sample if they were invited to respond directly to information about the research. We, therefore, liaised with Practice Managers to engage their support for the research and to highlight that all GPs were eligible to take part regardless of their interest or involvement with the health and work agenda. We also worked with communications staff within Primary Care Trusts and Clinical Commissioning Groups who were able to directly email Practice Managers to draw their attention to the research. Practice Managers were sent an information sheet for themselves and for their GPs via email or post. They were asked to convey information to GPs highlighting the important role they would play in participating in the research and the benefits there would be in doing so. We encouraged Practice Managers to invite whichever GPs were not working during the day and time of the focus group in their area, and should any GP wish to take part, to facilitate their attendance. As the groups took place at short notice, this may have involved tasks such as rearranging meetings and rotas.

Incentives were provided as part of the research: each GP who attended received £150 and each Practice Manager who facilitated their attendance received £50 to compensate them for the additional workload involved. Providing an incentive helped to ensure that the GPs and practices that took part in the study were not just those with an interest in occupational health or the health and work agenda. Nevertheless, we recognise that any GPs who believe that helping people to return to work does not form part of their role may have been reluctant to take part.

2.2 Sample

We recruited a sample of GPs that reflects a broad range of individual- and practice-level variables that may be important in influencing GPs' approaches to patient management and their attitudes towards health, work and wellbeing. A total of 39 GPs participated. The focus groups included GPs practising in areas of high, medium and low deprivation: our previous research for the DWP (Fylan *et al*., 2011) highlighted that this was an important factor influencing how GPs use the Statement of Fitness for Work. Participants included GP partners, GPs in their first five years of practise, GPs practising in a rural area, and GPs with a special interest in a wide range of professional areas. Few reported a special interest in occupational health or in work and wellbeing. This variability in the sample provides confidence that the results obtained from the focus groups can be generalised beyond the GPs that participated and will resonate with the wider population of GPs. Further details of each focus group are shown in the following sections.

Focus Group 1

This group comprised GPs who practise in areas of low, moderate and high deprivation. Some areas had a high proportion of ethnic minorities. The group took place in Greater London and comprised six GPs (four men and two women). The time they had spent practising varied widely, with two having more than 20 years' experience, four having between three and five years' experience and one who is a GP registrar. The group included four practice partners. Individual special interests were broad and included asthma, diabetes and rheumatology.

Focus Group 2

The group comprised eight GPs (six women and two men), four of whom were GP partners. Participating GPs practise in and around Leeds, in areas of high and low deprivation, with two areas of moderate deprivation. GPs were recruited from small-, medium- and large-sized practices. Some worked at multiple locations that included different levels of deprivation. The amount of experience that GPs had ranged from three to 20 years. One had a special interest in occupational health and others had a variety of additional special interests including drug misuse and medicines management.

Focus Group 3

This group comprised six GPs (four men and two women) who practise in areas of low, medium and high deprivation. The group took place in York and drew GPs from the city and surrounding areas. Some practise in rural areas which tend to have relatively high levels of patients who are self-employed. Practice size ranged from small (two GPs) to a group with over 20 GPs practising across multiple sites. Individual experience ranged from newly qualified to over 20 years' experience. Three of the GPs were GP partners and one had a special interest in mental health.

Focus Group 4

This group comprised GPs who practise in areas of moderate-to-high deprivation and included areas that have seen a structural changes in the labour market with a lot of the big employers (such as textile and engineering) closing down. The group took place in a market town in Calderdale and comprised eight GPs (seven women and one man) who practise in surrounding areas in Lancashire and Yorkshire. GPs were recruited from both small- and medium-sized practices and five were GP partners. The time GPs had spent practising varied widely; a few had between four and six years' experience and the remainder had up to 20 years' experience. Special interests in the group included drug and alcohol misuse and women's health.

Focus Group 5

This group comprised GPs who practise in areas of medium-to-low deprivation. The group took place in Chester and comprised three GPs (two women and one man), two of whom were GP partners. The GPs who participated practise in small- and medium-sized practices and had between seven and 30 years' experience. Individual special interests included diabetes, respiratory conditions and osteoporosis. The smaller number of participants in this group meant that the IAS options were explored in greater detail than in other groups and this provided valuable insight.

Focus Group 6

The group comprised eight GPs (six men and two women) who practise in and around Birmingham. The GPs who participated ranged from newly qualified to those with over 25 years' experience. GPs were recruited from practices in medium to generally highly deprived areas across the city that ranged in size from five to 11 GPs in total. Five of the GPs were GP partners. GPs had many diverse special interests including diabetes, rheumatology, mental health and gynaecology.

Focus groups took place in August and September 2012.

2.3 Data analysis

The data collected were analysed thematically using the methods of Braun and Clarke (2006). In this method text is broken down into units of meaning and grouped into themes that illustrate the ways in which GPs perceive the different models of the IAS and how these differences would influence the way they would interact with them as well as the benefits to patients and employers. We took a theoretical thematic analysis approach in which the data are organised under the main research questions. One researcher coded all the transcripts and a subset of codes were analysed independently by a second researcher. All three researchers reviewed the findings within each research question and the illustrative quotes included in the report. The findings are discussed and quotes are included that best illustrate the main points. Quotes were selected on the basis of being representative of some or all of the views of GPs in the study and of highlighting the point made concisely. To protect anonymity each quote is attributed to a particular focus group but not to an individual GP and details that could lead to GPs, practices or patients being identified were removed from the quotes. Where illustrative quotes are used any explanatory information added by the researchers is shown in square brackets. We have highlighted in the report where GPs had differing views and unless otherwise stated there was agreement. There was no pattern (e.g. based on different levels of experience, practice size) that underpinned different views.

2.4 Ethics

The researchers are members of the British Psychological Society and the Social Research Association and as such they conform to each society's codes of conduct, ethical principles and guidelines. The guidance released by the National Research Ethics Service indicates that this work fell outside the remit of NHS Research and Development offices. Specifically, the project explores how the different IAS options would impact on the care provided currently by GPs, it does not involve administrating an intervention, there is no requirement for GPs to make any changes to the care they provide for their patients, and there is no randomisation of participants to different conditions. As such it is concerned with service evaluation rather than research. Nevertheless, the project was reviewed internally by the Brainbox Research ethics group to ensure that the project was ethical, the information sheets were easy to understand and allowed potential participants to make an informed choice about taking part. Participants were able to contact us after the focus group should they have any queries.

3 Perceptions of the IAS options

In this chapter we explore GPs' perceptions of the different proposed models for an IAS. All the GPs had very positive views towards the importance of work for health and wellbeing and so saw the potential value of an IAS. Differences in their views on the potential IAS options are, therefore, reflective of their different experiences rather than different beliefs in the value of work.

3.1 Option A: Fit note plus telephone- and web-based occupational health guidance aimed at GPs and employers

While this option would mean essentially no change from the current system, most GPs were unaware of the support website and telephone line available either to employers or to themselves. They recalled the initial support materials distributed by the DWP about the change to the sickness certification system and some recalled the Royal College of General Practice workshops about health and work. But they were neither aware nor had they used the support available for GPs through the Occupational Health Advice Service.

Nevertheless, GPs recognised the value of additional guidance for themselves on completing the fit note, especially as they identified that they tend to rely on two of the four options: phased return and altered hours. However, they typically articulated this need only following discussions of what they might usually put on a fit note, so other GPs may not immediately recognise this need. GPs identified that over time they develop their own terminology when completing the fit note and that it is not necessarily consistent with that used by other GPs; they acknowledged that employers must find this confusing. They discussed how the guidance available for them could include recommended terminology.

> *'Generally I feel we definitely need more guidance for GPs and for employers.'*
>
> (Focus Group 4)

> *'I think it's quite nice, this extra guidance, because I don't know about you but I've found we develop certain phrases I've found particularly helpful in some scenarios to put on as a recommendation, they seem to work better than others but it's really quite random. You think yeah, that's all right. But it would be good if you can make it more sort of consistent amongst GPs so that the communication's clear for employers about what they can do.'*
>
> (Focus Group 3)

Few GPs were aware of the Occupational Health Advice Service that is currently available to small employers. Nevertheless, they discussed how such an advice line would be useful, and particularly so for small employers. They described how most of the small businesses in their areas do not have an occupational health service, either provided in-house or externally via an independent organisation or private healthcare. Furthermore, they often have little knowledge of occupational health problems or solutions and can be reluctant to consider how a patient's condition could be facilitated in the workplace. Therefore, GPs believed that small organisations have a greater need for an occupational health line than larger ones, although some were sceptical over the extent to which it would be used. GPs also discussed how employers can be reluctant to accept that patients can

work, even though they are not completely well and often prefer their employees to stay away from work until they are fully fit. This provides an obvious barrier to effective use of this option.

> *'You sometimes hear patients saying* [my employer says] *"we want you fully fit, come back when you're fully fit". I think there are anxieties as an employer, maybe a small employer, around liability.'*
>
> (Focus Group 2)

They believed that the advice line has the potential to help employers who do not have access to occupational health services make sense of the 'grey area' between health and illness where a patient can be supported to remain in the workplace while recovering from their illness or managing their long-term health condition.

> *'There are lots of small firms in our area and I think a lot of them have a very poor understanding of occupational health, the boss just says "you're fit" or "you're not fit", there's whole grey areas really, and I think being able to somehow tick a box to say you could call this line for advice, it might be quite helpful in that setting. Whether they would be able to carry out the advice that's given is another matter, of course, but having that extra option available would be useful.'*
>
> (Focus Group 6)

They highlighted that smaller employers may not want to be signposted for additional services or some workplace adjustments because of the cost implications.

> *'Could it be that they are legally bound by whatever the advice line says? It could create a whole raft of problems for small businesses who ring these people up, it could be quite a difficult thing from a business point of view.'*
>
> (Focus Group 2)

GPs also expressed concerns about whether employers of all sizes would adopt the recommendations they received from the advice line. They discussed the extent to which employers follow the advice they receive on the fit note. Some GPs were *'maybe naively optimistic'* (Focus Group 6) that in most cases their advice is followed while others thought that employers can be reluctant to make the adjustments they suggest, either to the physical environment or to the patient's role. Several GPs highlighted that employers are not obliged to follow the recommendations they make. They suspected that if the advice provided by the advice line was not from an occupational health doctor it might be even less likely to be followed than their own recommendations.

> *'Even with the current fit note, I'm sure on the small print on the other side or if you read the guidance to it I'm sure it says that even if you tick the conditions you may be fit, it actually says somewhere we can recommend this but your employer doesn't have to take any notice of it.'*
>
> (Focus Group 6)

They discussed that they rarely receive any feedback about the extent to which the suggestions they make are feasible or are implemented and that any feedback comes through the patient rather than the employer. GPs believed that their role as the patient's advocate means that they need to accept the patient's account of their employer's response to the recommendations even when they suspect that they may not be hearing a full or accurate picture.

> *'You are quite literally taking what the patient says at face value and there is no other way of knowing the realities of what's going on on the other side.'*
>
> (Focus Group 6)

> *'You say "you could do this, could do that" but if you have the patient "oh they won't accommodate me doing that", you have no other say, you don't know what goes on at their work, you don't know if they can accommodate it. So it can be very difficult I think to try and facilitate them getting back.'*
>
> (Focus Group 2)

Therefore, it is unlikely that Option A would adequately address concerns among GPs that their role as patient advocate makes it difficult to challenge a patient's account of either their health conditions or their employer's reluctance to facilitate their return. While GPs stressed that the vast majority of their employed patients are keen to return to work as soon as possible, they had all experienced the occasional patient that they suspected was exaggerating their symptoms in order to avoid returning to work.

GPs were initially concerned that the advice line may disclose details of the individual patient's condition, which they would not support as they saw this as breaching patient confidentiality. They were reassured that the advice line gives only generic information about a condition and how it could be facilitated in the workplace. However, they discussed how employers would need to recognise that patients recover at different rates. They were concerned that if an employee takes longer than average to recover from their condition, for example due to their age or co-existent health or social difficulties, the employer might put pressure on the employee to return before they are able.

> *'Some people go back to work in three weeks and some people take longer. It's still going to be individualised to that particular patient. So if they're ringing up this action line and the action line is telling them that this patient should go back in four weeks it might not be* [right] *for that particular patient.'*
>
> (Focus Group 5)

Furthermore, without specific details of the patient's condition, GPs were concerned that the advice obtained might not be particularly useful. They discussed how they can be *'deliberately slightly vague'* (Focus Group 5) on the fit note to mask the patient's real condition from the employer. GPs explained that they sometimes do this because patients can be reluctant to disclose their health condition to their employer. In some cases this is because they do not want their employer to know personal details. In others it is because the relationship with their manager is contributing to, or causing, their sickness absence and the patient is concerned that specific information would make the situation deteriorate further. Regardless of the reason, GPs discussed how the employer would not be able to obtain useful information about getting the patient back to work when the condition listed on the fit note, while true, is not the one that is preventing them from working.

> *'Well some employees are terrified of having something on their note and it might be stress-related but they might not want to put down it's work-related stress because they know that their line manager will know it's them and there are lots of issues around that. It's very common. You'll put something that's absolutely true on the sick note but it might not be the condition that the employer would want to ring up about so you might put gynaecological problem if it's early in a pregnancy when they're not duty bound to tell the employer at all. They might have a relationship breakdown and they're just completely falling apart and can't work but they don't want their employer to know that.'*
>
> (Focus Group 5)

In some cases, for example, mental health conditions, the patient does not want their colleagues to find out about their condition and suspects that if details are shown on the fit note then their colleagues would find out about it through their manager. However, GPs highlighted that patients

have individual views on this and while some do not want to disclose their condition others are happy to do so.

> *'People vary a lot. I remember one lady who I had written depression on her sick note and she was very keen that that stayed between her, me and her boss, but then the boss told everybody in the department that she worked in that she was off with depression. And she was extremely upset and it made it much more difficult to get her back. Then it'll vary, not everyone feels the same.'*
>
> (Focus Group 6)

Even when the fit note accurately reflects the condition that is preventing the patient from working GPs still had reservations about the quality of advice that would be available through this type of service. Because they were unfamiliar with the Occupational Health Advice Line they were not aware that it is staffed by occupational health doctors and nurses. Instead, they suspected that it might be staffed by non-clinical operators in the same way that NHS Direct is run and they were concerned that employers might overestimate the level of advice they could obtain.

> *'Well a fitness to work helpline sounds like it might be more appropriate in the sense that they could provide a little bit of information on simple conditions but calling it occupational health I think is really dodgy ground really.'*
>
> (Focus Group 4)

3.2 Option B: Patient assessment by an occupational health expert to give advice on capability to work and reasonable adjustments to enable return to work

Previous research has shown that few GPs perceive themselves as having occupational health expertise (Elms *et al*., 2005) and this acts as a barrier to effective use of the fit note (Fylan *et al*., 2011; Wainwright *et al*., 2011). GPs in the current research also reported this lack of expertise and therefore welcomed the ability to refer patients to an independent occupational health expert. They believed that the expert would be able to provide specific advice on what the patient can and cannot do at work and the adaptations that would be both possible and feasible.

> *'The problem I have is understanding what people's jobs entail and the structure and how therefore to advise them.'*
>
> (Focus Group 5)

For this reason, GPs thought that Option B would address a clear gap in the current sickness certification system, particularly for smaller employers who are less likely to have access to an occupational health service.

GPs welcomed the assessor as an independent expert who would provide an objective view of the patient's ability to work and what could be done to facilitate their return to the workplace. GPs discussed how, in some situations, they insist on exploring with patients how they could return to work even when the patient is reluctant to do so but that these take delicate negotiations and there is potential to damage their relationship with the patient. The ability to refer a patient to an independent expert would enable GPs to take additional action to return the patient to work without directly challenging their account. They described how they would explain to the patient that they had done as much as they can in order to help them return to work and that it is now time to obtain

help from somebody with more expertise. In this way the relationship with the patient is protected as the patient would not feel that the GP disbelieves them.

> *'I quite like the idea of it. It's one of those things when you sit there and actually your mind is whirring and trying to decide whether or not someone can work ... I don't want it to be up to me because I want to be on your side all the time, have somebody else make that decision. And I quite like that, not just because it's easy for us but also because that advocacy role and the relationship is maintained and if they don't get the outcome that they want you are not blamed and you still have that relationship.'*
>
> (Focus Group 6)

An additional benefit of this option would be that the GP is able to be clear with patients who they perceive to be reluctant to return to work, that there is a need to address the issue of a return to work. Early in the sickness certification process GPs could tell patients that they are required to refer patients to an independent expert after a set period. GPs thought that the knowledge that they would be referred would be sufficient in many cases to return the patient to work without the need to refer them for the occupational health assessment.

> *'I think if employed people knew that if they were to be signed off for a set period of time they would be assessed by somebody independent and they knew from the outset it would incline them to return to work sooner rather than us having to keep signing them off or actually refer them to a service like this.'*
>
> (Focus Group 1)

> *'This kind of system could help to actually alert the patient as well that he or she is a bit watched as well, you know so it gives a signal to them to actually become a bit more motivated.'*
>
> (Focus Group 3)

Similarly, they identified that the need for an independent assessment could also encourage GPs to raise the topic of work with patients even when they anticipated such a conversation would be difficult.

> *'I think this would be a useful step when people have been off work for a period of time, you know almost a compulsory hoop for everyone to have to jump through to recognise the need to actually address getting back to work, both for the employer, the employee and the doctor actually. Because I think there is sometimes an inadvertent collusion, an inadvertent lack of pressure on patients to get better or to start thinking about getting back to work. And I'm thinking of the doctor who will do another sick note for a quiet life to catch up in surgery, or maybe he doesn't know the patient particularly well, isn't really in a position to challenge the patient.'*
>
> (Focus Group 3)

GPs also described how Option B would be valuable when employers are reluctant to adapt the workplace to facilitate the patient's return to work. They believed the report would be more influential than their own recommendations on the fit note or even their letters to employers.

> *'It may help give the patients more power because I think even with our fit note, I think having an occupational health report which they can take back to work saying that they need certain adaptations at work.'*
>
> (Focus Group 2)

GPs also highlighted that a major benefit of the assessment is that it would be from an independent person and that it should be clear to employers that the report is independent and not one that had been produced for the GP, who is the patient's advocate and therefore, has the patient's interests at heart, rather than the employer's.

> *'I'd say it should go to the patient and a copy to the GP. It reduces our workload slightly and also it's a direct communication without our sounding, embellishment or explaining and it's from an official organisation and not the patient advocate I suppose.'*
>
> (Focus Group 1)

> *'I wonder if employers perceive the GP as being a bit of a soft touch and they'll just do whatever the patient asks them. Whereas they were getting a report from the occupational health doctor saying; "oh, well, they're impartial here, I'm going to pay more attention to this".'*
>
> (Focus Group 6)

GPs were confident that they would be able to manage a situation in which the occupational health advice received in the report from the independent occupational health expert differed from the advice they had given. In many respects they would expect the advice to add value and not simply to mirror their own assessment. They do not, therefore, see different advice as being problematic. They described how they can '*already have that situation with the consultant's advice*' (Focus Group 5) when they have referred a patient to a secondary care consultant.

Despite telephone consultations with occupational health specialists being a common means of service delivery, most GPs were concerned about the assessment taking place by phone. They believed that patients could easily misrepresent their condition, which would reduce the value of the assessment. Nearly all GPs assumed that the report would be based on information gained from a physical assessment and so obtaining information on the patient's physical condition over the phone would be subject to error.

> *'You get the person who says "I've got chronic back pain, I can barely move" and you see them skipping over the car park, leaping into their car. The phone's not going to pick that up is it.'*
>
> (Focus Group 6)

> *'I don't know it works by phone because you need the patient in front of you. If you're an occupational health expert and you know what is involved in certain occupations you can then pair up what the patient is capable of doing to what that job requires, which we don't know more often than not, and I don't think you can do that on the phone. They need a proper examination.'*
>
> (Focus Group 5)

Even those GPs who were happy that a good assessment could be done by telephone noted that patients would expect a physical examination and would place less value on a telephone service.

> *'I think you can be very effective over the phone, very effective, but it is about patient perception. If you haven't laid a hand on them they feel you haven't done your job properly.'*
>
> (Focus Group 6)

GPs suspected that patients would complain if the report did not say what they hoped and would use the lack of a physical assessment as grounds for appeal.

'My only comment is that if this is telephone advice I could just imagine our patients coming back to you, particularly if it didn't go in the way that they would have liked; "how could they assess me, they didn't even see me, how do they know what I was like?".'

(Focus Group 6)

They assumed that the reason for undertaking a telephone assessment would be to save money, but they would rather refer fewer patients to a higher quality (as they viewed it) face-to-face assessment.

'I would be happy to accept that it's a limited service and that we have to be careful who we refer and we can only refer so many if it's worth doing because I wouldn't want to use it if it were telephone based and in terms of who is doing it, the letters that I get back from patients who have seen occupational health through their own employer are, I would say, in excess of 90% helpful. So if they can get that calibre of trained staff on board, albeit in limited numbers, I think that will be a fantastic service to be able to offer to people. And I think generally most people accept that if you're going to have a quality service, you know, both GPs and the patients alike, then the NHS and the DWP or whatever isn't open-ended, there are limits to it that it, you know, it's better to have a quality service than a rubbish one that's open to everybody.'

(Focus Group 4)

Some GPs discussed how they would be less likely to refer to an IAS that involved a telephone consultation rather than a face-to-face one.

'I'd love to be able to refer somebody to a proper face-to-face consultation with the occupational health expert, that would be brilliant and I would take their advice with open arms but if they've sussed them out over the phone I'm not sure.'

(Focus Group 4)

Other GPs, however, could see the value of a telephone-based assessment, especially for patients who are highly motivated to return to work and therefore, willing to represent their condition accurately. They thought that a telephone-based system could provide rapid advice specific to that patient's individual condition, leaving a face-to-face assessment for more complex conditions or less motivated patients.

'It's more about being creative, what can they do instead or to what degree or so on. I think the telephone is sufficient for that, to actually just explore ideas, options, whatever. So this system could basically filter out, I think, the majority of people who are going to get better in a reasonable time scale just by giving advice and encouragement.'

(Focus Group 3)

There was no apparent difference, for example, in terms of experience, practice characteristics, or special interest between GPs who appreciated the value of a telephone-based assessment versus those who viewed this as unsuitable. GPs suggested that they should be able to indicate on the fit note whether they are referring to a telephone-based or face-to-face system.

There was discussion in the focus groups about the level of expertise required by the occupational health expert. GPs did not want a service in which an unqualified person used a flowchart or checklist to make recommendations. They believed this option should be one that would offer something over and above their own level of expertise so while they did not insist that the expert was medically qualified, they wanted them to have substantial knowledge of occupational health. As in Option A, they drew comparisons with NHS Direct in which the caller is triaged via a person who

is not required to have any medical knowledge and rejected this as an option. They also highlighted how the extent to which the patient is likely to trust the report will be influenced by the patient's perceptions of the level of expertise the assessor has.

> *'And if it's not somebody who's genuinely working in that field, not somebody who's just been hauled in to fill a Government tick box, patients aren't going to trust them.'*
>
> (Focus Group 5)

An additional major concern with this option is that the assessment would be similar to that undertaken by Atos Healthcare, which some perceived as being target-driven and set up to assess virtually all patients as fit for work.

> *'One of the problems with the present system is that it's certainly a perception that Atos are trying to get people off the sick. They have targets to fill.'*
>
> (Focus Group 5)

> *'I'm just concerned with what's happening with the patients at the moment when they're going off to Atos for medicals and the way that the decisions are being made there as far as whether people are fit to work. I think if this occupational health line worked in a similar way it could be equally as disastrous as what we're currently facing.'*
>
> (Focus Group 2)

Hence the results demonstrate that GPs could hold misperceptions that the aim of this possible IAS option is to classify all patients as fit to return to work rather than to identify appropriate return-to-work goals and advice about how to achieve them. While not all GPs who took part described patients who they believed had been inappropriately assessed by Atos as fit for work, there was a widely held recognition of this discourse within the GP community.

There was some debate about who should 'own' the report. The main concern was that this referral should not add a burden to the GP's administrative load. They suggested that the report should be sent to the employer for them to action. An electronic copy should be sent to the GP so that it can be included in the patient's medical records.

> *'I'm not too sure about the report coming back to me. You'd get sort of pages and pages of report after an assessment. What is the benefit to me?*'
>
> (Focus Group 1)

> *'I think it should go to all those three people but I think it should probably be up to the employer to try and action the recommendations.'*
>
> (Focus Group 2)

Option B was viewed as something that GPs need to be informed about but not centrally involved in once referral was made.

> *'It is for the employer and the patient really, we're copied in on it to be informed about it and to keep us in the loop but this is the employee/employer relationship.'*
>
> (Focus Group 6)

GPs also identified that if this option were to be effective, any further interventions or investigations recommended in the report should be actioned rapidly.

3.3 Option C: Holistic support for patients provided by case managers

Most GPs very much supported this option, describing it as a '*gold-plated service, top notch*' (Focus Group 3) and as if '*we have all moved to Sweden*' (Focus Group 4) because of the level and range of support it would provide for patients. However, they expressed concern over how much it might cost, and if not used in a staged approach, whether it would be appropriate for most of their patients. They agreed that most patients would not need this level of support. The minority of GPs who did not support this option had doubts over how effective the service would be in returning patients to work, particularly those who lack motivation do so, and believed that the cost of such a service would be difficult to justify given the low numbers of patients they would refer.

Indeed, most GPs indicated that it would be important to keep referral levels low to avoid long waiting times to access the service.

> '*They won't want us to refer everybody because obviously otherwise the service would just crumble and fail because it would just end up with massive waiting times and things. But I think there are, we've all got a few patients where actually having option C, if it would mean us producing that referral, would be worthwhile.*'
>
> (Focus Group 2)

GPs also identified that this level of support would benefit their patients with health conditions who are currently claiming sickness benefits but could potentially work. They believed that an holistic approach and sustained support would help them to move from benefits and into paid employment and that they see far more of these patients who would be suitable for such a service than those in employment.

> '*The bigger problem would be getting unemployed people back to work. We don't get all that much long-term sickness of employed people. It's actually not that common. I would say a ratio of 10:1 maybe unemployed versus employed. I'm just guessing. Maybe more; 20:1.*'
>
> (Focus Group 1)

> '*We can all think of patients, those ones who have just been for their Atos assessment and they're going through the appeals process, they're the ones who would probably benefit from this service.*'
>
> (Focus Group 2)

There was general agreement in all the focus groups that Option C would be most appropriate for patients with complex multiple health conditions or those with mental health conditions, including patients who have work-related stress. GPs in all of the groups identified that workplace stress is commonplace and it is often accompanied by complaints of bullying. They discussed how patients are often reluctant to return to work, even when they have recovered sufficiently to do so, because they will return to the same working environment that contributed to their illness in the first place.

> '*The ones with the anxiety at work like the line manager's broken down, the stress at work because they're difficult aren't they because you want them to be off work but then you think the longer you're off work the harder it is to go back, it becomes this bigger beast so I think it would be good for them.*'
>
> (Focus Group 2)

They talked about the need for an advocate who could negotiate with the employer to resolve difficult working situations and smooth the way for the patient to return. All GPs believed that workplace mediation would be one of the most useful aspects for those patients whose absence is caused or exacerbated by a breakdown in workplace relationships.

> *'Sometimes it's one of our biggest problems where there's been an industrial dispute at some point between employer and employee and they say: "well, I don't get on with the boss" and whatever and "so I've got to be off sick". And I think that's where we feel it's a particularly difficult situation where the person isn't ill and yet we're being asked to give them a sick note to cover a certain situation.'*
>
> (Focus Group 6)

GPs discussed how the case manager may be able to uncover problems that the patient might be reluctant to share with the GP but that are, nevertheless, preventing the patient from working. For example, a patient who has known their GP for a long time might be reluctant to disclose alcohol problems.

> *'I think a lot of people are not telling their GPs about particularly alcohol problems so a bit of expertise in that department would be useful.'*
>
> (Focus Group 4)

Another group who GPs would refer would be patients who are reluctant to take sickness absence but whose health could deteriorate if they do not rest. GPs identified that accessing this service would mean that patients are not simply waiting at home but feel that they are doing something active to ensure their recovery.

> *'They don't want to be off work but actually the doctor feels it will benefit them to be off work. This Option C I can see that being helpful in that sense because you ask to see some patient sometimes you know and this group of patients I actually feel sorry for them because they say "look, I cannot afford not to work, my back is aching but I have to go to work" and you say actually say to them, "take some few days off, you know get this sorted", you know, and they say "look, I can't do it".'*
>
> (Focus Group 4)

GPs differed in the extent to which they supported fast-tracking patients to access services. Some were heavily in favour of this as they anticipated it would pay for itself from savings in sick pay.

> *'That's a very good idea because at the moment we have got lots of patients who we have to give them sick notes because they can't get physiotherapies soon enough and that's a very good idea.'*
>
> (Focus Group 1)

> *'That's what you need. If you're getting somebody who's potentially going to be ill long term you need rapid intervention.'*
>
> (Focus Group 3)

Several GPs believed that there is already the facility to fast-track employed patients through the system, for example if they indicate on the referral form that the patient is off sick from work

they are seen quicker. Some highlighted that there is already an established fast-track system for members of the armed forces and that some NHS Trusts fast-track their own employees.

> *'Already I think if someone's missing work I'd put it on the form and they would be seen* [by physiotherapy] *within two weeks anyway.'*
>
> (Focus Group 1)

> *'The Armed Forces get it, why shouldn't the other workers?*'
>
> (Focus Group 1)

> *'If it's a Trust employee, you know the Hospital Trust, then they'll fast-track them.'*
>
> (Focus Group 4)

Others were opposed to fast-tracking patients as they believed that it would make waiting lists for non-employed people longer or that it would contradict the egalitarian principles of the NHS.

> *'If you have to fast-track people to physio or psychology or things like that you create a different elite group that access certain services because they are in employment. It doesn't seem fair. We'll get accused of having a two-tier system.'*
>
> (Focus Group 4)

Overall, there was substantial support for fast-tracking provided there would be at least some additional services over and above those already provided by the NHS so that people not currently in employment would not suffer as a consequence.

> *'Why shouldn't an old person who's retired with back pain get an appointment as quickly as a 40 year old person who's working? They've paid their contributions towards the NHS for plus 60 years that person. What will happen is that everyone who's in work will get seen first of all and the referral time for the people who aren't working because they're pensioners or whatever will just get longer and longer and longer.'*
>
> (Focus Group 2)

GPs believed that the role of the case manager would be to triage patients to different services and to be the person who communicates with the employer: they thought it would get too time consuming for the employer if they were to receive several different reports from different services. Some GPs were concerned that the case manager would have to possess a wide range of skills in order to identify which services patients would benefit from. However, they were happy for the case manager to refer the patient for further investigations, and when appropriately qualified, to instigate treatment. GPs did not assume that the case manager would be medically qualified, rather, that they would have occupational health expertise plus skills in negotiation and behaviour change. Because of this GPs recognised the case manager would be highly qualified and therefore expensive.

> *'This isn't going to be a cheap person to employ, the person who's going to be doing this case managing, because they've got to have lots of different skills.'*
>
> (Focus Group 2)

Some thought that the role of case manager would be the role that the GP would or should take if they had sufficient time to deal with individual patients. There were no consistent differences between GPs in terms of characteristics such as experience, size or location or practice in those who would like to assume this role if they had time to do so. GPs noted that there would be less need for

this option if GPs could arrange rapid access to services such as physiotherapy and psychological therapies. This was a very widely held view.

> *If somebody comes in and they've got a medical problem or a primary care problem, whether it's mental health because of anxiety or it's because they've got a back problem or a leg problem or whatever and they need some sort of intervention that isn't surgical necessarily. What they need is to get hold of that next service and that would get rid of an awful backlog up here, so if we could get hold of a psychotherapist within a fortnight, if we could get hold of physio within a week or a fortnight to get them moving straightaway.*
>
> (Focus Group 6)

All the focus groups highlighted that the function of many of services that might be provided through Option C are already available. Many patients can already access services through their employers (such as workplace mediation through trade union representatives or counselling available through a workplace scheme) though their community (for example, general help and support through neighbours) or through the voluntary sector (for example, debt advice through the Citizen's Advice Bureau). They were concerned about duplication of services.

> *'There's an awful lot of overlap with what we've got at the moment, you've got the unions, you've got Citizen's Advice, you've got counsellors and then this brings some counselling in and starts duplicating everything that's already in place.'*
>
> (Focus Group 6)

However, they discussed that that there has been a drop in the availability of these services, such as trade union membership being less common, reduced funding to voluntary sector organisations and a drop in community cohesiveness. They, therefore, recognised that there is a place for these sorts of services available through the case manager, but they remained concerned that there would be a degree of duplication of services.

Apart from the cost implications, GPs identified other potential disadvantages. Some expressed concern that patients would quickly get to hear about this service and would start requesting it because of the level of support they would enjoy and it might be a way to delay going back to work. They drew parallels with patients on sickness benefits and how news travels fast about new ways to get a sick note. However, others pointed out that patients in employment are usually keen to return to work, as shown in the following exchange.

> *'A lot of them* [patients] *they worked out that if you said like you're hearing voices or things like that, this whole rumour went round, and the hearing voices gang turned up and then every single one of them was hearing and they want it immediately. And I'd say fine. I'll send you to psychiatry. They'd get on the outpatient load. They're seen every three months and they're still hearing voices. You know how are you going to prove it? There's no blood tests.'*
>
> *'But if you're in a stable job and most of these people will actually, they'll do what it takes because they're scared because of the economic climate, recession, they'll actually work really hard. Even if they are hearing voices they won't say anything; they'll carry on doing their job.'*
>
> (Focus Group 1)

They discussed how a patient receiving this level of support may begin to rely on it and be reluctant to return to normal working patterns as it would mean ceasing to access support which they enjoy but no longer need. They discussed how patients need to develop independence in order to manage their own health condition and life and workplace situation and some were concerned that

this option would simply encourage a culture of dependency rather than patients seeking out the support they need for themselves.

> *'I think when we're trying to get people to go back to work we're trying to foster a certain amount of independence for them and I think Option C is very much about dependence.'*
>
> (Focus Group 6)

3.4 Staged model

GPs favoured this model as it would offer what they considered to be a high-quality service but delivered at the appropriate intensity. In this way they could tailor the service to the needs of individual patients.

> *'I prefer the staged one just because different options you know apply to different people. It just doesn't make sense to just have one thing that must apply to everybody.'*
>
> (Focus Group 1)

> *'I think the staged would be ideal in that you've got all those options and individual cases might benefit from one.'*
>
> (Focus Group 3)

They preferred to be able to refer patients directly to Options B or C, rather than all patients first accessing B, and then those not returned to work progressing to C.

> *'I think we could probably identify the ones that need C quite quickly so they don't need to go through A and B.'*
>
> (Focus Group 1)

GPs discussed how they believe that more complex cases, particularly those involving mental health conditions, would benefit from direct referral to Option C (see Section 3.3). They believed that the staged model would be more cost-effective than a model of the IAS that comprises solely of Option C as it would give more intensive support only to those who needed it. The following quote illustrates that while GPs successfully return most patients to work most of the time there are a few that present real difficulties for GPs. Some of these patients are at risk of falling out of paid work.

> *'The majority of people we sign off sick will go back to work no problem at all, there's going to be some in the middle where it's a little bit more difficult and this sort of thing might be helpful, and there's always going to be a few at the top of the pyramid where it's just a complete nightmare* [to get them back to work].*'*
>
> (Focus Group 6)

3.5 Summary

GPs recognise the benefits of all three possible tiers of support within an IAS. Option A was viewed as being most appropriate for patients employed in small organisations but it does not address the difficulty that GPs can experience when they are reluctant to challenge their patient's account of their condition or their employer's willingness to implement recommendations on the fit note.

Another challenge that GPs face is their lack of occupational health expertise which limits the extent to which they can make detailed recommendations about workplace adaptations. They, therefore, welcome the ability to refer patients for an expert occupational health assessment, as in Option B. Most GPs, however, would prefer the option to refer their patients for a face-to-face assessment rather than one that is conducted over the telephone, which is the model proposed in Option B. They believe that patients who are reluctant to return to work could more readily misrepresent their condition over the phone than they could do during a face-to-face consultation. GPs also assumed that the service would include a physical assessment, which again would be more difficult over the telephone.

A major benefit of Option B identified by GPs is that the assessment would be conducted by an independent expert and employers would be more likely to implement the suggestions made than if they had come from the GP. As such, Option B is viewed as particularly beneficial for patients with employers who are being inflexible about adapting the workplace to enable them to return to work.

Of all the proposed models of the IAS, GPs believe that Option C provides the highest level of support for the patient, and its holistic nature makes it particularly beneficial for patients with complex conditions that include both medical and social aspects, and for patients with mental health conditions. Some GPs, however, raised concerns about this option potentially creating dependency on the high level of support and also that some patients may try to get access to the support when they do not need it. GPs are also aware of the cost of Option C and believe that relatively few of their employed patients would need this level of support to return to work. For that reason their preferred model is a staged approach in which patients progress through Option A, to B and then to C, although with the flexibility to allow GPs to refer patients directly to B or C where they believe this is more appropriate.

4 Nature and scale of the IAS

In this section we explore GPs' perceptions of the services that an IAS should include and the likely demand for the service. GPs were asked their views on how patients should access the service and what the referral criteria should be. They also explored when patients should be referred and about their role in the referral process.

4.1 Expectations of the range of services

GPs suggested the following services be available in Option C. They are listed in the order in which GPs believed the greatest demand would be, starting with the most sought after:

- counselling;
- psychological therapies;
- physiotherapy;
- occupational health;
- workplace mediation;
- careers advice;
- addiction services (drugs and alcohol);
- general advice (similar to that offered by the Citizens Advice Bureau);
- occupational therapy;
- lifestyle advice (e.g. diet and exercise);
- work skills (e.g. literacy and numeracy, computer skills);
- pain management;
- acupuncture;
- deep sports massage.

GPs had difficulty identifying how many patients would need these services. They stressed that the bulk of the long-term medical statements they write are for patients on sickness benefits rather than those in employment and it is a very small pool of patients who they would refer to the proposed Option C. Nevertheless, through discussions in the focus groups it was apparent that all patients who GPs would refer to Option C would have complex problems primarily involving mental health conditions, addiction, or relationship problems at work.

> *'And I would envisage that a lot of those people will have either depression or stress-related illness on their sick notes.'*
>
> (Focus Group 3)

Hence, the most popular services that GPs anticipate are counselling and psychological therapies. The latter was described in particular as having such a long waiting list as to make the service as it currently stands virtually unusable.

'You think "I will refer you" but then the waiting list is so long you think "what's the point?".'

(Focus Group 6)

Physiotherapy was also anticipated as a commonly used service, although for these patients it would typically be where a longstanding musculoskeletal condition has led to depression. GPs also anticipated the need for an occupational health report for patients who could work but their employer's rules or regulations prevent them from doing so. Examples might be when a patient needs to move around but their employer prefers them to be seated, or when the patient needs frequent comfort breaks but their employer has strict rules on how often they can be taken. GPs discussed how the occupational health specialist might make workplace visits to make specific recommendations about adaptations that could be made.

Workplace mediation was also viewed as being an essential feature of Option C. GPs discussed how this service could be pivotal in getting patients with work-related stress back into the workplace.

'I get a lot of people with work related stress and it comes down to a line manager. They don't really need someone to do a workstation assessment. They need someone to go down there and sort them out.'

(Focus Group 2)

Many GPs highlighted how employers have policies on the number of different periods of sickness absences a patient can have before they are taken through a disciplinary process. They discussed how this can deter patients from returning to work before they are fully fit in case they need to take more time off, which would be viewed as an additional period of sickness absence. They believed that the independent occupational health expert would be able to explain to the employer why the patient should be exempt from this.

'I think the problem a lot of my patients seem to have, as soon as they've been off sick a number of times and they're on disciplinaries and it's that which is very difficult for patients, particularly you feel very sorry for those who have significant health problems. I've got somebody who's recently had surgery on a couple of occasions and has serious health problems, but she's back at work and very scared of having any more time off because if she has any more time off she'd be on a level three of something and she'll lose her job. But actually she's somebody who is really dedicated, loves the job, works very hard despite her health issues and actually she should be supported but she knows that she's at risk of losing her job.'

(Focus Group 2)

GPs highlighted that while the services provided through an IAS could address aspects such as confidence to return to work and undertake some motivational work with patients, fundamentally, the patient must be willing to return to work.

'A patient has to kind of want to [return to work] *because otherwise they're going to drag their feet and miss all the appointments, never answer the phone, not be there when somebody home visits them and generally drive everybody nuts.'*

(Focus Group 4)

GPs identified that patients undergoing a tribunal or who are involved in compensation claims are unlikely to benefit from the IAS as they are typically very resistant to interventions while their claim in underway.

'One of our biggest problems is where there's been an industrial dispute at some point between employer and employee and they say, "well I don't get on with my boss" and so they say "I've got to be off sick". And I think that's where we feel in a particularly difficult situation, where the person isn't ill and yet we're being asked to give them a sick note to cover a dispute situation.'

(Focus Group 2)

4.2 Anticipated numbers

GPs reported that the majority of the fit notes that they write are for short-term, self-limiting conditions such as minor illnesses and acute musculoskeletal problems. For this type of condition they believe the current fit note system works well: people need a period of recovery time off work and they return to work as soon as they are fit. They estimated that around ten per cent of the fit notes they write indicate that the patient may be fit for work with some alterations. These are the cases that would benefit from an IAS.

GPs talked about there being a 'pyramid' of patients who would benefit from an IAS, with most being suited to Option A. They estimated that approximately ten to 15 patients per full-time GP per month would benefit from this option. They would refer fewer patients to Option B and estimated that this would be in the region of four to six patients per full-time GP per month. They would probably not refer patients who have access to occupational health services via their employer. They anticipated that they would refer up to one or two patients per full-time GP per month to Option C. These estimates were consistent across the focus groups.

GPs were acutely aware of the potential for an IAS, particularly one involving Option C, to be very expensive and to receive many referrals, resulting in a long waiting list and little scope for a rapid intervention to return patients to work.

'I think we all know that you have to be careful with capacity in your system, so I think there might have to be certain criteria for Option C would have to be met before you could access it otherwise you could easily swamp a system.'

(Focus Group 3)

For this reason they were conservative about the criteria for referral and keen that there would be some clear guidelines that would limit the scope of the service. They also highlighted the need for the guidance to evolve as an evidence base is built up around which services are effective in enabling patients to remain in, or return to, work and which patients are more likely to benefit.

'There would have to be some criteria for referral and they would have to evolve as well. Because it's so new this whole idea I think it's going to take some time to actually work out who is appropriate and who isn't.'

(Focus Group 4)

They also highlighted that while the focus of the research is on employed patients, they see far more patients on benefits who they would like to refer to an holistic support service, as in Option C.

4.3 Expectations of when patients would be referred

While there was good agreement between GPs on the type of conditions and the number of patients they would refer, there was much more variability in when they believe that patients should be referred. GPs discussed how the referral point varies with the patient, their condition, and their job role but they agreed that directing employers to an occupational health advice line, as proposed in

Option A, is appropriate for some patients immediately. GPs differed, however, on when patients should be eligible for Option B, as illustrated in the following exchange.

> *'That option looks right for enduring patients who might be having difficulty in getting back to work after several months.'*
>
> *'Well what about muscular skeletal conditions, you know like shoulder pain, back pain where they're involved in moderate-to-heavy work. So, for example, if you're an employee of the Trust, if you're off I think up to six weeks you see the occupational health. So whether that could be taken as a guide I don't know.'*
>
> (Focus Group 4)

GPs anticipated that they would not normally refer to Options B and C within the first four-to-six weeks as most conditions will resolve without any additional input within this timeframe and patients need time rather than additional services to recover sufficiently to return to work.

> *'Have to keep it as a minimum of six weeks because most musculoskeletal conditions would take that long to get better anyway.'*
>
> (Focus Group 4)

However, GPs did not want the referral point to go much beyond six weeks as they were aware that longer periods of sickness absence reduces the likelihood that patients will ever return to the workplace.

> *'Well isn't there some evidence that if you're off for more than six weeks, that is likely to trigger long term? It's likely to lead to long-term sickness? So I think about six weeks might be a good cut off.'*
>
> (Focus Group 4)

All GPs, however, felt they should have the flexibility to refer patients immediately to different levels of an IAS, thereby over-riding any guidelines on referral times. They highlighted that there would be a need for a rapid referral process for patients who would benefit from early intervention.

> *'So if there's genuinely someone we think has got a chronic condition that we diagnose diabetic or whatever or we can see the alarm bells going, we know our patients, if an early intervention is going to help.'*
>
> (Focus Group 5)

Some GPs discussed that eligibility criteria for referral should be based on anticipated recovery time. They believe they have a good idea of how soon a patient can return to work given a particular condition and they should refer patients when their recovery time goes beyond this. They stressed that this would need to take into account individual patient factors, such as age and job role. As the patient's GP, they are best placed to judge when a patient should be ready to return to work and when it would be appropriate to refer them to Options B or C.

> *'We're probably in one of the best situations to be able to assess our patients. We tend to know most of them over the years as well.'*
>
> (Focus Group 5)

Despite this, most GPs (but not all) welcomed a guideline about when to refer patients to Option B or C. While they recognised that different patients recover at different rates, they all had experience of patients who they thought should have been fit enough to return to work but who insisted they were still unwell. They believed that a national guideline would enable them to refer the patient to the IAS

without losing their role as advocate or damaging the patient relationship. They could then adhere to the guideline, or if they thought there were special circumstances that meant that the patient has a good reason for not being well enough to return to work, they could override the guideline.

> *'It's a lifelong relation between a GP and a patient so we don't want to alienate the patient by pushing them. At the same time if there are some things like lies in the timeframe just say that you know, we have to follow the kind of guidelines.'*
>
> (Focus Group 1)

GPs discussed the things that make them suspicious that a patient's condition is likely to keep them off work long-term. Rather than based on a specific pattern of symptoms, GPs described that when a patient requests a sick note (rather than discussing when they can return to work), they recognise that the patient is at risk of long-term sickness absence. They would, therefore, like the flexibility to refer patients at any point to the appropriate IAS level.

> *'As soon as they're coming asking for a sick note I'm starting to get nervous because I think in the majority of the working population they don't need to get sick notes very much in their lives, so once people start asking for a sick note they're already into something fairly unusual, way out from the norm. And if it's for a reason that you would expect a normal recovery from post-op, then I'm not going to worry so long as there aren't specific complications with that recovery. But if it's for something a bit more nebulous like stress, depression, back pain, then I'm worried from the word go and I would do everything I can to not put them on a sick note to start with.'*
>
> (Focus Group 3)

The referral criteria suggested by GPs in each of the focus groups is summarised in Table 4.1. All the conditions or situations suggested by GPs as being particularly suitable or unsuitable for support from the IAS are listed as eligibility characteristics. The ranges on referral times and number of referrals indicate the lowest and highest numbers volunteered by participating GPs.

Table 4.1 Range of referral criteria suggested by GPs

Option	Eligibility characteristics	Time of referral	Number of referrals per full-time GP caseload
A	Non-complex conditions, e.g. muscoluskeletal, which would respond to relatively simple workplace adaptations recommended by the GP. Not for minor illnesses or self-limiting conditions which will resolve in time with little intervention. The employer does not already have access to an occupational health service.	Immediate.	10–15/month
B	Clearly defined and non-complex conditions, e.g. muscoluskeletal, which would respond to detailed workplace adaptations, beyond those that the GP feels able to make. Cases in which the GP perceives the employer as being unco-operative, or in which the employer's regulations are hindering a patient's return to work. The employer does not already have access to an occupational health service. The period off work has exceeded that which the GP believes typical for that condition.	Ranges from 4 weeks to 3 months, mode of 6 weeks.	4–6/month
C	Primarily, conditions that would benefit from a psychological intervention or workplace mediation, for example, workplace stress, anxiety and depression. The patient must be willing to return to work, even if they require some input to increase their motivation. Patients who are reluctant to take sickness absence but whose health could deteriorate if they do not rest.	Ranges from 4 weeks to 6 months, mode of 3 months. Existing cases GPs recognise would benefit immediately could be referred immediately.	1–2/month

4.4 Expectations of who should refer patients

GPs expected that they would refer patients who they thought would benefit from the IAS. This would take place during standard consultations, typically when the patient returns to the practice to ask for a further medical statement. GPs discussed how an electronic prompt on the patient's medical records about referring to the IAS would be important as patients who do not want to return to work will typically make appointments with GPs they do not know or GPs who are newly qualified as they believe this to be their best chance of being declared unfit for work.

> *'We provide services for a bail hostel and we had one last week who'd seen two senior GPs and they both said "okay you've been in prison, it's not a problem, you can go back to work now you're out of prison". And they eventually picked on the GP trainee who was less sure of her own standing and her own ground and she gave him a sick note.'*
>
> (Focus Group 2)

For both Option B and Option C, GPs were clear that they wanted the referral process for the potential services to be extremely simple, such as a tick box on the fit note. They did not want their administrative burden to be increased by a complicated or time-consuming referral process.

> *'One thing that worries me about Option B a bit, this might sound like I'm being extremely work shy, is that it might generate me more paperwork and I really can't be doing with that. I'm sorry. Everything is just creating more and more bits of paper these days and so if I'm going to get a copy of this report what do I do with it? Am I supposed to action it, talk to the patient about it, explain it? You know do I put it on the notes? I'd just be concerned, and I think a lot of GPs would be concerned, about the fact that we physically have to refer rather than tick a box on the fit note saying "this person would benefit from an occupational health assessment". Something like that would be so simple and obviously if they needed a report we could then write one with the patient's consent.'*
>
> (Focus Group 5)

> *'I do like the idea though that we can do Option B by ticking a box just because it would be nice to have access to this without necessarily causing so much extra workload for us.'*
>
> (Focus Group 2)

While GPs expected that they would refer patients to the IAS, they also discussed how they need not necessarily be involved and that employers should be able to refer their employees directly.

> *'Why can't the employer be the person who triggers Option B? It's trying to cut out unnecessary work with GPs. There's no reason why the employer shouldn't be doing that.'*
>
> (Focus Group 1)

GPs identified that it might actually be preferable for employers to refer patients directly to an IAS as in many cases they thought the issue is not the patient's health, but how the patient could be enabled to do their job. They felt there can be a dialogue missing between the employer and the employee around returning to work and the GP does not need to be involved in that dialogue. Some GPs went further and suggested that it is the employer's responsibility to refer patients.

> *'Well, I was just thinking actually, it's not so much about how many people we would be referring, it's how many people the employer would find benefit from having referred in, and it's almost that it should come from there really, this service.'*
>
> (Focus Group 6)

GPs also identified that the occupational health expert in Option B should be able to refer directly to Option C.

> *'Could Option B not refer on to Option C if Option B felt it was necessary? The occupational health expert referring on to Option C and that saves us from doing the referral. They would be doing a much more thorough informed assessment and they, whether the report's going to be enough or whether the patient needs further input.'*
>
> (Focus Group 2)

GPs wanted to be kept informed of referrals and reports so that they are able to advise patients appropriately during future consultations and not replicate approaches that have already been implemented by the case manager.

> *'We don't want to suggest things that have already been put in place or we could reinforce what has been suggested.'*
>
> (Focus Group 6)

GPs were also happy for patients to refer themselves directly to the IAS. They thought that this was especially appropriate when patients are motivated to stay in, or return to, work, or when their health condition is well managed but they need some workplace alterations to make it easier to remain in work.

> *'There're basically three parties who could trigger this assessment and that's the employer, they're probably most interested in it, the patient themselves if they're motivated, or us if we think well, this is going on for too long and we're a bit helpless about what to do next.'*
>
> (Focus Group 3)

GPs noted that hospital consultants could also have a role to play in referring patients to the IAS. They described how consultants can sign patients off for longer than the GP thinks is appropriate and patients are reluctant to listen to the GP's advice and prefer to wait until they have another appointment with the consultant.

> *'The specialists need to be thinking about people's return to work because work is never considered until they come out and come to us* [the GP] *and you'll say "did they say anything about work?" "No, they said they'll see me in three months so can I have a note for three months?".'*
>
> (Focus Group 6)

They also spoke of their frustration when they see patients post-surgery and have to make a new referral to physiotherapy, which might take many weeks before the patient is seen. They discussed how a more effective system would be for the hospital consultant to refer for physiotherapy at an appropriate time before surgery so that the patient has an appointment as soon as they are ready to begin treatment.

> *'The number of times people have an operation and you get them back and a month later, "did they sort out physio for you?" Oh no. Well, b****y h*ll, that should have been done before they had their operation, right, they're having an operation on the 20th, on the 10th they're referred for physiotherapy so that two weeks after their operation when the scars are beginning to heal they can start their physio and that would cut out a lot of the time wastage here that we're trying to deal with.'*
>
> (Focus Group 6)

4.5 Summary

GPs identified the services that they would like patients to be able to access through the proposed IAS, most commonly counselling, psychological therapies, physiotherapy, workplace occupational health visits, and workplace mediation. They also identified a range of services they also viewed as being important, albeit for a smaller number of patients.

GPs agreed that most patients they write long-term medical statements for are on sickness benefits and only around ten per cent are for people who are in employment. They suggested a full-time GP would use Option A for around ten to 15 patients a month, they would refer around four to six per month for Option B, and around one to two per month for Option C. GPs would like guidelines on who and when to refer to different IAS levels and the flexibility to refer outside these when they consider it appropriate.

Patients who would benefit most from Option B are those with clearly defined and non-complex conditions, such as musculoskeletal conditions that would respond well to workplace adaptations, and also patients with employers who are reluctant to make adaptations or those whose regulations and policies hinder the patient's return. Patients who would benefit most from the proposed Option C are those who require psychological interventions or those who would benefit from workplace mediation. The patient must be willing to return to work, even if they need support to increase their motivation or confidence to return.

GPs would welcome the ability to refer patients to an IAS, although they were concerned that the administrative process should be simple. GPs would be happy for others, such as the employer, hospital consultants, and the patients themselves to refer to an IAS although they would like to be kept informed of the patient's progress.

5 Anticipated benefits of the IAS

In this chapter we explore what GPs think the benefits of an IAS might be and how it might affect their perceptions of their role.

5.1 Patients

GPs who took part in the current research were aware of the benefits of work to wellbeing and the negative consequences of worklessness. They discussed how work gives people purpose, routine and structure to their lives. While it is possible that the lack of variation in GPs' views on the importance of work for wellbeing might represent a bias in the sample of GPs who volunteered to participate, GPs thought that their colleagues shared their views on the importance of work. As previous research with GPs has also found a widespread appreciation of the link between work and wellbeing (e.g. MacDonald *et al*., 2012; Wainright *et al*., 2011) we are confident that the views expressed by GPs in this study are typical of those held by GPs more widely.

All the GPs who took part believed that patients have the potential to benefit tremendously from a support service that enables them to return to work sooner than they would otherwise have been able to. They believe that if patients are at home with little to occupy them they will dwell on their symptoms, which could lead to increased anxiety, in turn leading to perceptions that their condition is worsening, as illustrated in the following exchange.

> *'And there's quite significant benefits associated with work over and above the financial benefit of working, the social aspects of it, things to do with people's self-esteem, so trying to keep people plugged into that is very important for their overall health.'*
>
> *'It gives a bit of routine and structure, doesn't it, as well, a reason to get out of bed in the morning?'*
>
> *'I think when people stay off work, even if it's for short periods of time they can become focused on more minor aspects of their health as well that really aren't pertinent to their everyday living but they become focused on them.'*
>
> (Focus Group 6)

They believe that if patients are away from work for prolonged periods they find it difficult to return to the workplace.

> *'I think it is, yeah, very, very important* [to return people to work]*, especially with the problem with long-term sickness. If you get someone back to work quickly and swiftly you're winning. If you don't they'll be off sick for x months and their chances of going back are slim.'*
>
> (Focus Group 5)

GPs identified specific groups of patients who might be more likely to benefit from an IAS. Patients employed in an organisation without access to occupational health services would benefit from both the occupational advice line and access to an occupational health expert, both of which may enable them to return to work sooner. Patients who may lack motivation to return to work quickly would benefit because knowledge that they will be referred by their GP to an expert may encourage both the patient and the GP to explore a return to work even though the patient may be reluctant

to do so. The facility to refer patients to an occupational health expert will enable patients who are resistant to the idea of returning to work to get the help they need to do so. Without this service GPs may have been reluctant to challenge their account of their condition and continue to give them a medical statement. Finally, patients with complex conditions could access the support they need in order to be able to return to work. This can include patients who may be reluctant to raise a sensitive issue, such as alcohol addiction, with their GP.

GPs discussed those patients who would benefit from a job brokering service as part of Option C. Some groups discussed how older men who have worked in the building or construction sector and who are no longer physically able to perform their work would benefit from job brokering. Many, particularly those who lack literacy and numeracy skills, would benefit from the wider support proposed for Option C as it would help them to develop skills that are in demand in different sectors or different job roles.

> *'We see a lot of factory workers and say who've been in that particular role for ten years and then all of a sudden they've got this condition where they're unable to go back to. They have no other skills. What do you do then? No reading or writing skills.'*
>
> (Focus Group 4)

Some GPs also highlighted that the ageing population will mean that there are increasing numbers of patients who need to work but are no longer physically able to do their jobs.

In all the focus groups GPs highlighted that while their employed patients would benefit from an IAS, they see far more patients who are not currently in employment who would benefit greatly from such a support service. They discussed how these patients face many different barriers to employment, which might be poor literacy, numeracy, or English skills, addiction problems, complex social difficulties, or a lack of confidence. They would like the ability to be able to refer these patients to an IAS.

5.2 Employers

GPs believed that employers have the potential to benefit greatly from an IAS as it will enable their employees to return to work sooner. As well as having the employee back in the workplace and contributing to the organisation employers will have lower costs arising from sick pay, replacement staff, overtime, etc.

> *'If they've got somebody they've been paying to be on sick for a long time and they want to get them back to work then this is a good investment for them, to get this kind of assessment.'*
>
> (Focus Group 2)

Many GPs described how having a valued employee on long-term sickness absence can be disastrous for small businesses and a service that supports people back into work could, therefore, be very valuable to small employers.

They described that smaller employers are less likely to have an occupational health service for their employees, either provided in-house or subcontracted, and so this group is more likely to make use of Option A. Having access to occupational health advice could also help reassure employers about their concerns surrounding liability if they allow an employee who has not completely recovered to return to work. GPs thought that in small businesses there may be less scope for people to identify an alternative role that they could fill while they are recovering and that the occupational health expert in Option B may be able to come up with some innovative ideas about how the employee could be accommodated in the workplace.

However, some GPs were concerned that an IAS would take some responsibility away from the employer to provide services for employees such as counselling and physiotherapy: they suspected that if employers knew that employees could access these for free through the IAS, there is no point in paying for them. This would result in patients experiencing what is likely to be a poorer service.

> *'And is it going to mean that employers take even less of a responsibility to provide occupational health for their employees anyway? Because that's the difficulty, you have people working for small organisations have very limited access to occupational health support anyway. They either use an external company who may or may not be that good or they just don't have access to anything. Obviously the people who have access to nothing – and that would never change – this would probably be helpful so it's better than nothing, but if it means that employers are going to use this instead of a better face-to-face occupational health service then actually we're doing patients a disservice.'*
>
> (Focus Group 4)

GPs recognised that an IAS could be useful for people who are self-employed. They spoke about this group of patients being typically very keen to return to work with financial pressures, often meaning that they return to work before they are fit to do so. GPs suggested that the occupational health advice line could help them identify the type of jobs they could do safely.

> *'They go back to work when they shouldn't. I mean some of the smaller outfits they really don't know* [how they can adapt their work so it is safer for them to return] *and me telling somebody, a painter and decorator to be off for two weeks because they've got vertigo and they shouldn't be going up ladders because they could fall off and they don't listen. They want to work and they have to work. There's all sorts of issues around it financially but these guys stay at work when they shouldn't be.'*
>
> (Focus Group 5)

5.3 GPs

GPs felt they themselves would also benefit from an IAS. Through their discussions they identified that they would benefit from further guidance on completing the fit note so that they rely less on '*stock phrases*' (Focus Group 3) they develop. This would in turn benefit employers. They thought that the principal benefit to GPs is in using the guidelines on referring to maintain a good doctor-patient relationship. GPs perceive a dilemma can occur in their efforts to return patients to work: while they recognise the advantages of work, they believe, very strongly, that they are the patient's advocate and that this involves accepting what patients tell them rather than questioning their accounts. For example, if a patient reports that their back pain is too great to consider returning to work the GP can believe that they must accept the patient's view of their pain despite any reservations they personally might have about the patient's ability to work. They are usually reluctant to challenge the patient's account of their pain and a referral to an IAS would enable them to facilitate a return to work without endangering their relationship with the patient. Guidelines about when a patient should be referred would help to protect the relationship as there is then no suggestion that the GP does not believe the patient's account.

> *'I think the minute we refer them to another service they will think that we don't believe in them, what they're saying. That's why, you know, if we can resort to guidelines, say, "look if anyone exceeds three months we have to refer to the service" it protects us from that sort of problem.'*
>
> (Focus Group 1)

They described how it can be challenging to maintain a good doctor-patient relationship when they disagree with a patient's view that they are not well enough to return to work. At present GPs do not usually like to challenge patients' accounts, viewing themselves very much as the patient's advocate, as described previously.

> *'The bottom line is that if our patient tells us they need X number of days off: stress, work-related stress, bereavement, you can't really sit there and say "I think you should have four days off, not ten days off" or "I think you should recover sooner than this", it's a subjective thing.'*
>
> (Focus Group 4)

Furthermore, while GPs may not typically view their role as including counselling patients about their career options and the need to consider alternative employment, they talked about this being an important barrier to many patients returning to work. They are reluctant to take on this responsibility, and indeed describe how it is very difficult for them to initiate such a conversation. GPs would welcome an expansion of their role so that they become a gatekeeper to these sorts of services and would happily refer patients to them.

> *'I think actually somebody who has access to the information about retraining or courses or even perhaps direct them to appropriate people to support them would be useful because I must admit a lot of the people that I'm dealing with have musculoskeletal problems and are struggling with their manual work are people who actually need a bit of help and hand holding in trying to look for something else. So they often, they need somebody to actually help them with that and sadly we just don't have the time, do we, and that's not our job.'*
>
> (Focus Group 2)

Similarly, GPs do not see their role as liaising with employers about workplace relationships yet recognise this as a barrier to returning to work. Rather, they would act as gatekeepers to services that could provide this type of help.

> *'We don't liaise with the employers, that's not our job to say "stop bullying this person at work". Whereas a mentor, I'd expect them to liaise with employers.*
>
> (Focus Group 2)

5.4 Society

While GPs were concerned about the potential cost, they recognised that the service has the potential to save money which would, therefore, benefit society more widely.

> *'The whole idea is if you can get people back to work sooner they're more productive, you're going to save a lot of money. You've got more taxes coming in; you're not having the sick pay so this is, the whole idea here is to save money for the Government isn't it at the end of the day? So you've got to invest sometimes to do that, that's why you need extra resources to do it.'*
>
> (Focus Group 5)

They discussed how setting up an IAS should be viewed as a good investment as it could prevent people from becoming unemployed and, therefore, presenting a greater cost to society.

> *'I think maybe that you invest in a service like that to try and save money at a later date.'*
>
> (Focus Group 2)

As the population ages there will be increasing numbers of older people who will need to work with health conditions that will prevent them from continuing with occupations that they have done throughout their working life, for example, due to back pain. These people could potentially do different types of jobs but would need some help in identifying alternatives, and in some cases in developing the required skills. GPs' discussions indicated that they felt society would benefit by these people being able to continue in employment rather than claiming sickness-related benefits.

> *'As the workforce gets older we're going to have more and more people who can't carry on doing the jobs they've always been doing.'*
>
> (Focus Group 4)

5.5 Summary

GPs recognise many beneficiaries of the proposed IAS. They believe that patients would benefit as they would be enabled to return to work sooner than they would otherwise have done, which benefits them both psychologically and financially.

GPs felt that employers would benefit financially from reducing their costs arising from sickness absence. Small employers would particularly benefit as they are less likely to have access to their own occupational health support. Benefits to society were also highlighted by GPs. By preventing people from moving from paid work into unemployment or sickness benefits, GPs thought that an IAS has the potential to save money, and as such would be a good investment.

GPs also felt they themselves would benefit because they would protect their relationship with the patient while taking steps to overcome resistance to work. GPs already recognise the importance of work for health and wellbeing and so an IAS would not change this perception of their role, rather, they would view their role as expanding to be a gatekeeper to services that will help patients remain in employment.

6 Organisation and funding of the IAS

In this section we explore GPs' views on how the IAS should be presented to patients, GPs and employers and on how it should be organised and funded.

6.1 Explaining the IAS

6.1.1 Explaining to patients

GPs provided their views on how an IAS should be explained to patients. They did not necessarily think that Option A required much explanation as it would not involve the patient directly. Instead they suggested that they could advise the patient that they have recommended that their employer telephone the help line.

GPs believed that Options B and C would need careful introduction. They were aware of the potential for patients to be intimidated by the idea of an independent assessment and discussed the need to present any service as being for the patient's benefit and a means of accessing more expert help than they can provide to enable them to return to work. They thought patients should be aware of the IAS from the beginning of their sickness absence so that they are less likely to feel threatened or scrutinised when they are referred.

> *'I think involving the patient is important as well because a lot of this is telling them, referring them. I mean you have to try and involve them from the start and have information to give them to explain the system because most people are scared of occupational assessments, they think they're criticising, they think they're judging them, they're thinking it's all for the employer and they're scared of that. They need to understand that it's confidential and only things relating to their work. I mean that's ... a lot of people are very scared of the word 'occupational health'.'*
>
> (Focus Group 5)

GPs discussed the ways in which they would explain Option B to patients. They highlighted that there would be a need to stress that the service would work on the patient's behalf to try to enable the patient to return to work.

> *'I think the majority of patients would go along with it if you're saying that this is to help them, to support them, to look at ways that their employer can actually make it easier for them to return to work if they want to return to work then I think that they would be happy with that support.'*
>
> (Focus Group 2)

> '[The way I would] *sell occupational health services to my patients is that they will also work for you, this is an occupational doctor, they're a specialist in this area, they will be able to advise you as to what you can do and what you can't do, they will liaise between you and the employer, particularly if there is conflict between the patient and the employer.'*
>
> (Focus Group 6)

They highlighted that patients would have to consent to the GP sharing their medical records with the IAS and so it would be important to explain the benefits that patients would enjoy.

6.1.2 Explaining to GPs

GPs who took part in the research fully supported the concept of an IAS and did not think that their colleagues would have difficulty accepting this type of service. The only potential barrier to its use was the referral process. GPs wanted a quick and easy means of referring patients to any services. Their discussions indicate that messages to GPs need to highlight that the IAS would provide a support service to help them manage more difficult cases.

None of the GPs who participated in the research described having used the existing helpline for GPs. During discussions they identified that they do not feel that they have the necessary expertise or understanding to provide detailed recommendations on workplace adaptations, i.e. they lacked self-efficacy in using the fit note to its full potential.

> *'So much of the time I don't know what would help them at work: I don't know what light duties would really mean.'*
>
> (Focus Group 2)

When communicating with GPs about any IAS services, it would be useful to show how the first level of support, Option A, would provide them with advice about what to recommend on the fit note and that when recommendations need to be more detailed and specific to that patient's work role, more detailed advice could be provided to the patient through Option B.

> *'You could really do with a third party not necessarily coming into the workplace but getting a fairer assessment, having more time to go through what the job actually entails and what they can realistically be expected to do and perhaps explore alternatives for what they could do and still be useful within that workplace that might involve shorter periods of time at the computer station and this sort of thing. So I'd probably use it for that.'*
>
> (Focus Group 4)

They highlighted that providing GPs with information on the evidence base underpinning the effectiveness of Option C would encourage GPs to engage with an IAS. Several GPs talked about the need for any service to be trialled and so communication with them about the service would need to highlight evidence of its effectiveness.

> *'Whatever is going to go ahead should be piloted. If these things are going to take place they shouldn't just be blanketed across the country without being trialled in certain areas to see what the benefits are from each service. If they run these pilots in different areas and you can actually see proven benefits, an increased return to work, less time off sick or however it's costed in terms of days off work, I think there needs to be a proven benefit before these things are implemented otherwise we're all wasting our time.'*
>
> (Focus Group 2)

6.1.3 Explaining to employers

GPs believed it would be easy to tell employers about the occupational health line by providing details of it on the fit note. GPs could recommend that the employer contacts the advice line. GPs believed that employers would immediately recognise the benefits of an IAS and so would not need convincing to use it. They did, however, highlight that small businesses may be deterred in case they were asked to make expensive workplace adaptations, and so suggested some case studies might be useful to help employers understand that it is often small changes that can enable an employee to return to work.

6.2 Structure and funding of the IAS

To gain the support of their colleagues and of the wider society, GPs indicated that the IAS should be viewed as a separate body to the NHS. While they acknowledged the link between work and wellbeing they believed that because this service is for employees it should be funded from a different source and, therefore, one that does not divert resources away from the NHS. Some supported a model in which patients referred to an IAS could be fast-tracked to access NHS services more rapidly than they otherwise would do but others believed that this would contradict the egalitarian principles of the NHS. All GPs would support a model in which the IAS could purchase additional services to allow patients rapid access to services without increasing the waiting times for other NHS patients.

GPs discussed how, as employers receive clear benefits from their employees getting back into the workplace, they should contribute financially to the IAS. They discussed various ways in which this could occur, for example through corporation tax or through National Insurance contributions. They believed a direct payment per employee referred would be unpopular with small businesses.

> *'Small businesses, they just will refuse to pay won't they so people won't, so then that incentive to the patients just won't get the benefits of the service because their employers won't pay for it.'*
>
> (Focus Group 2)

An alternative discussed by a few GPs was that the Health and Safety Executive (HSE) should contribute to funding the IAS. While they did not expect that the HSE should be involved in running the service, they thought that having the HSE as a stakeholder would emphasise employers' responsibility to provide a safe working environment for employees with chronic health conditions.

> '[The HSE is] *a respected organisation and they don't have all the trappings of a health burden, labelling it as a health problem. You know they're actually about keeping people in work, keeping them safe. I don't suppose the HSE would* [run the IAS] *but if it just came under their name, we're about keeping people in work safely.'*
>
> (Focus Group 3)

The focus groups explored how an IAS should be organised and there was agreement that it should be a national organisation with the same eligibility criteria, regardless of where the service is based. GPs thought that having a national organisation would be more cost effective and fairer, as illustrated by the following exchange.

> *'It would have to be national level.'*
>
> *'It costs far more to organise everything regionally than it does nationally.'*
>
> *'Yeah or that postcode lottery thing.'*
>
> *'It also gives it more credence doesn't it if it's a national organisation.'*
>
> (Focus Group 2)

The service should, however, make use of local knowledge and services. For example, GPs in one focus group talked about a local service they can refer to that provides lifestyle management that addresses diet and exercise. They described this as being a very useful and beneficial service that the IAS should also be able to refer to. They discussed how this would only be useful if the IAS were able to tap into services available on a local rather than a national basis.

6.3 Summary

GPs highlighted the importance of carefully describing the benefits of an IAS to patients as otherwise they could find it intimidating. They felt that the benefits to patients should be emphasised, with the service presented as one that works for them, giving them access to expert help to enable them to return to work. They also thought that patients should be made aware of the IAS at the initial consultation with their GP so that the patient would not feel that their account was being challenged if they were subsequently referred to the service.

GPs who took part in the research fully supported an IAS and did not think that their colleagues would have difficulty accepting or using the service. The only barrier they perceived was the referral process, indicating that messages to GPs would need to highlight that the IAS provides a support service to help them manage more difficult cases. Some GPs also felt that buy-in would be greater from their colleagues if an IAS was trialled, and evidence of its effectiveness highlighted.

GPs believed that employers would appreciate the benefits of the proposed IAS, although smaller ones might need reassurance that the recommendations made by the occupational health expert would not necessarily be expensive to implement.

GPs believed that the IAS should be a national organisation with consistent policies and eligibility criteria, but flexible enough to respond to specific local needs. They thought it should tie in to services that are available locally rather than replicate services unnecessarily. They preferred it to be a separate organisation to the NHS and to be funded separately, at least in part by employers.

7 Conclusions and policy considerations

This study aimed to examine GPs' views on models for potential services to help employees on sick leave return to work. This section discusses the key study findings and draws out considerations for policy development in this area.

The study was based on sample of 39 GPs who participated in six focus groups, and as such it has drawn from a limited range of views. However, our sampling strategy meant that we included GPs with a wide range of experiences and we are confident that the research findings will resonate with the wider population of GPs.

7.1 GPs' perceptions of potential services

We found that GPs support the idea of an IAS and would be happy to engage with one. They recognise the benefits of work to patient wellbeing and view the services within an IAS as supporting and complementing their role. We have established GPs' preferences for how an IAS would operate. They anticipate that a staged model would be the most effective as it would provide the appropriate level of support for patients at the point at which they are most likely to benefit, without wasting resources by providing an expensive holistic service for patients who do not need it. While GPs anticipate that each individual GP would refer relatively few patients to an IAS, they believe it could fill a gap in the services they are able to provide and could make an important contribution to enabling patients on sick leave who are at risk of falling out of paid work to return to work.

GPs recognise the value in each of the tiers of support. They believe that Option A (occupational health advice for employers and GPs, and enhanced guidance for GPs on using the fit note) has the potential to help them to develop appropriate recommendations to put on the fit note and employers to implement them. Option A does not, however, overcome the difficulties that GPs can experience when their role as patient advocate makes it difficult for them to challenge the patient's account of their condition.

GPs are aware that they lack occupational health expertise and would, therefore, welcome the ability to refer patients for an independent assessment with an occupational health expert (Option B). They believe that the expert would be able to make more specific and detailed recommendations of how the patient could make a return to work than they would be able to. Their independent status meant that GPs believe employers would give the report serious consideration.

GPs welcome the holistic support in Option C that could allow patients who may be unable to return to work without additional input to do so. They valued the wide range of services that address physical, psychological and social needs as well as life- and work-skills. GPs highlighted that even with this holistic service the patient must be willing to return to work, even if they need support to increase their motivation or confidence to return. However, they are aware of the potential cost of Option C and believe that relatively few of their employed patients would need this level of support to return to work.

7.2 GPs' views on the nature and scale of potential services

While GPs' estimates of the numbers of patients that they would refer to an IAS are low, when scaled up, this could amount to a large volume of service users nationally. They believe that most of their employed patients are keen to return to work as quickly as possible and most can do so under the current system of sickness certification but there are some who would benefit from additional support.

GPs anticipated that they would use Option A most frequently for patients who could return to work given workplace adaptations that they are able to recommend on the fit note and for patients employed by SMEs, as their employers would be less likely to have access to an occupational health service. They estimated that each full-time GP would use Option A for around ten to 15 patients per month.

GPs believed that they would be most likely to use Option B for patients who have clearly defined and non-complex conditions such as musculoskeletal conditions that would respond well to more specific or complex workplace adaptations than they are able to make. They also anticipate referring patients with employers who are reluctant to make adaptations or those whose regulations and policies hinder the patient's return. They estimated that they would refer four to six patients each month to Option B.

GPs believe they would be most likely to use Option C with patients who have mental health conditions or complex conditions that include both medical and social aspects. Suggestions for the type of services that should be offered indicate a desire for the service to be able to address employment needs and other social concerns as well as health issues. GPs believed that the greatest demand for services in Option C would be psychological interventions and workplace mediation. They would also refer patients whose health condition meant that they would need to change employers or job roles but who lack the literacy and numeracy skills or the confidence needed to do so. They estimated that they would refer one to two per month to Option C.

GPs anticipated that an IAS would need to be a national service encompassing a wide range of support and offering personalised expert help. While GPs would prefer it to have national guidelines and procedures it should be able to take into account local issues and make use of, rather than duplicate, existing local services.

7.3 GPs' perceptions of the benefits of an IAS and influence on their role

We found that GPs believe that an IAS would have both economic and social benefits. Because they believed a service would enable people to return to work sooner, GPs saw that there would be financial benefits of an IAS for employers, patients and taxpayers alike. As SMEs are less likely to have access to occupational health, GPs recognised that these employers are likely to be key beneficiaries. It follows that employees of SMEs would also be particularly likely to benefit from access to occupational health support through both Options A and B. The psychological and social benefits of keeping people in work and preventing unemployment were also highlighted by GPs. For this reason they believed that their patients who are claiming benefits but who could potentially work would also benefit from accessing a similar service, which offered the holistic support available within Option C.

Our findings suggest that GPs would support an IAS because of its potential to advise patients and their employers about facilitating health conditions in the workplace and because they sometimes experience conflict in their own role as the patient's advocate when they try to encourage patients back to work. A major benefit identified by GPs is that the assessment would be conducted by an

independent occupational health expert and, as such, employers would be more likely to implement the suggestions made than if they had come from the GP. We found that GPs would welcome expanding their role to be a gatekeeper to services such as advising patients on changing their occupation or role.

7.4 Policy considerations

The findings raise a number of issues for consideration when developing policy. This section outlines our interpretation of the key findings from the study which have implications for the design of any future services.

Balancing the desire for clear, national guidelines with the desire for flexibility. Our findings indicate that GPs want clear guidelines about the purpose of the service, who to refer, and at what point in a patient's sickness absence duration. However, they believe there should be flexibility in the service offer and their interaction with it and want the ability to use their discretion when considering a referral and the intensity of support required for a patient. For this reason, the preferred model was a staged approach. There was also a desire to have the option to refer their patients for a face-to-face assessment rather than one conducted over the telephone.

Ensuring occupational health expertise. As GPs often felt that they lacked occupational health expertise, the wanted any services to be a source of authoritative back-to-work advice for patients and their employers. Staffing any future services in this area with people who have occupational health expertise is likely to promote GPs' trust and use of them.

Minimising burdens on GPs. GPs wanted systems that would minimise the administrative burden on them and maximise the ease of referral to an IAS. To promote take-up, any new service would need to place as little additional administrative pressure on GPs as possible.

Complementing existing provision. GPs believed that to avoid a 'postcode lottery' an IAS should be a national organisation with national policies but the support accessed through it should integrate with and make best use of existing local provision rather than duplicate services. They supported fast-tracking to assessment or treatment providing it is based on purchasing additional services rather than existing NHS provision.

Developing clear messages about the purpose of an IAS. In some cases, GPs were concerned that the IAS might focus on assessing whether a patient is fit for work in a similar way to the Work Capability Assessment. As some patients may be anxious about having an assessment, it should be explained as a service that works for them in order to help them return to work. Referral to Option B should be described as a consultation rather than an assessment. Clear messages for GPs about the purpose of an IAS and its benefits could help to encourage service use, and these messages could usefully incorporate evidence on the effectiveness of the IAS, as this is developed.

Funding. GPs believe that the IAS should be organised and funded separately from the NHS and that funding should, at least in part, come from employers. This funding route could be indirect, for example, through National Insurance or Corporation Tax.

Defining the target group. While GPs recognised the value that services in this area would have for helping people remain in work, they believed that far greater numbers of their patients who are not in employment but who are claiming Jobseeker's Allowance or similar benefits would benefit from the support offered by such a scheme.

Appendix
Focus group topic guide

Introduction and briefing

Clarify that this is about patients who are in employment.

Clarify that the three models are not mutually exclusive – there is a continuum of support that could be offered, and these models illustrate three points along this.

Opportunity to clarify/sense-check any major points about the three options (detailed discussions to wait)

1 First of all I want to find out about how you view your role in enabling patients to get back to work.

- Is this part of a GP's role? Why?/Why not?
- Do you think that work has any effect on patient wellbeing? Why?/Why not?
- Can you give me any examples of the type of thing that you would write on the 'amended duties' or 'workplace adaptation' sections of the fit note?
- How do you identify/come to the conclusion that the patient's illness might stop them working in the long-term? Is it different for different conditions? Different types of patient? (e.g. based on age, occupation, area in which they live?)

2 Let's talk now about these three different options that are being proposed to support employees getting back to work.

- Option A is based on the fit note, pretty much as it is now, although with extra guidance for GPs on using it. There would be an Occupational Health Advice Line for employers. They can use this to get information on their employee's health condition which should help them put into place appropriate support to either keep the patient in work or to enable them to return to work. The advice line would also signpost employers to relevant professional specialist advice and services.
- What are your thoughts on this option?
- How would you explain this option to patients?
- How would it benefit patients? You? Employers?
- Are there any drawbacks that you can think of?
- Do you think employers would make use of the Advice Line? Why/Why not? Which employers are more and less likely to do so?
- Which type of patient (e.g. age, condition, occupation, where they live) would really benefit from this option? Why? Which wouldn't? Why? At what point in a sickness absence might the Advice Line be useful?

Option B is based on you being able to refer patients to an Occupational Health expert who would assess the patient's capability to work and give advice on reasonable adjustments that could be made to return the employee to work. This would probably take place by phone. They would produce

a report that you, the patient and the employer would all have access to. They would also signpost the employee or their employer to relevant professional specialist advice and services.

- What are your thoughts on this option?
- How would you explain this option to patients?
- How would it benefit patients? You? Employers?
- Are there any drawbacks? [Prompt if not brought up spontaneously: Do you see any conflicts with your role as patient advocate in using this model?]
- Do you think there would be any barriers to referral?
- Would you feel confident referring to this service? Why/Why not?
- Should there be any eligibility criteria? If so, what should they be? How long into a patient's absence do you think it would take you to assess eligibility? At what point in a sickness absence should patients be able to access the service?
- The advice on reasonable adjustments could be both on their current job and role, and also on other roles or jobs too. What are your thoughts on this?
- Which type of patient (age, condition, occupation, etc.) would really benefit from this option? Why? Which wouldn't? Why?
- The idea is that the report would be shared with you, the employee and the employer. Who do you think the report should be sent to? Why? How – practically speaking – would the information be shared?
- Sometimes the advice in the report might not match the advice that you have given the patient and employer through the fit note process. How do you think you might feel about that? How do you think you would manage the situation?

Option C is based on you being able to refer patients to a longer-term, more holistic service to support them back to work. Once the referral has been made the patient would be allocated a case manager who would work with them until after they have returned to work (so the support doesn't stop when they are fit to return, it continues for a specified time afterwards). This would be a more holistic service so that in addition to support and advice on the specific health problem the patient has, they could also help with workplace issues such as the relationship with their line manager, bullying, workplace stress and so on. There would also be help with non-work-related matters such as debt advice for a patient whose money worries were contributing to their stress.

- What are your thoughts on this option?
- How would you explain this option to patients?
- How would it benefit patients? You? Employers?
- Are there any drawbacks? Prompt: Do you see any conflicts with your role as patient advocate in using this model?
- Would you feel confident referring to this service? Why/Why not?
- Should there be any eligibility criteria for this service? If yes, what do you think they should be? How long do you think it would take you to assess eligibility? At what point in a sickness absence should patients be able to access the service?

- Potentially it could offer all sorts of different types of support but of course it could get very expensive to run. What type of support do you think would be most appropriate to have available for patients? If you were funding it out of your own budget which would you be happy to pay for?
- What are your thoughts on offering a job brokering service, so giving sick employees advice about seeking a new job while they are receiving sick pay? Useful? Appropriate?
- Which type of patient (age, condition, occupation, etc.) would really benefit from this option? Why? Which wouldn't? Why?
- Potentially, this service could be used to fast-track patients through the system to allow them to access services faster than they would using the normal referral routes. For example, it might be a two-week wait to see a physio rather than 12 weeks. The benefit of this is that patients return to work faster and so they are on sick pay for shorter periods. What are your thoughts on this?

Finally, there is the option to combine these. Employees would first receive Option A, then progress to B, and then possibly C if they need it. Or you could identify from the beginning that patients would benefit most from Option B or C and refer them directly to this level of support. This approach would be to provide patients with the appropriate amount of support – so probably relatively few people would need Option C.

- What types of patients (e.g. age, condition, occupation, duration of sickness absence) do you anticipate would end up being referred to the different levels?
- Do you think many of your patients off sick from work who would benefit from the sort of services specialist that would be available? OH advice? Assessment? Therapies? workplace adjustments? Advocacy (i.e. calling up the employer on the employee's behalf)?
- How would you decide which level of support a patient would be most suited to? How confident do you think you would feel that you could make that judgement?
- What information do you think you would need in order to be able to direct patients to the most appropriate level?
- What kind of patient volumes do you imagine directing to these different levels?

General questions

- How should the service be presented to ensure patients who would benefit want to use it? How should it be presented to GPs?
- This service [i.e. all the models] would be independent of the GP practice and employer. Do you think it should be embedded within the NHS or a separate organisation? Why? Do you think it should be organised regionally or nationally? Why?

3 Now let's talk about our patient vignettes.

Cathy is a supermarket worker. Her job involves some lifting, some checkout work, and some customer service duties. She has developed back pain over the last month. She has self-certified for the last week and says that she doesn't feel able to lift.

Which option do you think would best suit this patient? Why? How is it better than the other options? Are there any disadvantages? To the patient? The GP? The employer? If you were using the staged model, which level would you refer to? Why?

Sarah is a solicitor with rheumatoid arthritis who has undergone a knee operation. After four months' recovery time she would like to return to work but has problems negotiating public transport.

Which option do you think would best suit this patient? Why? How is it better than the other options? Are there any disadvantages? To the patient? The GP? The employer? If you were using the staged model, which level would you refer to? Why?

John is a driver for distribution company and his job involves sitting for long periods and lifting heavy loads. He has had his third episode of back pain in the past 12 months and needs physiotherapy. He has been advised against heavy lifting, twisting and bending. John wants to continue working and thinks it may be possible for him to work in the office for a few weeks.

Which option do you think would best suit this patient? Why? How is it better than the other options? Are there any disadvantages? To the patient? The GP? The employer? If you were using the staged model, which level would you refer to? Why?

Peter is a call centre worker who has been off work with depression and anxiety for four weeks. He has started to improve but tells his GP that he is experiencing bullying from his line manager at work and does not want to return. He also says he is worried about the amount he is drinking to cope with the stress he is experiencing.

Which option do you think would best suit this patient? Why? How is it better than the other options? Are there any disadvantages? To the patient? The GP? The employer? What information would you feel comfortable being communicated to the employer about workplace issues that are affecting the employee? If you were using the staged model, which level would you refer to? Why?

General questions

If you had to pick one of the models, which do you think is the most useful?

Imagine you had to pay for this out of your own practice budget: which do you think would offer the best value for money? Why?

4 Those were all the questions that I have. Does anybody have any more thoughts on how these options could be adapted or combined to help you to keep your patients in work or return them to work?

Thank you and debrief

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This report covers findings from a series of six focus groups with GPs to explore their views on a possible new support service to help employed people who are off sick from work to return to work quickly and prevent them from falling out of paid work. During the focus groups GPs were presented with four different possible models for the service and discussed their views of each option; the nature and scale of potential services; and the benefits they thought they would offer. Focus groups were carried out in August and September 2012 and the findings raise a number of issues for consideration in the design of future support services in this area.

If you would like to know more about DWP research, please email:
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