Getting the best from the fit note

Investigating the use of the statement of fitness for work

Report submitted to the IOSH Research Committee

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Abstract

Background/Introduction

The fit note was introduced in 2010 to replace the sickness certificate and facilitate those with health conditions to stay in work by encouraging GPs to focus on what a patient is able to do at work. However, despite this major policy change, no research studies have been published that have evaluated the fit note from the perspective of all the main stakeholders, namely employed patients, GPs and employers (including human resources, line managers and occupational health practitioners). This study aimed to investigate and reach agreement on how the fit note can best be used by all stakeholder groups to aid return to work and work retention.

Methods

There were two consecutive phases. In the first phase, actual fit note data were collected from employers, employed patients and GPs. The return-to-work outcomes and usefulness of these fit notes in helping individuals return to work were investigated through postal questionnaire. Experiences and perceptions of fit notes were explored with employers, employed patients and GPs through semi-structured interviews. The findings of this first phase were used to inform phase two. The aim of the second phase was to reach consensus with an expert panel on recommendations for best practice in fit note use. The recommendations were further sent to a reference panel for comment on the achievability of the findings.

Results

Consensus was reached for sixty-seven recommendations which focused on five main aspects of fit note use: general format and application; completion; management; communication and training. Although most of these were considered achievable in practice, a number of obstacles to implementation were identified: legislation governing the fit note and GP contracts; the costs and complexity of IT systems and software; the limitations of the GP consultation; the lack of dissemination and uptake of guidance; insufficient clarity of terms; issues regarding patient/employee consent and confidentiality; indistinct responsibility for funding and delivering education and training and conducting audit.

Conclusions

This study demonstrated that consensus was reached for many aspects of fit note use. However, the resulting recommendations require the provision of education and training for all stakeholders, modifications to the fit note itself, changes in GP clinical practice and practice organisation, and in organisational policies and procedures. The fit note is not achieving its aims and is unlikely to do so without increased investment of time, money, commitment, and further legislation.

Executive Summary

Background

Sickness absence is associated with substantial financial expense to the government, the economy, employers and individuals in respect of healthcare, sick pay, productivity, foregone taxes and loss of earnings. Sickness absence can also impact negatively on health and wellbeing. In order to address these costs, and to change the prevailing philosophy that illness is incompatible with work, the UK government replaced the sickness certificate with the 'fit note'. The fit note was introduced in 2010 with the purpose of facilitating those with health conditions to stay in work by encouraging GPs to focus on what a patient is able to do at work. GPs can use the fit note either to advise that a patient is 'not fit' for work, or that they 'may be fit', taking into account certain advice, including: a phased return to work; altered hours; amended duties and/or workplace adaptations.

However, despite this major policy change, no research studies have been published that have evaluated the fit note from the perspective of all the main stakeholders, namely employed patients, GPs and employers (including human resources, line managers and occupational health practitioners).

Aims

This study sought to address the gaps in the current literature by investigating how the fit note is used in practice and by trying to identify how best to optimise its effectiveness in aiding work retention and return-to-work from the perspective of all three main stakeholders: employer, employee/patient, GP.

The objectives were:

1. To reach a consensus on the content of the ideal fit note from the perspective of employers, employees and GPs in order to facilitate return-to-work and work retention.
2. To produce recommendations for good practice in the completion, timing, transmission and application of fit notes.
3. To identify acceptable methods of facilitating dialogue between these stakeholders.
4. To develop specific training for employers and GPs in the effective use of fit notes.

Methods

There were two phases to the study. Ethical approval was obtained from the University of Nottingham Medical School Ethics Committee and from the Northampton Research Ethics Committee for both.

In the first phase, actual fit note data were explored and quantitative and qualitative data were collected from employers, employed patients and GPs located in Nottinghamshire, Derbyshire and Leicestershire.

Employers: Thirteen organisations were recruited to the study from which 827 anonymised copies of fit notes were collected. Representatives from each organisation responsible for managing the fit notes were asked to complete a questionnaire concerning the outcome and usefulness of a proportion of these fit notes. A total of 498 questionnaires were completed. Face-to-face individual interviews were conducted with 21 of these representatives to explore their perceptions and experiences of fit notes.

Patients: Eleven employed patients were recruited to the study who had been issued with a fit note by their GP. Each completed a questionnaire concerning the outcome and usefulness of their fit note. Face-to-face individual interviews were conducted with ten of the participants to explore their perceptions and experiences of fit notes.

GPs: Eleven GPs were recruited to the study from whom 94 anonymised copies of fit notes were collected. The GPs were asked to complete a questionnaire concerning the outcome and usefulness of each fit note. A total of 93 questionnaires were completed. Face-to-face individual interviews were conducted with each GP to explore their perceptions and experiences of fit notes.

Quantitative fit note and questionnaire data were analysed descriptively. Fit note and questionnaire comments were analysed using thematic content analysis. Interview data were analysed thematically. The findings of the first phase informed the design of the subsequent second phase.

In the second phase of the study a series of fifty-three statements were generated by the research team based on data collected in Phase One, on published literature and with members of the steering group and used to conduct a modified Delphi study. The aim was to reach consensus (≥ 75% agreement) with an expert panel of stakeholders on recommendations for best practice in fit note use. Participants were invited from the following groups: patient organisations, general practice, government departments, occupational health, trades unions, employers, academics in the field of work and health and allied health professionals delivering work-focused interventions. A total of seventeen individuals participated. The statements were presented in three rounds. Participants were asked to select a response option (strongly agree; agree; disagree; strongly disagree) and to insert any comments regarding the statement in a free text box. In the second and third rounds, statements where consensus had not been achieved were re-presented together with reworded or additional statements generated from comments and responses in the previous rounds. Consensus recommendations were sent to a further reference group (n=12) for comment on the achievability of applying the recommendations in practice.

Results

Consensus was reached for 67 recommendations which focused on five main aspects of fit note use: general format and application; completion; management; communication and training. Although most of these were considered achievable in practice, a number of obstacles to implementation were identified: legislation governing the fit note and GP contracts; the costs and complexity of IT systems and software; the limitations of the GP consultation; the lack of dissemination and uptake of guidance; insufficient clarity of terms; issues regarding patient/employee consent and confidentiality; unclear roles and responsibilities for the funding and delivery of education and training and the further evaluation of practice.

Conclusions

The study demonstrated that consensus could be reached between the stakeholders for key issues concerning the content of the ideal fit note, and has produced recommendations for good practice in their completion, timing, transmission and application. It has identified ways in which dialogue between the stakeholders might be promoted, and potential training requirements.

The fit note is not achieving its aims and is unlikely to do so without increased investment of time, money, commitment, and further legislation.

List of Abbreviations

CBI	Confederation of British Industry
CIPD	Chartered Institute of Personnel and Development
DWP	Department for Work and Pensions
EEF	Engineering Employers Federation
HR	Human Resources
IMD	Indices of Multiple Deprivation
OH	Occupational Health
OHA	Occupational Health Advisor
RTW	Return to work

CHAPTER 1. INTRODUCTION AND OVERVIEW OF THE LITERATURE

1.1 Introduction

Sickness absence costs UK employers £9 billion a year in sick pay and associated costs and the government spends £13 billion annually on health-related benefits.[1] Unnecessary absence is known to be harmful to an individual's health and well-being.[2] It is therefore a priority to reduce sickness absence and work disability due to ill health and to improve the health of the working population through closer collaboration between the health and employment sectors.[3] The Statement of Fitness for Work or 'fit note' is one of the main tools the government has introduced to effect this change.[4;5]

The fit note was introduced in April 2010 to replace the previous sickness certificate and to encourage GPs to change the focus to what a patient is able to do at work. GPs can use the fit note either to advise that a patient is 'not fit' for work, or that they 'may be fit', taking into account certain advice, including: a phased return to work; altered hours; amended duties and/or workplace adaptations. The 'fit note' has the potential to be a significant tool in facilitating the support that people need by stimulating dialogue that can pave the way towards return to work. Fit note advice on work modifications that help patients remain in work or return to work also has the potential to control and reduce future workplace risks to health.

However, although the fit note has been broadly welcomed by GPs and employers as a way of supporting return to work and job retention in those with health problems, difficulties and uncertainties have resulted in wide variations in their use. GPs regularly report that employers fail to act on the advice given; employers often complain that GPs fail to use the fit note to provide sufficient advice. Despite such a major policy change, necessitating huge investment, no systematic approach to evaluate the fit note from the perspective of all stakeholders has been conducted. Research on fit notes to date is limited in scope and based mainly on small interview studies, questionnaire surveys of employers or reports published by the Department for Work and Pensions (DWP). No research has reported on a consensus view of the ideal content of the fit note, the factors that facilitate it, or what training is needed to improve best practice.

1.2 Research aims and objectives

This study sought to address the gaps in the current literature by investigating how the fit note is used in practice and by trying to identify how best to optimise its effectiveness in aiding work retention and return-to-work from the perspective of all three main stakeholders: employer, employee/patient, GP.

The research question was:

"How can fit notes best be used by employers, employees and GPs to aid return-to-work and work retention?"

The objectives were:

1. To reach a consensus on the content of the ideal fit note from the perspective of employers, employees and GPs in order to facilitate return-to-work and work retention.
2. To produce recommendations for good practice in the completion, timing, transmission and application of fit notes.
3. To identify acceptable methods of facilitating dialogue between these stakeholders.
4. To develop specific training for employers and GPs in the effective use of fit notes.

1.3 Background

1.3.1 Sickness absence in the UK

In the UK, employees who consider themselves unable to work due to a health condition can self-certify for up to 7 days. After this period, sick leave must be validated by a medical practitioner, usually a GP, in order to claim Statutory or Occupational Sick Pay, or health-related benefits. During an average week a full-time GP will sign approximately ten certificates.[6]

Since 1970, sick leave rates have risen steeply in the UK. In 2013, 131 million days were lost to sickness absence.[7] Nearly one million employees a year reach the four-week sickness absence point. The state spends around £12 billion a year in healthcare, sick pay reimbursement and foregone taxes, employers face an annual bill of around £9 billion for sick pay and associated costs, and individuals collectively face loss of earnings of £4 billion.[8]

In addition to the financial consequences, sickness absence also negatively impacts on health and wellbeing. It is recognised that work has a positive impact on people's longer term health and wellbeing and that absence from work is generally detrimental.[2]

In order to address the escalating costs of sickness absence, and to change the prevailing philosophy that illness is incompatible with work, the government introduced a strategy for work, health and wellbeing (Health, Work and Wellbeing, caring for our future) and commissioned a review of the working age population.[9] One of the main tools designed to drive the strategy forward is the Statement of Fitness for Work, better known as the 'fit note', which replaced the 'sick note' in England, Wales and Scotland in 2010.[4] This changed the focus to what a patient may be able to do at work rather than simply recording a yes or no judgement by the doctor.

1.3.2 Development of the fit note

Until the introduction of the fit note, the procedure followed by GPs, and the forms they used, had altered little since the foundation of the NHS. However, in contrast, the work and health arena had undergone considerable change,[10] for example:

- work itself has become safer and less physically demanding
- employers are obliged to take account of disability rights legislation
- the healthcare professions have recognised their role in assisting patients to work

As a result, there has been growing recognition that medical practitioners, particularly GPs, need better support in advising their patients on returning to work. Dame Carol Black first recommended replacing the 'sick note' with a 'fit note'.[9] In response to her recommendation, the government developed a revised statement through consultation with a wide range of stakeholders including GPs, employers, health professionals and trade unions. A trial of the proposed fit note was conducted with over 500 GPs, [11] and following this, the government conducted a 12 week consultation on the draft changes to the regulations governing the medical certificate.[10]

The results of the consultation were published in January 2010.[4] There was broad support for the proposed fit note, although caution was expressed particularly by trades unions. The main change made to the fit note from the draft version was that the option of 'you are fit for work' was removed. A sample copy of the fit note can be seen in the appendix. The electronic version of the fit note was introduced in 2012 with roll-out nationally to be completed by early 2013.

The purpose of the fit note has been described[12] as to:

- improve return-to-work advice for individuals on a period of sickness absence
- improve communication between individuals, GPs and employers on what a patient can do and how a patient's condition might be facilitated at work
- reduce sickness absence
- support people with health conditions stay in work or return to work more quickly

- contribute to creating new perspectives on the link between work and health and improve awareness and understanding of the importance of work for good health

GPs can use the fit note to advise either that a patient is 'not fit' for work or that they 'may be fit'. Where it is considered that a patient 'may be fit' for work, GPs are required to advise on one or more of four workplace modifications (phased return; altered hours; amended duties; workplace adjustments) and to provide additional comments in a free-text box including the functional effects of the patient's condition. If the employer and employee are unable to make necessary modifications, then the 'may be fit' note is treated as a 'not fit' note, and the employee remains off sick. GPs are also required to state the duration of the fit note, either by entering an amount of time (days, weeks, months) or by specifying the date that the fit note starts and ends. In addition the GP should state whether or not they will need to assess the patient's fitness for work again at the end of the period covered by the fit note. However, patients do not have to be reassessed by the GP prior to returning to work; the patient can return to work when they feel able, even if this is before the fit note expires, providing the employer has conducted a suitable risk assessment.

1.4 Literature review

Since the introduction of the fit note, a number of research studies have reported on its use. These studies, which have been conducted with GPs, employers and employees, have reported on data collected using both quantitative and qualitative methodologies. However, there are a number of limitations with the existing literature which are highlighted below.

Experience of the fit note – GPs

Literature reporting on GPs' experiences of the fit note has been mainly qualitative in nature. Two of these studies[13,14] had comparatively small samples, and in these cases it is unlikely that saturation would have been reached. All of the studies relied on general recall about fit notes, rather than using actual examples.

Welsh et al.[13] conducted an interview study with 15 GPs between August and November 2010 and reported that overall the fit note was well received and many GPs felt that it facilitated an earlier return to work when used as a negotiation tool. However, other participants were sceptical. Employers were perceived as the major obstacle in the return-to-work process and that they wanted patients to be signed as 'fit' for work. Some GPs would have liked the option to access early independent assessments of patients' work ability, and to receive feedback on the impact of the fit note on employees' behaviour. Many considered this aspect of their practice to be a low priority and they lacked the time to access educational resources.

In another interview study with 13 GPs conducted between April and October 2010, Wainwright et al.[14] also found support for the rationale behind the fit note, but again identified barriers to its use. These included concerns about the impact of the fit note on maintaining the doctor-patient relationship, inconsistent engagement from employers, GPs' lack of occupational health knowledge, issues with training, and doubts about whether the new format could achieve the cultural shift required. Most GPs felt the fit note 'might' help negotiate return to work because of the extra space available for comment and that the four work modification options encouraged more in-depth thought about return to work. Others felt that it had made little change to their practice. However, this study specifically related to the use of fit notes for patients with chronic pain, four of the sample had specialist OH qualifications, and the authors acknowledged potential bias as a limitation of the study.

Fylan et al.[12] conducted a larger interview study with 45 GPs between February and May 2011, commissioned by the Department for Work and Pensions. The authors reported that GPs found the fit note useful in initiating discussion with the patient about their potential return to work. However, barriers to successful use were again identified, including GPs' self-efficacy in dealing with conflict, their unwillingness to damage their relationship with their patients, and the local economic and labour market conditions. Some reported difficulty in understanding and distinguishing between the modification options and confusion over date fields. Not all GPs understood the level of detail they should include on the fit note and perceived their self-efficacy in using the fit note was reduced because they receive little feedback about the usefulness of their advice.

A survey conducted in 2010 of 1,405 GPs in England, Scotland and Wales for the Department for Work and Pensions investigated GPs' attitudes to work and health and their views about the fit note.[15] The survey was repeated with 1,665 GPs in 2012 and the results compared.[16] The authors reported an increase in the proportion of GPs who were positive about the impact of the fit note on patient outcomes and the quality of work-related discussion however, 29 per cent still reported that it had made no change to their practice. In 2012, as in 2010, only a very small minority of GPs had received training in work and health within the past 12 months. Those who had received training tended to report higher levels of confidence in dealing with patient issues around return to work, but there was no significant association between training and reported impacts of the new fit note.

Experience of the fit note – employers

Research studies of employers' experiences of the fit note have also been mainly qualitative in nature. The only quantitative data has been collected by employer organisations, and obtained through annual surveys, rather than through more robust research methodologies.

In semi-structured interviews with 13 employers and 13 employees, Wainwright et al.[17] found that the fit note was perceived to be helpful if used in combination with other strategies for managing sick leave and return to work for people with chronic pain. The fit note was valued for its positive language, interrogative format and 'biomedical' authority. Employers liked the format, which they thought encouraged conversation between stakeholders. However, as with a previous study,[14] this focused specifically on employees with chronic pain thus limiting generalizability.

In a study commissioned by the Department for Work and Pensions, Lalani et al.[18] conducted interviews with employer representatives and employees from 54 organisations of varying size. Participants included 58 Human Resources specialists, six Occupational Health specialists, 15 line managers and 11 other managers. Although the intent of the fit note was welcomed, views as to its usefulness were varied. Some felt it had focussed attention on return to work, leading to adjustments being considered and implemented more fully, however others thought it had not changed their management approach and was irrelevant to discussions with employees.

Three UK employer organisations have also reported on the fit note from data collected in their annual survey of employers. The Chartered Institute of Personnel and Development (CIPD) conducted an on-line survey in 2013 completed by 618 respondents representing organisations of all sizes.[19] Only 7% of respondents believed that the fit note was being used effectively by GPs. Three-quarters disagreed that the fit note had helped to reduce sickness absence levels in their organisation. Two-fifths reported that the fit note prompted conversations about absence/health between staff and line managers and just over one-fifth that it helped line managers to manage absence.

The Engineering Employers Federation (EEF) also conducted a survey in 2013 and received 353 responses from manufacturing organisations across the UK.[20] Of these, 40% reported that employees were not returning to work earlier as a result of the fit note, compared to 26% who said they were. A greater proportion of companies felt that the fit note had not improved the advice given by GPs about employees' fitness for work.

In the same year, in a survey of absence and workplace health, the Confederation of British Industry (CBI) received responses from HR practitioners and managers representing 153 organisations across the public and private sectors.[21] Only one fifth of respondents reported that the fit note had helped their rehabilitation policies, or contained constructive advice. Only 17% believed that the fit note had actually changed the culture around rehabilitation and return to work.

Experience of the fit note – patients

Only two studies have reported specifically on patients'/employees' experiences of the fit note. Both were qualitative, one being conducted mainly through telephone interviews.

Lalani et al.[18] also conducted interviews with 87 employees from organisations of different sizes as part of their research commissioned by the Department for Work and Pensions. The employees broadly supported the purpose of the fit note, however their reports indicated variation in the content of fit note discussions with their GP. Consultations did not always include a conversation about the nature of the employee's job and

discussions about adjustments varied considerably in detail. Some employees felt empowered by the fit note in negotiating adjustments with their employer and felt that their employer had been more willing to make them, others that their health had been negatively affected by returning to work too soon.

In a survey of 1,398 employees conducted for the Department for Work and Pensions Chenery et al.[22] found that of those respondents who recalled a discussion about their job, 71% agreed that the fit note had been helpful and 68% that it had facilitated discussion with their employer about work modifications. However, this retrospective study relied on a long recall period and not the actual fit notes. In many cases modification were not recommended and nearly half of respondents did not discuss changes with their employer. The survey was conducted mainly through telephone interviews with employees who had received a sickness certificate in the previous 12 months.

Content of the fit note

Only two studies have reported on the content of actual fit notes.

Coole et al.[23] reported on a service evaluation of 1,212 fit notes. This study focused on the completion of the comments section of both 'not fit' and 'may be fit' notes using content analysis. They found that there was a wide variation in the content of the comments – fourteen different categories were identified. Although most comments made some reference to the patient's return to work, few described the functional effects of the patient's condition as advised by DWP guidance. This study only reported on the comments section of the fit note.

In a further study commissioned by the Department for Work and Pension, Shiels et al.[24;25] reported on fit note data collected from 49 GP practices in five geographical locations. They reported that less than 12% of patients had been given 'may be fit' notes, and that only 6% of all the fit notes collected indicated that the patient 'may be fit' for work. However, use varied significantly between practices, including the use of the 'may be fit' option, the provision of advice, and the indication as to the need for reassessment.

Neither study differentiated between fit notes issued to patients who were in work and those who were unemployed.

Summary of literature

In summary, this review of existing literature has demonstrated that although research studies have been published about the fit note, many are not peer-reviewed (e.g. those commissioned by the DWP). The majority have reported on the perspectives of specific stakeholders, or focus on specific health conditions, or were small qualitative studies where data saturation is unlikely to have been reached. The majority were based on participant recall rather than on actual examples. The distinction between fit note use with those in work, as opposed to the unemployed was not always clear, nor whether the studies concerned 'not fit' and/or 'may be fit' notes. No studies have investigated how the fit note can be best used by all the three main stakeholders when the individual is employed – i.e. the individual, the employer and the GP, and by using mixed methods to further substantiate the findings.

1.5 Introduction to the present study

The study is presented in two phases. Ethical approval was obtained from the University of Nottingham Medical School Ethics Committee and from the Northampton Research Ethics Committee for both phases.

Phase One: Study of fit notes

Actual fit note data were explored and quantitative and qualitative data were collected from participants representing the three main stakeholder groups involved:

- Employers (including human resource professionals, managers and occupational health practitioners
- Employed patients
- General Practitioners

Quantitative fit note and questionnaire data were analysed descriptively. Fit note and questionnaire comments were analysed using thematic content analysis.[26] Interview data were analysed thematically.[27]

Phase Two: Consensus study

The findings from Phase One were used to conduct a modified Delphi technique to reach consensus with an expert panel of stakeholders on recommendations for best practice in fit note use.

Consensus recommendations were sent to a further group of stakeholders for comment on the achievability of applying the recommendations in practice.

CHAPTER 2. PHASE ONE: THE STUDY OF FIT NOTES

2.1 EMPLOYER STUDY

2.1.1 Aim

The aim of the employer study was to explore and evaluate actual fit note data. The perceptions and experiences of employers concerning fit notes was sought in order to inform the statements for the consensus study.

2.1.2 Method

Participating organisations were asked to collect all fit notes they received for up to a six month period. All identifiable employee and GP information was removed by the organisation and the anonymised copies were sent to the research team. Two weeks after the expiry of each fit note, those who received/reviewed the fit note in each organisation were asked to rate the usefulness and outcome of each fit note using a postal questionnaire developed by the research team. If organisations were unable to complete a questionnaire for every fit note, they completed a questionnaire for all 'may be fit' notes, and for 20% of 'not fit' notes which were selected randomly by the researchers using a computerised random number generator.

A total of twenty individuals employed by the participating organisations who received/reviewed the fit note were interviewed at the end of the data collection period. Recruitment was based on the available resources and timeframe of conducting the study. Each interviewee was offered a £25 gift voucher in appreciation of their help. Participating organisations were further offered a free workshop on the management of sickness absence as a recruitment incentive.

Postal questionnaire

The questionnaire comprised three main sections:

1. The employee's work status following the fit note.
2. The communication, in addition to the fit note, that had taken place between the GP and the workplace (including occupational health).
3. The respondent's perceived usefulness of the fit note.

Questions were developed by the research team and approved by the steering group. Separate questionnaires were designed for 'not fit' notes and 'may be fit' notes. The questionnaires were piloted with six individuals representing occupational health, human resources and management. As a result, minor amendments were made to the wording of some of the questions to improve clarity.

Semi-structured interviews

Interviews were recorded using a digital voice recorder, and took place in a private area at the participants' place of work. A list of topic areas and prompts were developed by the research team and included:

- Experience of, and attitude towards, fit notes.
- Opinion of the usefulness and acceptability of the fit notes received during the study period.
- Perceived optimum content of a fit note required to facilitate retention in, or return to work.
- Views as to the need to facilitate dialogue between employees, employers and GPs and how this might best be achieved.
- Views regarding the training needs of employers and GPs in effective fit note completion and delivery.

Analysis

Interview data were transcribed verbatim in Word. Each transcript was checked and corrected by the researcher conducting the interview then uploaded onto Nvivo 10. The researchers conducting the interviews independently coded a sample of interviews line-by-line, then compared and revised these initial codes. Each interview was then coded and themes identified through constant comparison of the scripts. Themes were then discussed, revised if needed and finally agreed.

Initial coding of the content of fit note comments took place independently by three researchers. Codes were then reviewed, revised and agreed mutually.

Recruitment

The overall aim was to recruit ten organisations to the study, approximately half with occupational health provision, representing different sectors and sizes of business organisation. A combination of opportunistic and random sampling methods was employed, for example through news items in the newsletters of employer organisations, and by letter/email to employers identified through the local Chambers of Commerce. Organisations that expressed an interest in the study were visited by members of the research team, who described the study and answered any questions. Written consent was obtained at, or following, the meeting.

2.1.3 Results

Participants

A total of 17 employer organisations expressed an interest in participating in the study. Of these, two withdrew prior to giving consent and two withdrew prior to data collection, leaving 13 organisations participating. Ten organisations were based in Nottinghamshire and three in Derbyshire. None of the three 'small' organisations had occupational health provision.

Demographic details of the participating organisations are shown in Table 1.

Table 1. Demographic details of the participating organisations

Size of organisation	**N=13**
Large (> 250 –employees)	10
Medium (50 – 250 employees)	3
Small (>50 employees)	0
Sector:	
Service (private)	5
Service (public)	2
Charity – service	1
Not for profit – service	3
Manufacturing	2
Occupational Health:	
In-house	6
Contracted out	4
None	3

Fit note data

Data were collected between May 2013 and February 2014. Data collection periods for each organisation ranged between five and 27 weeks.

A total of 827 anonymised copies of fit notes were sent to the research team for analysis. Details of the number of fit notes received per organisation and the number of employees per organisation are shown in Table 2.

Table 2. Number of fit notes collected per organisation

Number of employees	Number of fit notes (n=827)
650	25
1,750	117
700	28
100	12
2,000	53
890	3
68	7
380	103
900	104
300	59
100	4
1,000	166
500	146

The fit notes were analysed descriptively (Table 3). The majority (n=753, 91.1%) were marked as ‘not fit’, 55 (6.7%) were marked as ‘may be fit’,15 fit notes had no option selected, three fit notes had both options selected, and one fit note had both options deleted.

The most common single work modification selected by GPs was ‘amended duties’ which was selected in 23 fit notes (63.8% of single work modifications). The second most common single work modification selected was ‘phased return’ found in eight fit notes (13.3% of single work modifications). The least common single work modifications selected were ‘altered hours’ (11.1%) and ‘workplace adaptations’ (2.7%).

The comment section of the fit notes was completed in 100 of the fit notes of which 49 (49%) were ‘may be fit’ notes and 40 (40) were ‘not fit’ notes. Seven (7%) of the fit notes with a comment had neither of the options selected, three (3%) had both options selected and one (1%) had both options deleted.

The mean number of days of fit note duration, across all fit notes, was 18.8 days with a mode of 14 days and a range of 90 days.

The review section of the fit note was completed as required in 38.4% of the fit notes. In 28.4% of these the GP recorded that they did not need to assess the patient again and in 10% that they did. In the remaining cases the review section was either not completed (59.4%), was illegible (1.5%) or had been deleted (0.1%).

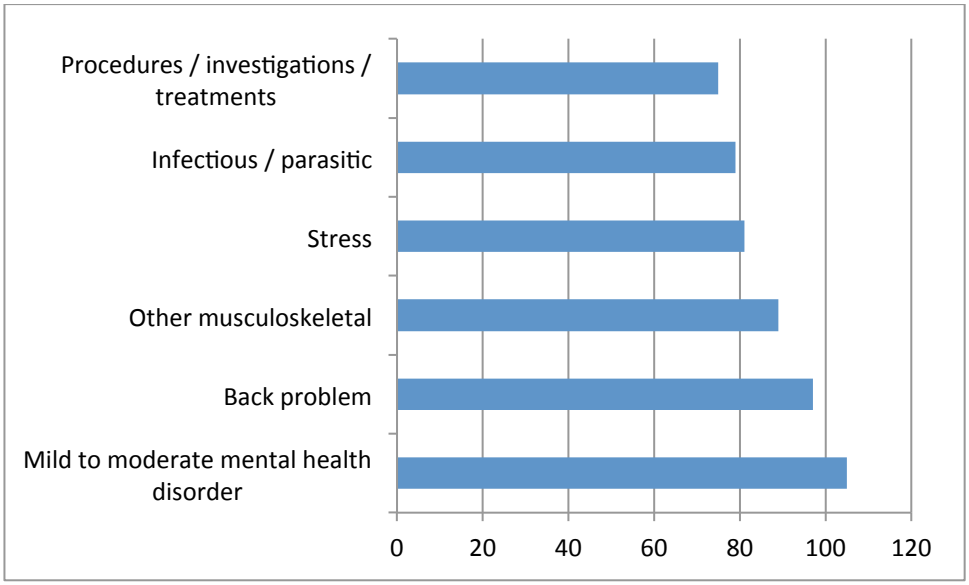
In 0.4% of the cases the review section was missing altogether due to the GP using a different fit note format. In 0.2% of the fit notes the GP had added other comments instead of completing the section as required. The comments were: 'self-certificating for one week' and 'assess at clinic'.

Table 3. Descriptive statistics for the fit notes received from all employers

Fit notes		**N**	**%**
Number in sample (n=827):	Not fit	753	91.1
	May be fit	55	6.7
	Neither option selected/ blank	15	1.8
	Both options selected	3	0.4
	Both options deleted	1	0.1
Number of fit notes with single modification selected (n=36):	Amended Duties	23	63.8
	Phased Return	8	22.2
	Altered Hours	4	11.1
	Workplace Adaptations	1	2.7
Number of fit notes with more than one modification selected (n=24):	*Any combination of the above four modifications*	24	40.1
Number of fit notes with comments (n=100):	May be fit	49	49.0
	Not fit	40	40.0
	Neither option selected/ blank	7	7.0
	Both options selected	3	3.0
	Both options deleted	1	1.0
Completion of review section (n=827):	Not completed	491	59.4
	I will not want to assess patient	235	28.4
	I will want to assess patient	83	10.0
	Illegible / unclear	12	1.5
	No review section	3	0.4
	Other comments	2	0.2
	Question deleted	1	0.1

The specific conditions stated on the fit notes were categorised based on a taxonomy used by the Department for Work and Pensions,[24] although stress and bereavement were given separate categories. Figure 1 illustrates the proportion of fit notes for the six most frequently specified conditions. The most common was 'mild to moderate mental health disorder' (105; 12.7%), followed by 'back problem' (97; 11.7%) and 'other musculoskeletal' (89; 10.8%), stress (81; 9.8%) and procedures/investigations/treatments (75; 9.1%).

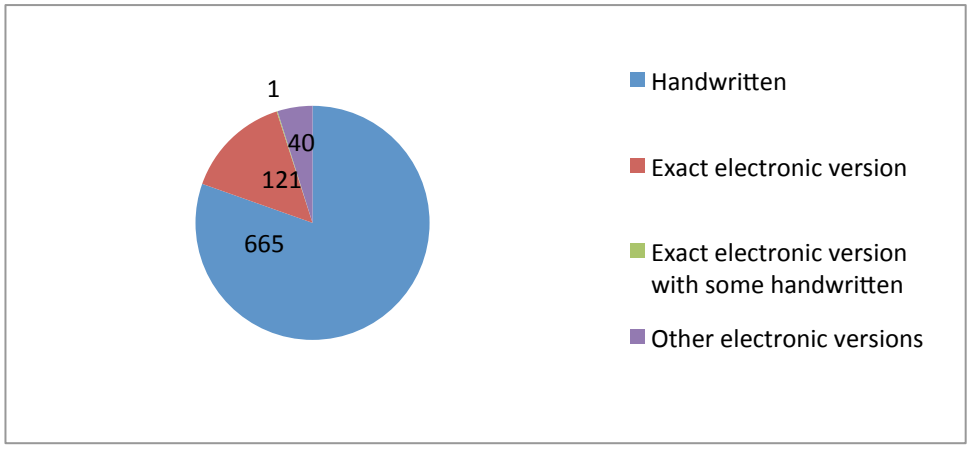
Figure 1. Proportion of fit notes issued for the six most frequently specified conditions



Fit note format

The fit note copies collected from the organisations encompassed a variety of different formats as illustrated in Figure 2. The majority (n=665, 80.4%) were handwritten, using the standard format and 121 (14.7%) were exact electronic versions of the standard format. One was an exact electronic version, but some data had been entered by hand. The remaining 40 fit notes (4.8%) were completed using seven different electronic variations, i.e. 25% of electronic fit notes were non-standard. Variations included using the term 'medical condition comments' instead of the standard heading 'comments, including the functional effects of your condition'; exclusion of a comment box; exclusion of the reassessment section; use of the term 'fit for work with restrictions' rather than 'you may be fit for work taking account of the following advice'; not including the comments section in a box specific to 'may be fit' notes; additional duration options of days, weeks and months; headed 'sick note' or 'MED 3 – Statement of fitness for work'.

Figure 2. Format of fit note copies collected from the organisations (n=827)



Fit note comments

A total of 101 GP fit notes had comments entered in the designated box. In one case the comment referred to the patient 'self-certificating', the other the GP had entered a tick (✓3), These were both excluded from the analysis. In a further case the comment was 'see above' referring to a comment that had been made in the 'condition' section. This comment was included in the analysis, thus a total of 100 comments were coded according to thirteen categories identified through thematic content analysis. The categories are described in Table 4 below with examples of comments and number of fit notes per category. Some comments covered more than one category.

Table 4. Frequency of categories with examples of comments per category

Category	Examples of GP comments	N
Work-related advice/recommendation/instruction	"Light duties. No heavy lifting."	58
Date for RTW suggested/indicated	"Well enough to return to work on 15/7/13"	21
Clinical management/intervention	"Requires extensive speech and language and occupational therapy"	17
Functional effects of a patient's condition	"Partial weight bearing"	11
Additional information on health condition	"Sustained injury on 8/7/13 reportedly off work since"	8
Reference to the duration of fit note or date when the patient is to be reviewed	"4 hours/day for the first 2 week then review; to run from 23 October 2013"	5
Comment illegible	n/a	5
Fit note used to inform employer that patient is fully fit for work.	"Pt says rash cleared, feels well, fit to go back to work"	5
General statement regarding RTW plan or progress (rather than advice, recommendation or instruction)	"Reduced hours and duties as agreed with occupational health"	4
Decisions/plans regarding return to work delayed	"Awaiting test results and further investigations"	3
Reference to previous fit note	"To be continuous with last certificate"	2
RTW dependent on action to be taken by the employer	"Will allow HR to assess"	1
Other	*"ongoing"* *"father died unexpectedly"* *"patient did discuss this with management on 26th October which is when this problem dates from, but was unable to see us before now to obtain this sick note"*	*3*

Questionnaire data

516 questionnaires were sent out, of which 498 were returned (96.5% response rate). 87.6% of these related to ‘not’ fit notes and 10.2% related to ‘may be’ fit notes. 1.6% related to fit notes where neither option had been selected, 0.4% related to fit notes in which both options had been selected, and one (0.2%) related to a fit note where both options were deleted (Table 5).

Table 5. Number of questionnaires completed for each type of fit note found in the sample

Questionnaires completed	N=498	%
Not fit notes	436	87.6
May be fit notes	51	10.2
Neither option selected	8	1.6
Both options selected	2	0.4
Both options deleted	1	0.2

Questionnaire data for ‘not’ fit notes

A total of 441 questionnaires were returned relating to ‘not fit’ notes. This included:

- 4 questionnaires for fit notes where neither option had been selected
- 1 questionnaire for a fit note where both options had been selected

The responses are shown in Table 6.

Return to work outcome

The details of employee’s return to work outcome are also shown in Table 6. In 89.9% (n=392) of cases the respondent knew what had happened to the employee following the fit note – the most common situation being that the employee had received another ‘not fit’ note’ (50.8%) or had returned to normal hours and duties (29.1%). In 23 cases (5.8%) the option ‘other’ was selected, for example where the employee had resigned or was on maternity leave.

Table 6. Questionnaire data for 'not fit' notes

Question	Response	N=441	%
Do you know what happened following this fit note?	No	49	11.1
	Yes	392	88.9
If yes, what happened?	Another 'not fit' note	199	50.8
	Normal hrs/duties	114	29.1
	Normal hrs/mod duties	23	5.8
	Other	23	5.8
	Mod duties & hours	14	3.6
	Mod hrs/normal duties	12	3.1
	RTW but don't know details	4	1.0
	Issued with 'maybe fit' note	3	0.8

Communication between GP and workplace

In 44 (9.9%) cases it was reported that Occupational Health had contacted the GP regarding the employee's return to work and in 304 (69%) of the cases it was reported that they had not. In 93 (21.1%) cases the respondent did not know or had made no response.

In 5 (1.1%) cases it was reported that the GP had contacted the workplace regarding the employee's return to work and in 422 (95.6%) cases that they had not. In 14 (3.2%) cases the respondent did not know or had made no response. The nature of the GP contact with the workplace related to letters or reports.

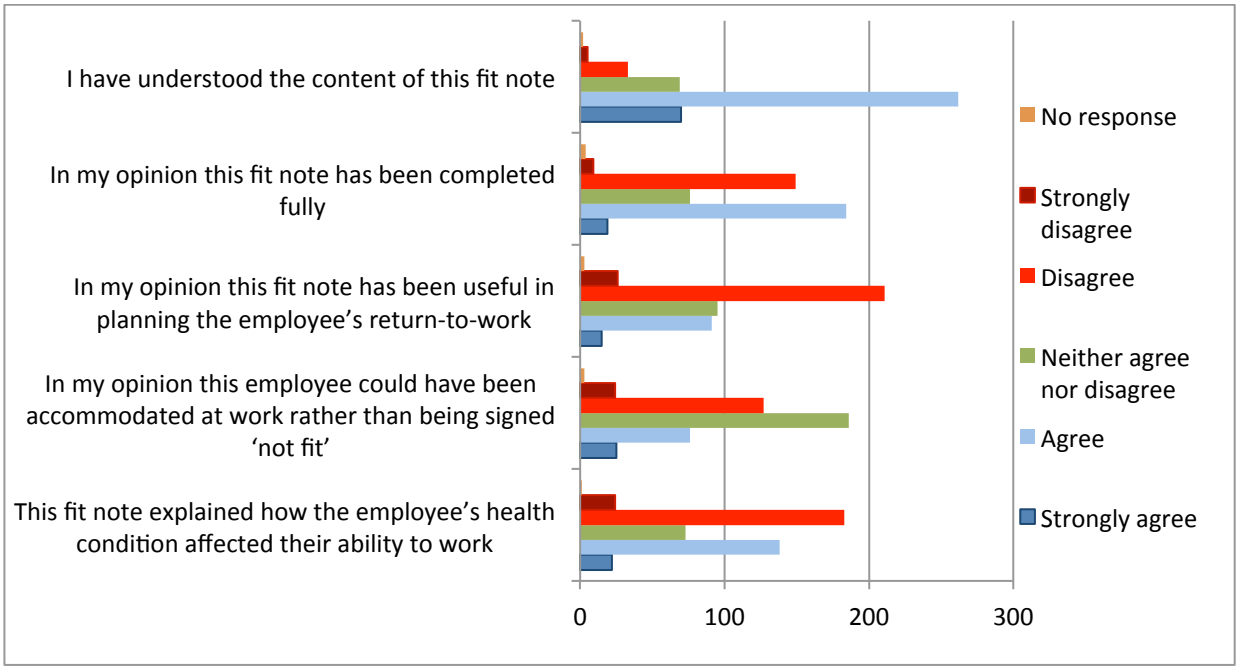
In 411 (93.3%) cases it was reported that the workplace had not been in contact with the GP regarding the employee's return to work. In 20 (4.5%) cases the workplace had been in contact with the GP and in ten (2.3%) cases the respondent did not know or had made no response. Details concerning the contact made by the employee's workplace with his/her GP related to letters and reports.

No-one else had contacted the workplace with regards to the fit note in 394 (89.3%) of the questionnaires. In 25 (5.7%) cases contacts included those between the line manager/supervisor/HR/OH/ income protection insurers and the employee and/or their partner.

Usefulness of the 'not fit' fit notes

Questionnaire responses (n=441) made in regard to the usefulness of the 'not fit' notes are illustrated in Figure 3.

Figure 3. Employer questionnaire responses (n=441) regarding usefulness of 'not fit' notes



I have understood the content of this fit note

- More than three-quarters (332; 75.3%) of the respondents agreed or strongly agreed with the statement, 69 (15.6%) neither agreed nor disagreed, 38 (8.6%) disagreed or strongly disagreed and in two cases the response was missing.

In my opinion this fit note has been completed fully

- In the greater proportion of cases (203; 46.0%) the respondents either agreed or strongly agreed with this statement, and over one third (158; 35.9%) disagreed or strongly disagreed. In 76 (17.2%) cases the response was neutral, and in four cases the response was missing.

In my opinion this fit note has been useful in planning the employee's return to work

- More than half of respondents (237; 53.7%) either disagreed or strongly disagreed. Almost one quarter (106; 24.0%) agreed or strongly agreed, 95 (21.5%) gave a neutral response, and in three cases the response was missing.

In my opinion this employee could have been accommodated at work rather than being signed 'not fit'

- More than a third of respondents (151; 34.2%) disagreed or strongly disagreed with the statement, and almost a quarter (101; 22.9%) either agreed or strongly agreed. The largest proportion (186; 42.2%) of the respondents gave a neutral response and in three cases the response was missing or described as 'not applicable'

This fit note explained how the employee's health condition affected their ability to work

- The greater proportion of respondents (207; 46.9%) disagreed or strongly disagreed with this statement, 160 (36.3%) either agreed or strongly agreed, 73 (16.6%) were neutral and one response was missing.

Questionnaire data for 'may be' fit notes

A total of 57 questionnaires were returned relating to 'may be fit' notes. These included:

- 1 questionnaire for a fit note with both options deleted
- 1 questionnaire for a fit note with both options selected
- 4 questionnaires for fit notes where neither options were selected

Return to work outcome

Responses concerning the return to work outcome of the employees are shown in Table 7. In 94.7% of cases the respondent knew what had happened to the employee following the fit note. The greater proportion of employees (29.6%) had returned to modified duties and hours; 24.1% returned to normal hours and modified duties, 13.0% returned to normal hours and duties, 13.0% returned to modified hours, normal duties, 7.4% were issued with a 'not fit' note, 5.5% were issued with another 'may be' fit note.

Table 7. Employer questionnaire data for 'may be fit' notes

Question	Response	N=57	%
Do you know what happened following this fit note?	No	3	5.3
	Yes	54	94.7
If yes, what happened?	Modified duties & hours	16	29.6
	Normal hrs/mod. duties	13	24.1
	Normal hrs/duties	7	13.0
	Mod. hrs/normal duties	7	13.0
	Issued with a 'not fit' note	4	7.4
	Another 'may be fit' note	3	5.5
	Other	3	5.5
	RTW but don't know details	1	1.9

Communication between GP and workplace

In 11 (19.3%) cases it was reported that Occupational Health had contacted the GP regarding the employee's return to work, and in 36 (63.1%) of cases that they had not. Seven (12.2%) respondents reported that they did not know the answer, two stated 'N/A (not applicable) and one did not complete the question.

In two cases (3.5%) it was reported that the GP had contacted the workplace regarding the employee's return to work, and in 53 cases (93%) that they had not. In two cases the respondent did not know the answer to the question. Details concerning the GP's contact with the employee's workplace concerned letters and reports.

In four cases (7%) it was reported that the workplace had contacted the GP regarding the employee's return to work and in 52 cases (91.2%) they did not. In one case the respondent did not know the answer to the question.

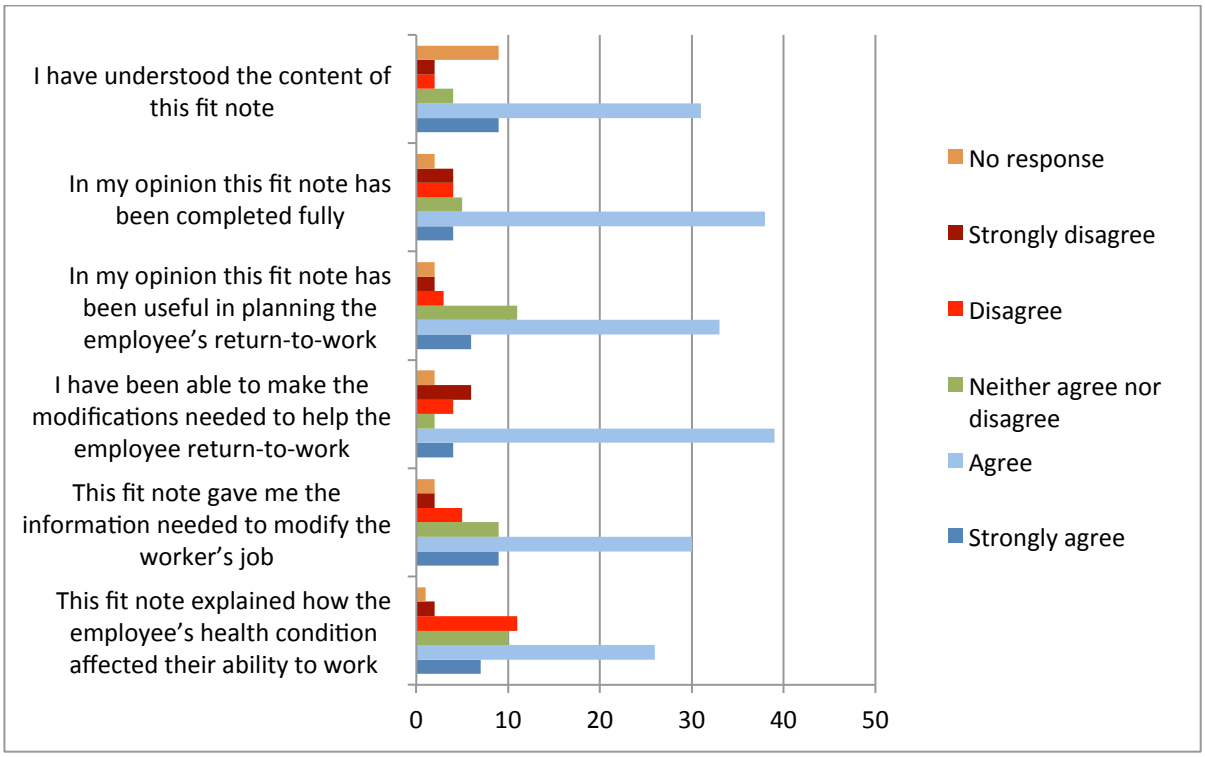
In five cases (8.7%) it was reported that someone else had contacted the workplace regarding the employee's return to work and in 44 cases (77.2%) that they had not. Seven (12.3%) respondents reported that they did

not know and in one case the response was missing. Contacts included communication between HR/manager/OH/private medical insurers and the employer.

Usefulness of the 'may be fit' fit notes

Questionnaire responses (n=57) made in regard to the usefulness of the 'may be fit' notes are illustrated in Figure 4.

Figure 4. Employer questionnaire responses regarding the usefulness of 'may be fit' notes (n=57)



I have understood the content of this fit note

- The greater proportion of respondents (40; 70.2%) agreed or strongly agreed with this statement, four (7.0%) neither agreed nor disagreed and four (7.0%) either disagreed or strongly disagreed. The remaining responses were missing.

In my opinion this fit note has been completed fully

- The greater proportion of respondents (42; 73.7%) either agreed or strongly agreed with this statement, eight (14.0%) disagreed or strongly disagreed, five (8.8%) were neutral and the remaining responses were missing.

In my opinion this fit note has been useful in planning the employee's return to work

- The greater proportion of respondents (39; 68.4%) agreed or strongly agreed with this statement, 11 (19.3%) were neutral, five (8.7%) disagreed or strongly disagreed and the remaining responses were missing.

I have been able to make the modifications needed to help the employee return to work

- The greater proportion of respondents (43; 75.5%) agreed with this statement, ten (17.5%) disagreed or strongly disagreed; and the remaining respondents neither agreed nor disagreed or did not respond.

This fit note gave me the information needed to modify the worker's job

- The greater proportion of respondents (39; 68.4%) agreed or strongly agreed with this statement, nine (16%) were neutral, seven (12.2%) either disagreed or strongly disagreed and two responses were missing.

This fit note explained how the employee's health condition affected their ability to work

- Just over half (33; 57.9%) of the respondents agreed or strongly agreed with this statement, 13 (22.8% disagreed), ten (17.5%) neither agreed nor disagreed; one response was missing.

Questionnaire comments

A total of 251 comments were made by the participating organisations in response to three items on the questionnaire. The greatest number of comments (n=152) was made in response to the question 'What, if any further information on this fit note would help/have helped you support this employee back to work?'.

The proportion of comments made per organisation varied. Some made a comment on almost every questionnaire whereas others had comparatively few or none.

A total of 32 different categories covering five main areas were identified through content analysis of the comments. Those categories where more than one comment was made are listed in Table 8 for each main area, with the number of comments made per category. The most commonly made comments concerned the need for further information, particularly regarding the need for review/reassessment by the GP (45), recommendations about return to work (45), the functional effects of the condition (37), the duration/prognosis of the condition (31) and diagnosis (25). Other frequently made comments were those regarding completion of the fit note (22) and whether the employee had been referred elsewhere for help in returning to work (24).

A total of 21 comments referred to cases where the fit note had been helpful. Fit notes perceived as helpful were clear, legible and well explained; gave detail on treatment and investigations and guidance on modifications; had stated whether or not the GP needed to reassess the patient and how the condition affected the employee's ability to work.

Table 8. Content analysis of employer questionnaire comments

Comment category		Number of comments
1	**The need for further information to be included on the fit note regarding:**	
	Review/reassessment by GP	45
	Recommendations/guidance on return to work	45
	Functional effects of condition	37
	Duration/prognosis of condition	31
	Diagnosis/condition	25
	Referral to specialist/treatment/investigations	18
	Cause of the condition	11
	Reason for 'stress'	8
	Clarity regarding duration of work adaptations	7
	Severity of the condition	5
	Details of surgery/post-operative recovery	4
	Information on progress (long term sickness)	4
	Clarity of medical terms	4
	Clarity/completion of duration of fit note	4
2	**General comments regarding the completion of fit notes**	
	Illegibility	12
	Too brief/incomplete	22
	The ability of GPs to complete fit notes	5
	GPs' awareness of the business perspective	2
3	**Specific problem with the fit note:**	
	Disagreement with the fitness for work decision	6
	Conflicting return to work date	4
	Capacity of the employer to accommodate recommendations	4
	Employee declined suggested RTW plan	2
4	**Action taken by the employer to facilitate return to work:**	
	Employee referred elsewhere	24
	Reports for further information requested	4
5	**No further information required**	
	Fit note helpful	21
	No further information needed or applicable at this time	12

Employer interviews

A total of twenty one participants consented to be interviewed. Interviews were conducted with at least one representative of each of the organisations recruited. Ten interviews were conducted with human resources managers, advisors or assistants, six with managers, three with occupational health nurses or advisors, two with company or managing directors. All interviews were conducted face-to-face and took place in the employer's workplace, apart from two which were carried out in the interviewee's home. Interviews took place between August 2013 and March 2014. Interviews took place between August 2013 and March 2014. The duration of the interviews ranged between 22 minutes and 68 minutes (mean: 37 minutes). The themes and sub-themes identified by the thematic analysis are shown in Table 9.

Table 9. Employer interviews: Main themes and sub-themes identified by thematic analysis

1. Overall opinion
2. Completion of the fit note
a. Legibility
b. Detail on the condition
c. The functional effects of the condition
d. Variation between GPs
e. Employers' needs not considered by the GP
f. Dates, duration and re-assessment
3. The 'may be fit' option
4. Perceptions of the GP consultation
5. Processing the fit note
a. The role of the line manager/supervisor
b. The role of Occupational Health
c. The role of Human Resources
d. The role of the employee
6. Communication between the workplace and the GP
a. Opportunities for increasing contact
b. Medical reports
c. Sending fit notes electronically
7. Knowledge and understanding of the fit note and training needs
a. Employer training
b. Employee training
c. Joint training for GPs and employers

1. OVERALL OPINION

The majority of the participants thought that the fit note was an improvement on the sick note and supported the principle behind it. Others saw little difference between the two. However, it was generally felt that fit notes would be more useful to employers if they were completed and used effectively. Some thought the fit note had made little impact on sickness absence within their organisation, others that it had enabled employees to return to work sooner.

Others believed that the fit note had made sickness management more difficult for the employer:

A sick note and a fit note are practically the same, apart from the fact that for employers the fit note is more onerous, because it puts the emphasis on the fact that the employee can, in some way, do work. (EMP_19)

There was a perception that some organisations were now receiving fewer 'may be' fit notes than when the fit note was originally introduced:

Yes definitely less and less of 'may be'. I prefer the 'may be' because if there is something we can do to get someone back into work, when they first came out doctors were ticking those and it allowed us to say, oh right okay you might be fit for work come in and let's have a chat. (EMP_14)

2. COMPLETION OF THE FIT NOTE

a. Legibility

Most participants stated that a fundamental problem with fit notes was legibility. Illegible information could not be acted upon. Electronic fit notes were preferred as they were easier to read. There was also a perception that the electronic fit note might ensure that all sections were completed:

What I have noticed is you know the electronic versions, it looks to me as though they have to complete that bit with the electronic version. Maybe because the doctor's going onto the system and completing it on the computer system and maybe it doesn't allow him to continue unless he's filled in certain areas. So it's always filled in on the electronic ones, but on the written ones a lot of the time it's not filled in. (EMP_12)

b. Detail on the condition

A common complaint from participants was that GPs often recorded something in the 'condition' box for medical conditions, which the employers did not perceive to be a health condition, and therefore queried whether a fit note was justified. Examples included the terms 'low mood' and 'tired'.

Participants reported problems in interpreting the fit note due to the use of medical terminology and jargon by GPs. Few interviewees had any sort of medical knowledge so were reliant on others or the internet for information. Where OH services were available these were consulted if an explanation of the medical condition was required. Employers were loath to go back to the GP to provide a fuller explanation as this could incur a substantial fee. A more complete fit note might avoid this.

Employers reported that some conditions seemed to come in and out of fashion, indicating that they questioned the validity of these fit notes:

Then stress was quite in vogue for a while. I notice now there is an increase in an illness I'd never heard of five years ago, fibromyalgia, which is basically what my mother would call aches and pains. That seems to be another - that seems to be morphing into the top ten of popular conditions (EMP_6)

For some conditions, particularly mental health problems, employers were particularly keen to know what the 'cause' was:

so you will get something that will say 'stress', or get something which says 'depression'. And there's no guidance as to what the cause of that could be. So is it work-related? Is it something that we could be helping? Is there something that we could be doing externally to support that person if they're having a difficult time? Often, my own personal view would be that sometimes when there are performance issues, that it's a get-out for an individual and really we'd like to support them and help them with that, as opposed to them being absent from work. And it tends to be just a blanket sign-off, as opposed to anything that we could perhaps help them within the organisation (EMP_5)

'Stress' was perceived by most employers to be particularly difficult to manage:

Many times in my career I've been presented with work-related stress. And as the employer, you're utterly powerless. You're utterly, utterly powerless. And you get no information whatsoever. (EMP_11)

These employees were more likely to receive continuation notes:

That's a major problem with the medical certificates, that's one of our biggest problems because they'll just go back to the doctors and they'll be signed off time and time and time again. (EMP_17)

If the fit note stated 'work-related stress' it would usually trigger an automatic referral to occupational health, if that facility was available. Employers acknowledged that in some cases the GP might not reveal the true condition on the fit note if it was of a sensitive nature.

More information was also expected on any interventions such as specialist referrals or investigations that might be taking place.

c. The functional effects of the condition

More information was not only required as to the condition but also what the GP believed was the functional impact. Employers needed to know how the condition might affect the employee and how this might impact on their return to work - or - when they returned to work, whether they would be likely to have any more time off. Employers also required information on what the employee could actually do rather than what they could not do:

It would be helpful if when they said, you know, what a condition was, that it explained the impact that that has on an individual. So even if it's just, a headache, or a migraine, that means they can't deal with bright lights or loud noises or need to be somewhere quiet, need to rest; just something that just helps elaborate it because then you think well why does that mean that they can't come into work? (EMP_5)

This was important in 'not fit' as well as 'may be fit' notes. Where employees had more than one condition, employers felt it should be clear which condition the fit note referred to, and if an employee had more than one job, if the advice should cover both jobs.

d. Variation between GPs

Employers noted that some GPs were better at completing the fit note than others. They felt that some GPs put more effort into enabling their patients to return to work at the earliest possible opportunity:

And it's that sort of suggestion, it's that the GP's just not bothered, just filled it to get him out there. Do you know what I mean? Something that was rushed, hurried and — I know GPs haven't got the best, aren't the best hand writers, but if somebody's actually there putting details down, it just looks as though they actually considered what they're doing. It's interpretation, it just gives that perception. (EMP_8)

e. Employers' needs not considered by the GP

Although fit note information is expected to be read and acted on by the employer, many participants felt that GPs did not have the employer in mind when completing the fit note. Their needs did not seem to be considered. They needed information to help them plan what staff cover might be required, and gauge the impact on other employees:

GPs need to understand you know, how it affects – negatively affects – other people in the work force, particularly on a production line. You know, this guy being off meant everybody else had to double up and that creates, you know, there are consequences. There are always consequences. And I think GPs need to understand that. (EMP_10)

If there was more information on the fit note it would save the employer the time and money required in requesting a full GP medical report, and could avoid the need for, or help to inform, a referral to Occupational

Health. Some organisations required fit notes to cover bank holidays, which GPs might charge the employee for.

Employers sometimes felt that they were being deliberately kept in the dark by the GP:

> *GPs put that there so as just to hide the condition. Like rhinitis is a runny nose - we are not silly this side of the table. We will look things up, so give us a bit of respect. (EMP_4)*

f. Dates, duration and re-assessment

The duration of the fit note was of paramount importance to the employer as it gave them an indication of how long they might need to arrange work cover. However employers reported ambiguity in the completion of the date section of the fit note. They would prefer the GP to sign someone as not fit for the probable length of time that their medical/mental health problem would make it impossible for them to fulfil their role. Instead they perceived that GPs 'err on the side of caution' and sign patients off for repeated consecutive periods of one or two weeks making it very difficult for the employer to manage:

> *If I were to express cynicism it's the ones where someone comes in, they're signed off unfit for two weeks. Two weeks goes by, they get another two weeks and then another two weeks and then another two weeks and then another two weeks. Which sort of, on reflection begs the question, well why didn't the GP spot this as a potential long-term sickness in the first place? (EMP_6)*

Not all participants were aware that the employee does not need to be signed fit for work unless the GP specifies this on the fit note, or that the fit note is advisory. Some employees attempted to return to the workplace prior to the expiry date on the fit note. They are entitled to declare themselves fit for work but many employers insisted that they would tell the employee to return to their GP to get signed fit for work:

> *I think the majority of our employees know that if they want to come back to work prior to the end date, then they should get it amended. They should go back to the GP and get an amendment that signs them back to work fit, because if it says you are unfit and they come back the middle of it, from our understanding is they're not insured to be at work from our company insurance, liability insurance. (EMP_13)*

Other employers believed that the fact that the onus was on the employee to declare themselves fit for work was a positive thing. They perceived that employees do not seem to be aware of this responsibility however. They also perceived that it was easier for the GP to leave it up to the patient to decide if they were well enough to return to work and saved unnecessary appointments. Participants thought that GPs could be clearer about the actual date when the employee was expected to return to work:

3. THE 'MAY BE FIT' OPTION

The majority of participants welcomed the introduction of the 'may be fit' option on the fit note as it was seen as a constructive way of getting employees back into the workplace. However, the recommendations made by the GP needed to be practicable and clear. The 'may be fit' note allowed for the opening of a dialogue between employer and employee on how they might be accommodated back into the workplace. Some saw them as an unwelcome addition to their workload:

> *These boxes and the general vague information that the GP puts are more hindrance than use to us. We have a policy –if any of these boxes are ticked or comments are mentioned, the immediate line manager has to hold a meeting with the employee and say, "Can we accommodate or can't we not accommodate?" basically. So that's extra administration that we didn't have to do before. Before it was either, "Yes, you can come back," or, "No you can't." There was some ambiguity in it, but it's more ambiguous now than it was. (EMP_19)*

Some modifications were easier to apply than others. Phased returns or altered hours were comparatively easy to implement and meant that the employee could return to work in some capacity. However, the period suggested for the phased return was often too long and consequently impractical. The optimum period for a phased return with most employers was reported to be two weeks.

The selection of 'amended duties' could be more onerous for the employer as there was not always the opportunity, and in some cases the inclination, to implement these changes. Some employers felt pressured into creating non-productive roles for employees in order to get them back to work. This has obvious cost and staffing implications for the employer. Employers consequently reported that they would prefer the employee to remain absent as this would be the easier and cheaper option:

> *Because not only are we actually covering the individual's role that they're not able to undertake, most of the time we're creating a role for them to undertake which is not then a productive role because it's not a role that's really necessary. Plus, we're having to have somebody there to mentor them, to train them, to shadow them. It's actually easier to manage that individual's absence (EMP_8)*

Although modification options might be selected, they were often not supported by further advice that the employer considered important.

Other participants believed the fit note placed extra demands on the employer and raised the expectations of the employee. They perceived that GPs did not always ask the patient for any details about the requirements of their work, and that this placed the onus on the employer to interpret when, and in what capacity, the employee could return to work. Some employers reported that they would prefer a fit or not fit decision to be made by the GP as this would make administration easier.

The more specific the advice, the more helpful it was reported to be by the employer. Terms such as 'light duties', 'reduced hours' and 'must not be placed in a stressful environment' were seen as non-specific. Employers wanted examples of what could and could not be done.

Employers found that they could not always comply with the recommendation made by GPs on the 'may be fit' note. They reported that employees had false expectations raised by their GPs due to the GP having little knowledge or insight into the demands of the patients job which could impact on relationships in the workplace. Employers might advise those on long-term sick against being issued with a 'may be fit' note as this would 'complicate matters' and would involve more formal meetings**:**

> *If we want the employee back to work, during a long-term meeting I would typically say to them, you know, "This is an example of a fit note and if you tick any of these four boxes, or if you put any comments in here, we're going to have to have another meeting with you to discuss this. Either get the fit note and bring it to your next formal meeting for us to discuss, or simply not have any of this and we will discuss it with you and then have you back to work on an agreed return schedule." (EMP_17)*

4. PERCEPTIONS OF THE GP CONSULTATION

Employers thought that GPs were giving out 'not fit' notes 'too easily' without a full assessment being made, and that this was because GPs had a very large workload and were under pressure of time.

Employers wanted to know more about the process of the consultation, how the subject of sickness absence arose and how the judgment about fitness to work was made:

> *That would be invaluable as well, in terms of what are people asking for when they go and see the GP; what are they asking for? Are they presenting and saying, "Please may I have a sick note because I've got a knee injury." Or are they presenting and saying, "Please can you have a look at my knee." Who gets to judge whether that guy there couldn't have hopped in; his wife could have driven him on her way. (EMP_11)*

Employees were perceived to have considerable influence in the consultation:

> *Because I'll sometimes say to them did you tell your doctor what work you do here, or did your doctor ask you? Or did you tell your doctor that you might be able to come back on other hours or on a different type of a job or something like that on a temporary basis. There might be something else that you could do if you can't do your normal job, depending as I say on what the situation is with them. So one just wonders what the situation is when they actually go to the GP. They're telling us*

one thing and probably the GP saying something else and they're not quite getting it across to us as they should do. I think there is a loss of communication there definitely. (EMP_12)

Employers believed that it was the GP's responsibility to find out about their patients' jobs, whether by face-to-face or telephone consultation. This would enable them to give more informed advice to the employer on what aspects of the job the patient might have problems with and might avoid unnecessary sickness absence. It was seen as the GPs responsibility to ensure that, if there was any chance of the patient returning to work, they would issue a 'maybe fit' note with recommendations to enable a return to work:

I think just for a doctor to say 'no', perhaps without delving a bit deeper into the patient's job, I think, you know, perhaps they could be writing people off that don't need to be at that time. (EMP_3)

They recognised that GPs were at a disadvantage, and that their advice could be one-sided. One participant believed that the GP should not produce a 'not fit' fit note purely on the basis of the patient's self-report. If the GP stated on the fit note what the patient was actually capable of doing, then the employer might be able to accommodate the employee back into work with some changes to their role.

5. PROCESSING THE FIT NOTE

The way that the fit note was processed differed depending on the size and structure of the company and the in-house services they had access to. In some cases the fit note was received directly by HR who had an overview of the whole sickness and absence process. In others the fit note was sent initially to the line manager, or to an administrator or receptionist. On occasions it went directly to the company director or the occupational health nurse. A copy of the fit note was then sent to wages or payroll staff/departments. Usually the employee was required to phone in and speak to their manager on the first day of absence. Some, but not all employers had a process for dealing with the 'may be fit' option, but this would depend on when the fit note was received.

An important aspect of the fit note, according to employers, was the time taken to process it. Employers requested that the fit note be forwarded to them at the earliest opportunity but this was not always straightforward as the note had to be brought in personally or posted. Employees might not want, or be able to, deliver it in person. The fit note did not always go to the correct department which posed consent and confidentiality problems:

If someone's off with stress, they don't want to come to work to give you their medical certificate. So they'll post it to you, second class, and by the time you get it, they may have come back, or their medical condition has changed, or it goes somewhere else. Sometimes it can go to a random other department and as a confidential piece of paper that's not marked so, is opened and is forwarded to us. (EMP_19)

The fit note might be sent to the employee's line manager who might fail to forward it to HR, or it could be handed in at a reception desk. Administratively this made the process more protracted than necessary and delayed getting the employee back into the workplace. In the majority of cases, the employer kept the original fit note rather than taking a copy and returning the original to the employee.

a. Role of the line manager/supervisor

In some organisations, the procedure was for the employee to send the fit note directly to their line manager, with variable consequences:

Well either the individual will hold onto it or they will hand it to the manager. The manager will file it somewhere, forget to send it on. Yes, it – there are a variety of different things, so it's sometimes we don't receive the fit note and then when we get it we will ring the manager. It's, "Oh no, they are back. They came back the other day." Or last week, or whatever it is. (EMP_1)

Other organisations had different systems in place because they felt that they could not rely on the manager:

If the line manager dealt with the fit note it would probably get lost en route. It would probably never make it from the ground floor to the first floor. (EMP_14)

It was felt by non-managers that the managers saw the fit note as more of a hindrance than a help, particularly if they had no clinical knowledge. Managers were reported to be more interested in when employees were returning to work rather than the content of the fit note. However, the ability of line managers to manage their teams was perceived as variable. Some managers struggled with undertaking risk assessments and making adjustments:

> *But when you've got to start thinking about someone's condition and their duties and the manager and the operation, can we get this person back in and make all these amendments when time is of the essence. And it can be a challenge to try and get the manager to be as sympathetic as we like to be, that this person can come back but you're really going to have to change their duties….he's got a mass of time constraints and lots of other issues. And the last person he needs to deal with is someone who's been sick for six months and now wants to come back. He's got bigger, you know, problems…..we're trying to get that message across that, okay, it's not ideal that they're at home and we're paying for them to be at home - if they come back to work, that is the best thing really. And some managers are better than others. That's the nature of life, I suppose. (EMP_13)*

In some organisations, the line manager might deal with fit notes for conditions such as stress or mental health problems. The only time when it might not be applicable for the line manager to be in touch with the employee was when there were work related stress issues involving the employee/manager relationship. In others, for example one organisation were fit notes were sent directly to HR, line managers were not informed of the health condition, although they were likely to find out unofficially:

> *I don't give them the diagnosis. Nine times out of ten the manager knows what that person's off with just because rumours or that person has rang and spoke to a supervisor and said, "I'm signed off with depression." And then that supervisor will relay that to the manager. And then if they don't tell anyone what they're off with, they might have told a friend and then, you know, they say, "Oh why's Fred Bloggs off work? Do you know what's wrong with him?" "Oh no, he's, you know, he had a bit of an issue at home. He's suffering from stress at the moment." So rumours go around and generally they'll know what's going on with that person, even if we've not said. (EMP_13)*

It was seen as important that the line manager maintained contact with the employee during their period of sickness. However, line managers felt that the onus was on the employee to keep them informed on the progress of their medical condition. Most of the managers interviewed did not want to get into a situation where they were questioning employees about their illness as it might be awkward for both parties.

Some organisations were investing in absence management training for line managers to improve their procedures.

Where a good relationship existed between the manager and employee, then this could lead to informal arrangements being made between employer and employee. This allowed for workplace changes to be made to enable the employee to return to work without the need for a fit note:

> *I can think of two examples of employees who have said their doctor has offered to give them a fit note to say they are not fit, and they've declined to have that note and come to work, and they've been okay at work. What they've done, on both occasions, is come to me and said, "Look, I've been to the doctor. They've said they would sign me off, but I don't think I need to be, but can we amend my hours, can we amend my duties?" We have done that on an individual basis with a member of staff. (EMP_16)*

b. Role of occupational health

Those organisations that had their own in-house occupational health (OH) service tended to rely on it for help in interpreting the fit note as they were considered better placed to advise the employer on how the employee's condition might impact on their work.

If it became apparent that the condition given on the fit note was incorrect, that the duration of the fit note was dubious, or if there were several consecutive fit notes, the opinion of OH was sought instead:

say if it said headache or migraine and they were going to be signed off for six weeks then I probably wouldn't notice it to start with. It would be (OHA) that would know what the condition was and she would then say, "Hang on a minute, that's quite a long time off work for headaches. You know, there's more to this than, you know, meets the eye." (EMP_13)

If the OH service was contracted in, then this had cost implications. However, the involvement of OH could also save the time and cost of requesting a GP report to back up the information given on the fit note.

Employers reported that the involvement of the OH advisor or contracted OH service at an early stage, particularly with stress and other mental health issues, was vital to getting the employee back to work:

We just explore it with the employee and if we need more information then we possibly – things like the stress ones, and bereavement, anxiety, we tend to involve our Occupational Health providers in helping us understand the condition, what the impact is on work. (EMP_18)

If there was disagreement between the employee and GP regarding their return to work, these cases were often referred to OH, particularly if the fit note stated that they were not fit. Employees might need educating as to whose advice took precedence in these cases:

I mean, individuals sometimes don't understand that Occupational Health overrules the GP's note, and we explain that to them, because obviously GPs can't always understand the implications of somebody not being at work and what kind of role they do. And that's the purpose of Occupational Health, really. (EMP_7)

Most employers with internal OH facilities reported that the management of sickness absence would be more complicated and time consuming without OH input.

Managers and HR representatives were very clear that any communication between the GP and the employer should involve the OHA as they had the necessary knowledge and experience. The OHA was often in a better position to discuss mental health issues, particularly when the patient was unhappy with the employer having information on their health problems.

When there were doubts about the employee's ability to act as an intermediary with the GP, OH could perform this role. Most employers with an in-house OH service reported that it was they that made contact with GPs or other medical professionals rather than HR or line managers. OH services were utilised to act as a 'go between' when the fit note specified that the employee had mental health issues.

It was perceived that OH would be more likely, and better able, to communicate with GPs more effectively than HR or managers. It was felt that their medical expertise would give them a better chance of getting accurate information from the GP:

When we go to occupational health they are usually - I think because obviously the medical – in the medical profession, GPs are more inclined to give them the information that we are requesting. So sometimes there is a bit of a blockage getting it directly from the GPs. They will, I think being in the medical – medically trained, it sort of does help that. (EMP_1)

Workplace assessments and return to work procedures, if carried out, were generally overseen by OH representatives in conjunction with line managers. The OH advisor would usually be the one who making decisions on whether the employee was fit to return to their role or if workplace modifications needed to be applied. There was a perception that employees would feel more comfortable speaking to OH rather than their own manager particularly when there were mental health issues.

c. Role of Human Resources

HR representatives interviewed reported that one of their main roles was the monitoring and recording of sickness absence. They also offered advice and assistance to line managers in the management of sickness. In some cases HR received and processed the fit note. Relevant information would be relayed to the manager by HR and the sickness absence procedure would be monitored by HR:

As a department, they come into HR rather than via managers, and then we speak to the managers directly, you know, promptly see to the fit note and then we deal with them and process them for payroll. (EMP_3)

They also provided prompts for the manager and communicated with the employee if necessary. The HR department also saw it as their role to communicate any relevant sickness absence regulations to the manager. This was particularly pertinent when there was an issue of work related stress as it was seen as inadvisable for the line manager to contact the employee. HR was also instrumental in the setting up of welfare meetings either individually or in conjunction with an OH advisor:

Some people don't feel comfortable talking to their supervisors anyway and they'd rather it be with sort of HR, anything confidential, and you know, on the sideline. But yeah, we will talk to them about it and try and see if we can find out a bit more and sometimes they are willing to talk to us, and sometimes they are not! (EMP_5)

d. Role of the employee

Participants perceived that employees should be more aware of their responsibility for their own health and wellbeing. It was felt that the employee adopted a fairly passive role and did not communicate regularly enough with the employer. In some cases they felt that the need for a fit note could be avoided:

They think they can just run along to their GP, get a fit note and that is it, that is 'me done'. Instead of actually taking the responsibility for their own health and wellbeing and actually talking to the manger if they have got a problem. (EMP_2)

Many of the companies included in the study had access to an Employee Assistance Programme or a well-being service. Employers were keen to point out that employees had the opportunity to contact these confidential services where they could receive advice and counselling. It was also perceived that employees had certain roles and responsibilities in managing their return to work and keeping the business informed about their absence and possible return to work date. However, interviewees were unsure whether employees knew how to use the fit note:

Again, I'm not sure whether they know that they can come back before it expires. I think they just wait for the expiry date and then return. I think it's a combination of things, but I think probably they just don't know, they don't realise they can. (EMP_18)

Although there was a feeling amongst a small proportion of employers that their employees were 'colluding' with their GP to stay off work, the majority felt that employees would prefer to return at the earliest opportunity. This was seen to be not only for financial reasons but also because employees didn't want to be 'stuck at home' unnecessarily.

HR in particular felt that they had to 'chase' the employee to find out more about the progress of their medical condition. Employees were reported to rarely complete the section on the back of the fit note and needed to be reminded to do this – although some considered this to be the GP's responsibility. Employers wanted employees to take a much more active role in the management of their own sickness absence, and directed employees as to how to manage the GP consultation:

we would then say to the employee, "No, I want you to go and explain these main aspects of your role," and then the GP can then provide some really valuable information on the fit note coming back to work. (EMP_9)

6. COMMUNICATION BETWEEN THE WORKPLACE AND THE GP

a. Opportunities for increased contact

All participants reported problems communicating with GPs. Whilst they acknowledged that increased communication might raise problems around confidentiality, all felt that it would assist in accommodating employees back into the workplace after a period of sickness. Although some managers thought it valuable to

have some mechanism whereby they could contact GPs regarding fit notes, most of those interviewed thought that ideally all GP contact should be through OH. In the absence of an OH service then HR would make any contact required and would convey any salient information to the line manager.

Having to obtain permission from the employee before approaching their GP for information made the process more protracted than necessary which was why many employers used their OH service as an intermediary. Employees, however, did not always give consent, even to OH:

> *That gets frustrating again because you don't want to have to be in a position where you are dismissing someone from their role because they refuse consent because they have a socially unacceptable disease, which we've done and it's difficult, really. What can you do - if you don't have the information? (EMP_19)*

HR professionals particularly felt the need to communicate directly with GPs whether by phone or email. They felt that this assisted in supporting the employee back in to work and raised the understanding amongst GPs of the pressures that the fit note placed on employers:

> *What's frustrating for me sometimes is that it's not a two way dialogue with doctor……I don't feel I could ring a GP up and say, I want to talk to you about that sick note that you sent in for so and so. You see, the thing is they're only listening to the patient aren't they. (EMP_15)*

b. Medical reports

If employers wanted more information from the GP about a patient's fitness to work, the main route was by requesting a written report. An important issue for employers was the length of time it took to get a medical report from the GP. On occasions the report had arrived after the employee had returned to work:

> *The only criticism I would have, and it's a major criticism, is that when we've written to GPs for a medical report, which as you know you need the consent of the employee. So we get the consent. It's the amount of time it takes to get it. It takes weeks for them to respond and I've not actually written - certainly since I've been here I've not had cause to write to many GPs, but I reflect on previous employers I've worked at it takes weeks. And when I say weeks, I don't mean one or two it can be seven or eight or nine or ten and that is a criticism. (EMP_6)*

Some GPs, when clarification of the fit note was requested by from the employer, reported that they were not qualified to give OH advice. There was also some cynicism expressed about GP reports:

> *And I guess if they gave us lots more information [on the fit note] and we don't ask for the reports, they'd lose that revenue wouldn't they?!.... We can get fantastic medical reports back for, say, £30. I've had one sentence back for £150. (EMP_14)*

c. Sending fit notes electronically

Employers reported that they would find the opportunity to receive fit notes electronically an advantage. An electronic fit note could potentially be linked to payroll systems further automating sickness absence procedures. Employers did acknowledge that there would be confidentiality and data protection issues but did not think that these were necessarily insurmountable. This would however require the systems being used by GPs to be compatible with those of the employer:

> *You know, it's an electronic world and these hand-written notes, whereas there should be some software within a GP's system that links with some system within employers that you could just get an email. (EMP_11)*

7. KNOWLEDGE AND UNDERSTANDING OF THE FIT NOTE AND TRAINING NEEDS

It was apparent during the interviews that several of the participants, and/or their employees were unclear about aspects of the fit note. This was particularly pertinent of the need for the GP to re-assess the employee before they returned to the workplace, and whether or not the GP's advice could be disregarded. There were differing views on the need for further education/training in the use of the fit note.

a. Employer training

Few of the participants had received any training in the fit note, or were aware of any guidance and had mainly gained the knowledge they had through experience. Some remembered receiving information when the fit note was introduced, but little else since.

Some thought that more formal training would be useful. Those employers with access to in-house OH services felt more confident in the interpretation of the fit note and consequently less in need of training. Some considered that because line managers had little to do with fit notes that training was not required, whereas others disagreed and were taking steps to address this:

> *Some managers automatically freeze when they see a fit note with recommendations, and they think 'How on God's earth am I going to be able to support that?' And that is part of the plan, that Occupational Health are going to deliver some sickness absence management to the managers, and we would look at the likes of fit notes and supporting managers in implementing that. (EMP_9)*

b. Employee training

A minority of participants thought that employees had a good understanding of the fit note, and actually used this to their advantage - either to return to work before they were able, or to negotiate absence fraudulently. However most participants perceived that employees had little, if any, knowledge of the fit note, and that their main concern would be about whether they were 'covered', and how their attendance was being monitored. Many employees would not have had much experience of the fit note and would not understand the difference with the 'sick note'.

Some employees might have received information about sickness absence policies in their induction. Not all participants saw a need to provide employee training, although they recognised that a greater understanding might assist the consultation.

Some felt it was the GPs responsibility to inform patients about the fit note during the consultation:

> *I suppose we assume that when a person asked to actually go and get a note or is given a note (laughs), whichever the case may be, then we would expect that the GP would explain or that they would actually read what it says on the note itself, even on the back. Because there is guidance on there for them as well. (EMP_12)*

Others considered it could perhaps be addressed at work.

c. Joint training for GPs and employers

Most participants felt that the opportunity for joint training with employers and GPs would be beneficial. This would allow both parties to understand the fit note from the others perspective:

> *Rather than just people moaning about each other it would be useful to actually have that dialogue so that GPs understand what employers are trying to achieve, which, ultimately is actually getting and supporting the individual back to work. Rather than just letting them hide behind a fit note, which is sometimes what we think happens. (EMP_2)*

One organisation reported making attempts to bridge the gap with GPs but without success:

> *we invited local GPs in here just to come and have a look around the building look at the facility. And we didn't have one up-take. (EMP_14)*

2.2 PATIENT STUDY

2.2.1 Aim

The aim of the patient study was to explore and evaluate actual fit note data, and to examine the perceptions and experiences of employed patients concerning fit notes, in order to inform the statements for the consensus study.

2.2.2 Method

Participating GP practices were asked to give study information packs to all employed patients to whom they had issued a 'new' fit note (i.e. not a continuation fit note). The information pack included a reply slip, information sheet and freepost envelope. If the patient was interested, they were instructed to contact the research team either by phone or email, or by posting the reply slip with their contact details. If the participant was willing to take part, their written consent was obtained, and the researchers requested an anonymised copy of their fit note from their GP practice manager. Six weeks after the fit note had been issued patient participants were sent a questionnaire asking them to rate the usefulness and outcome of their fit note.

Twenty of the patient participants were interviewed at the end of the data collection period, half of whom had been issued with a 'may be fit' note and half who had not. Recruitment was based on the available resources and timeframe of conducting the study. Each interviewee was offered a £25 gift voucher as a token of appreciation.

Participating GP practices received an incentive of £250 when a minimum of four patient participants took part in an interview. All of these patients had to have been issued with a 'new' fit note (i.e. not a continuation) and at least two had to have been issued with a 'may be fit' note.

Postal questionnaire

The questionnaire comprised three main sections:

1. The outcome of the fit note on the employee's work status
2. Communication, in addition to the fit note, that had taken place between the GP and the workplace (including occupational health).
3. The respondent's perceived usefulness of the fit note.

Separate questionnaires were developed for 'not fit' notes and 'may be fit' notes by the research team, with input from the steering group. The questionnaires were piloted with three university employees who had been issued with a fit note in the previous twelve months. Minor amendments were made to the wording of some of the questions as a result.

Semi-structured interviews

Interviews were recorded using a digital voice recorder, and took place at the home of the participant or at the work base of the research team. A list of topic areas and prompts were developed by the research team and included:

- Knowledge and experience of fit notes.
- Opinion of the usefulness and acceptability of fit notes received
- How fit notes might be improved/used more effectively
- Views as to the need to facilitate dialogue between employees, employers and GPs and how this might best be achieved.

Analysis

Interview data were transcribed verbatim in Word. Each transcript was checked and corrected by the researcher conducting the interview. Each transcript was then uploaded onto Nvivo 10. The researchers conducting the interviews then independently coded a sample of interviews line-by-line, then compared and revised these initial codes. Each interview was then coded and themes identified through constant comparison of the scripts. Themes were then discussed, revised where needed and finally agreed.

Recruitment

The overall aim was to recruit five GP practices from Nottinghamshire and Leicestershire.

A combination of sampling methods was employed in order to ensure a representation of a range of socio-economic settings (identified by Indices of Multiple Deprivation (IMD) rating of the practice). We also wished to recruit a minimum of 20 patients, half of whom had been issued with a 'may be fit' note.

GP practices that expressed an interest in the study were visited by members of the research team, who described the study and answered any questions. Written consent was obtained at, or following, the meeting.

2.2.3 Results

Participants

A total of six GP practices expressed an interest and agreed to participate in the study. Practices included those located in areas of the lowest (10), middling (4) and highest (1) levels of deprivation.

Fourteen patients contacted the research team about the study between August and November 2013. Of these, three were unemployed and so did not meet the eligibility criteria, and two could not be contacted. Only one of the patients had been issued with a 'may be fit' note. Due to the slow recruitment rate, a three month extension was obtained from the Northampton Research Ethics Committee and permission was given to recruit GPs participating in the GP arm of the study to also hand out information packs. A further two patients were recruited as a result, thus a total of eleven patients were recruited, two of whom had been issued with a 'may be fit' note. All participants completed a questionnaire. Of these, one participant declined to be interviewed; thus ten interviews were conducted.

Demographic details

Six participants were male and five female. The mean age was 43.5 years (range 29-65). Seven were White British, one was Asian, one British Asian, one Polish and one Indian.

The participants were engaged in the following occupations or professions: stores; jobcentre; postal; call centre; receptionist; assembly line; solicitor; sales; warehouse work.

The conditions recorded on the fit note ranged from specific diagnoses to more general conditions such as 'low back pain' and 'stress at work'.

Fit note data

- Nine of the eleven fit notes were 'not fit' notes, two 'may be fit'. The duration of the notes ranged from 1 to 6 weeks. The most common duration was 2 weeks.
- In eight cases, a copy of an electronic / computer-generated fit note was provided. In two cases the practice sent a duplicate copy of the handwritten fit note. In one case the practice sent a summary of the entry in the patient records as they were unable to provide a duplicate.
- Six of the electronic / computer-generated fit notes differed from the official format. Differences included no option to select a work modification, the heading for the comments section was 'medical

condition comments' rather than 'comments including functional effects of your condition' and the 'may be fit' option was labelled 'fit for work with restrictions'. The section concerning whether or not the GP would need to re-assess their condition was missing.

- Neither of the 'may be fit' notes had a work modification option selected. Three fit notes (both 'may be fit' notes and one 'not fit' note) included a comment, one of which referred to the functional effects of the patient's condition.

- In neither of the handwritten fit note copies had section on the need for the GP to re-assess the patient's condition been completed. This section had been completed in only two of the 'not fit' notes.

Questionnaire data

Following their fit note, four participants who had received a 'not fit' note had returned to normal hours and duties at work; three had returned to normal duties but with altered hours (including both those issued with a 'may be fit' note; four had been issued with another 'not fit' note.

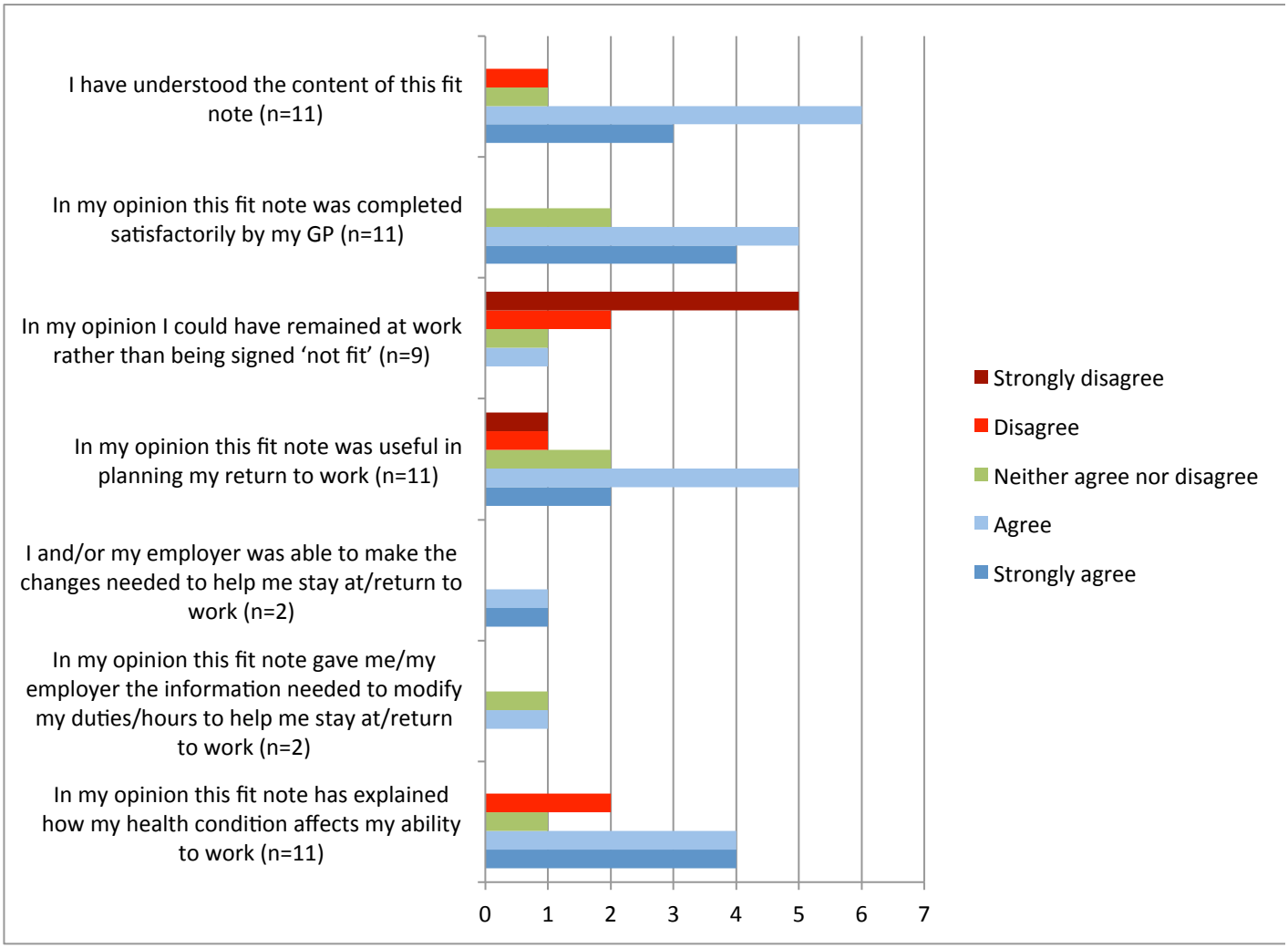
Six participants reported that their employer provided an occupational health service. Of these, four reported that there had been no contact between occupational health and their GP. Two did not know if there had been any contact – one of these participants had received help from a Fit for Work Service. Another participant had been contacted through her employers by an ergonomist regarding her return to work.

Three participants reported that their employer did not provide an occupational health service and two participants said that they did not know whether or not this service was provided.

Patients' perceived usefulness of the fit notes they received is illustrated in Figure 5.

- Nine participants (91%) either agreed or strongly agreed that the fit note had been completed satisfactorily by their GP.
- Nine participants (82%) either agreed or strongly agreed that they had understood the content of the fit note.
- Eight participants (73%) either agreed or strongly agreed that the fit note had explained how their health condition affected their ability to work.
- Seven participants (64%) agreed or strongly agreed that the fit note was useful in planning their return to work
- Of the nine participants issued with 'not fit' notes, the majority (7; 78%) disagreed or strongly disagreed that they could have remained at work rather than being signed 'not fit'
- Of the two participants issued with 'may be fit' notes, both agreed or strongly agreed that their employer had been able to make the changes needed to help the participants stay at work

Figure 5. Patients' perceived usefulness of the fit notes received



Patient interviews

A total of eleven participants were recruited to the patient arm of the study. Of these, ten agreed to take part in a face-to-face interview. All interviews took place at the participant's home, except one conducted at the researcher's workplace, between October 2013 and May 2014. The duration of the interviews ranged from 25 to 50 minutes (mean 38 minutes). Two of the participants had been issued with a 'may be fit' note on entry to the study; the remaining eight participants had been issued with a 'not fit' note.

The main themes and sub-themes identified as a result of thematic analysis are shown in Table 10.

Table 10. Patient interviews: Main themes and sub-themes themes identified as a result of thematic analysis

1. The GP Fit Note
a. Knowledge and understanding of the fit note
b. Opinion of the 'may be fit' option
c. Clarification of the term 'fit note'
d. Information about the health condition
e. Comments on the functional effects of the condition
f. Re-assessment by the GP
2. The GP Fit Note Consultation
a. How the subject of sickness absence arose
b. Telephone vs. face-to-face consultation
c. Continuity
d. Variation in GP approach
e. GP reliance on patient report
3. Workplace Management
a. Delivery of the fit note to the employer
b. The experience of sickness certification and the return to work process
c. Experiences related to stress at work
d. Other opportunities for communication between the GP and the workplace

1. THE GP FIT NOTE

a. Knowledge and understanding of the fit note

There was little knowledge or understanding among the participants of the change in sickness certification. Of the two interviewees issued with a 'may be fit' note, only one had prior experience or knowledge of a fit note. Most participants reported little previous experience of sickness certification and/or infrequent consultations with their GP. Of the eight participants who had been issued with a 'not fit' note, all except one reported no knowledge of the change in certification, despite the fact that this information is provided on the reverse of the fit note:

> *I mean, to be honest, this is the first time I've seen this one, the new type. I just read it and saw I was unfit to work. I didn't read the others saying – I didn't notice those. And to be honest, I didn't realise they were there. (PAT_4)*

There were differing views as to how people might be best informed about the fit note. Some thought information could be provided at the workplace, others suggested that information could be made available through the GP practice.

b. Opinion of the 'may be fit' option

Participants who had been issued with 'may be fit' notes considered them to be a good idea, and those who had not seemed to be in favour of the concept. Participants considered that, in addition to the availability of modifications, the employer was a key factor in the application of a 'may be fit' fit note. The outcome would depend on the willingness and ability of the employer to consider modifications. Patients might be able to successfully negotiate modifications with their employer to return to work, but a 'may be fit' note could be helpful for others who might not be so adept:

> *I think that's a good idea. Some people just don't know how to express themselves, so probably if someone else was saying it for them, it's helpful isn't it? (PAT_5)*

Patients may also be supported by their GP in modifying their work, but not necessarily through the use of a 'may be fit' note, for example through a letter from the GP. There was a concern that having been issued with a 'may be fit' note might be interpreted by the employer that the patient was unwilling to return to work.

c. Clarification of the term 'fit note'

Even amongst the participants who had some knowledge of the new certificate, there was confusion about the terminology, with participants frequently referring to 'sick notes'. There was uncertainty about whether the GP could, or should use the fit note to sign people as 'fit' for work, including those who had been issued with a 'may be fit' note, and whether it was possible to consult the GP about a fit note while self-certificating:

> *So she (GP) gave me the fit note rather than a sick note…… I didn't have to go back to get a fit note to go back to work….. because you've been signed unfit, you can't go back to work until you've been – if you want to go back early, you've got to then go back to the Doctor to say, "Well, I feel fit enough to go back to work. Can you sign me fit to go back to work?" (PAT_10)*

d. Information about the health condition

Participants had varying views concerning the information that the GP had recorded on the fit note about their condition. More detail could help to explain their condition, and justify their absence, and get the help they needed at work. GPs often made the decision about what to write, even if challenged by patients:

> *I think mine says 'panic attacks', doesn't it? But I mean it was a bit more than panic attacks, and I did question this with the doctor …..you know, maybe my employers are going to think, well, panic attacks, that's not much, you know. They don't understand that a panic attack can affect you all day. I said, "I feel as if I'm suffering from depression as well." And he said, "No, panic attacks is enough, they've got no right to query what I've put down." I think he was a little bit – well, not very happy that I'd questioned what he'd put on my fit note (PAT_7)*

Patients might have other conditions which also impacted on their ability to work, but which were not necessarily mentioned on the fit note. Details as to symptoms, or treatments received could also help to validate the fit note. Medical terminology might not be understood by the employer which could put the patient at a disadvantage.

e. Comments on the functional effects of the condition

None of the 'not fit' notes issued to the participants had explained how the condition had affected the individual's ability to work, although most participants were able to describe this. Functional effects could include physical activities the patients had difficulty in carrying out, the side-effects of medication, poor concentration and communication skills, difficulty sleeping and travelling to work:

> *I had a really, really massive problem with excess of sweating due to stress. ……..and also, as I said, my job is you have to be very, very careful and accurate in how – there's high-value orders involved. A bad transfer can cause a lot of work - frustration builds up and I could get kind of stroppy. I just reached a point that I couldn't really –I just couldn't keep up any more with it – the GP gave me some sort of tablets, you know, in order to put the stress away and the best thing to do was to take some time off because there was some possibility of some sort of side-effects (PAT_8)*

Where GPs did comment on the functional effects of a patient's condition they were not necessarily accurate.

f. Re-assessment by the GP

The review section on the fit note was not necessarily completed. Participants felt uncertain about making the decision to return to work if the GP had not indicated that a review was needed. The GP might leave it up to the patient to decide whether to consult them again. Patients might think it was not possible to return to work before the expiry date because their employers would not have been insured. Participants seemed to think the reassessment option a good idea, although even those employed at GP practices were not necessarily aware of it:

> *That's interesting, as well, "I'll not need to assess you." Because most of the time we tell people they have to come in [to the practice] for that. If people want to go back to work before the sick note is due to finish, we tell them they have to come in to see a doctor, but there, they could – yes, I've not seen one of those before. …. That's brilliant. (PAT_6)*

2. THE GP FIT NOTE CONSULTATION

a. How the subject of sickness absence arose

The request for sickness certification in some cases was raised by the patient, in others offered by the GP which some participants declined. The attitude of the GP was perceived to be influenced by the patient's previous sickness absence history – infrequent consulters might think they would be more likely to have a sympathetic response from the GP:

> *Well, you know, the thing you look at is the bloke's or the person's history, their sickness "Oh, no sickness for years and years and years, it must be something really bad for him to phone up or be sick. (PAT_2)*

b. Telephone vs. face-to-face consultation

Some patients had received their fit note via a telephone consultation – of which opinions were mixed. Following the phone call, the patients had to collect the fit note from the practice reception desk.

If patients had a good understanding of their condition, or had already had one face-to-face consultation this might be acceptable, although the patient might question accuracy of this assessment method. It could be an advantage in not having to attend the practice for an appointment; however the use of mobile phones with variable signals could result in missed calls. Patients also felt that a face-to-face consultation would help to justify a certificate, and reassure them about their health condition:

> *He [GP] gave me a time that he was going to phone me, but I must have had a bad signal, so I missed the phone call. So I tried to ring back and couldn't get through. Luckily, my GP is only here on the corner, so I was able to go in and make a time again that he was going to phone me. So I sat there with the phone in my hand all day (laughs) to make sure the signal was ... you know? (PAT_7)*

c. Continuity

Some participants considered it beneficial to see the same GP regarding their fit note so that time need not be spent in repeating information in the limited time available, particularly if this involved explaining or discussing their emotional state. They preferred to see the same GP on the basis that the GP had more in depth knowledge of the individual:

> *It's just information off the screen against another patient…..just to be seen by the same person, could feel a little bit more comfortable, I guess, in some cases…… You can't really explain much, how you feel and everything. You can't just – it's not enough time. (PAT_8)*

d. Variation in GP approach

Participants were aware of differences between GPs in how the fit note was used and in the amount of detail that was provided on their health condition:

> *But that was with my previous Doctor and he would just give me a sick note and say, "Here you go. You need to be off for two weeks," well – why? that sort of thing [the 'may be fit' option] - that was never mentioned to me. (PAT_10)*

e. GP reliance on patient report

Participants described how GPs were reliant on patients to inform on their ability to work. In some cases the GP asked about their work, whilst other participants described leading the discussion. The GP had little option but to trust patient report and presentation during the consultation was acknowledged. Participants thought it was easy for employees to obtain sickness certification fraudulently:

> *Yeah, I could have squeezed it as long as I wanted. People have done it six months, four months…..but the doctor, he can't tell the difference really, can he? (PAT_1)*

3. WORKPLACE MANAGEMENT

a. Delivery of the fit note to the employer

None of the participants had been asked to provide a copy of the fit note, or reported that their employer had taken a copy. In all cases the original was delivered to the workplace, but the method varied – as did participants' knowledge as to how the fit note was then managed. There seemed to be no particular procedures to safeguard confidentiality or privacy. Some took the note into work, others gave the note to a work colleague to hand in:

> *Yes, I took it into the lady that does the wages. I just gave it to her and then she puts – well I don't know what she does with it. She keeps it in a file somewhere or whatever she does, I don't know to be honest. (PAT_10)*

Some employees also had to phone in to an automated number to report their absence, which was perceived as impersonal.

Those who knew about the 'may be fit' option were not aware that their employers responded to it in any different way to a 'not fit' note.

b. The experience of sickness certification and the return to work process

For some participants the decision to return to work was associated with the problems experienced in being away from the structure and routine of work, although it seemed that GPs were often quite willing to extend the period of sick leave. If they had been issued a 'not fit' note, participants would have appreciated some advice or information on the process of returning to work, or more appropriate recommendations. Participants did not always consider adjustments were viable, particularly to duties, and that employers were variable in the support they provided.

Participants remarked on the impact of more or less generous sick pay schemes on the decision to return to work. Employees might take advantage of generous sick pay schemes, whereas those who were on temporary contracts would be more likely to go back to work as soon as they could. Sickness absence monitoring could impact on decisions to return to work early; patients did not want to risk a relapse, which could add another 'episode' to their sickness record:

> *She [GP] wanted me to have a full six weeks but I said, "No that'll be too long." Good grief, I'll be bankrupt! (PAT_9)*

A period off work could be seen as beneficial initially but there were also anxieties about the return process. Employer management of sick leave might raise concerns about disciplinary procedures and employers were perceived to be more sympathetic if the employee was rarely absent.

c. Experiences related to stress at work

Participants who had been issued with a fit note for a stress-related condition described a gradual build-up of their symptoms, over several weeks or months before consulting their GP. They had not sought formal help at work, either because they did not know where to gain support from at work, that their problems were ignored or that it was commonplace for employees to accept a certain level of stress:

> *Well, I could have had a 'stress-related' thing. You fill a form in and you put down why you're stressed, and then that goes to (the occupational health provider) and they have a look at it. But to be honest, you know, we all were stressed out and we just carried on working. I mean, we'd all moaned. You know, I'd moan to myself, "Oh, I can't cope with this. It's getting a bit much," you know, and they'd say, "Well, it's not long now until your retirement." (PAT_7)*

Patients might be unaware of whether their workplace had an occupational health service, or it might only be accessible through their line manager, or when a certain threshold of sickness absence had been reached. Participants felt that that those at the workplace might question whether it was a valid reason to be off work, particularly as the 'treatment' often involved encouraging the patient to engage in normal/pleasurable activities, including holidays.

However, once employees had been issued with a fit note for 'stress', participants observed that employers then found the condition difficult to manage because of their concerns about potential risks:

> *People say it's stress-related, the company can't do anything to you. They can't say anything to you…because it's kind of depression and you could say you're suicidal couldn't you? Obviously they're not allowed to be heavy on you, are they? (PAT_01)*

d. Other opportunities for communication between the GP and the workplace

Participants were, in principle, in support of additional communication to take place between the GP and the workplace although they could see practical issues of time, consent and confidentiality that might impede this. Email or phone could be quicker, acceptable options. Contact could help to validate the health condition and facilitate support at work:

> *Could be an email. Time is precious to everybody in today's day and age. There's email. There's telephone. It doesn't necessarily have to be pen to paper. It's not too difficult, really, in the grand scheme of things. I would be happy to sign a consent form. It's not as though I'm hiding behind anything. (PAT_9)*

Where patients were receiving treatment from several specialists, the GP was seen to be in a good position to co-ordinate the specialists' reports and inform the employer rather than depending on the patient. Unless there was a formal capability issue, patients might perceive employers to be reluctant to initiate communication with the GP because of issues of trust, or that their employers might be difficult to communicate with.

2.3 GP STUDY

2.3.1 Aim

The aim of this study was to explore and evaluate the data from actual fit notes, and investigate the perceptions of GPs concerning fit notes, in order to inform the statements for the consensus study.

2.3.2 Method

After giving their written consent to participate, GPs were asked to record the first ten 'new' fit notes issued to patients (i.e. not continuations of previously issued fit notes), including a minimum of five 'may be fit' notes. The participants then sent a copy of each fit note to the research team, having first given each an identification code and deleted all patient/practice/GP details. Six weeks after issuing the fit note, participants were sent a questionnaire asking them to rate the usefulness and work outcome of their fit note.

The GPs were interviewed at the end of the data collection period. Recruitment was based on the available resources and timeframe of conducting the study. Each interviewee was given a £25 gift voucher as a token of appreciation.

Postal questionnaire

The questionnaire comprised three main sections:

1. The outcome of the fit note on the patient's work status.
2. Communication, in addition to the fit note, that had taken place between the GP and the workplace (including occupational health).
3. The respondent's perceived usefulness of the fit note.

Separate questionnaires were developed for 'not fit' notes and 'may be fit' notes by the research team and with input from the steering group which included two practising GPs.

Semi-structured interviews

Interviews were recorded using a digital voice recorder, and took place at the GP's practice. A list of topic areas and prompts included:

- Years of GP practice and details of any training related to fit note completion.
- Opinion of the fit note and its usefulness in practice.
- Recommendations as to how the fit note might best be used.
- Views as to the need to facilitate dialogue between employees, employers and GPs and how this might best be achieved.
- Views regarding the training needs of GPs in effective fit note completion and delivery.

Analysis

Interview data were transcribed verbatim in Word. Each transcript was checked and corrected by the researcher conducting the interview then uploaded onto Nvivo 10. The researchers conducting the interviews independently coded a sample of interviews line-by-line, then compared and revised these initial codes. Each interview was then coded and themes identified through constant comparison of the scripts. Themes were then discussed, revised where needed and finally agreed.

Recruitment

The overall aim was to recruit ten GPs to the study from Nottinghamshire and Leicestershire. A combination of opportunistic, quota, convenience and snowball sampling methods was employed in order to obtain a range of socio-economic settings (identified by Indices of Multiple Deprivation (IMD) rating of the practice):

- Opportunistic sample of 39 GP practices identified though steering group members across Leicestershire & Nottinghamshire (Leics & Notts)
- 48 GP practices in Leics & Notts (3 practices per 16 districts)
- All 56 GP practices in Nottingham City
- All GP practices in Rushcliffe, Nottinghamshire not included in previous samples (n=14)
- Convenience sample: 154 GP practices across Leics & Notts
- Snowball sampling: colleagues of 9 participating GPs

GP practices that expressed an interest in the study were given the choice of discussing the study face-to-face with a researcher visit, or by phone and/or email. All chose the latter option. Written consent was obtained at, or following, the discussion, by post or email.

2.3.3 Results

Participants

A total of 12 GPs expressed an interest in the study. Of these, one withdrew prior to data collection. The remaining eleven GPs participated in the study.

The IMD rating for the practice location in which each GP participant was based is shown in Table 11.

Table 11. IMD rating for GP participants' practice

IMD rating (1= highest deprivation)	Number of GPs recruited (n=11)
1-3 (most deprived location)	4
4-7	2
8-10 (least deprived location)	5

Six of the participants were male, five female. The mean number of years' experience as a GP was 15 with a range of 1.5 – 26 years.

Fit note data

Fit note data were sent to the research team in different formats depending on how fit notes were completed by the GP. Five sent photocopies of handwritten fit notes, four sent copies of electronic fit notes, and two sent the fit note details in an Excel format as they were unable to print off a copy of their electronic fit note.

Ninety-eight fit notes were submitted. Of these, four related to unemployed patients and were excluded from the study, leaving a total of 94 fit notes. The results are shown in Table 12. The majority of these (n=62, 66.0%) were marked as 'not fit' and 25 (26.6%) were marked as 'may be fit'. Six notes (6.4%) had no option selected and one note (1.1%) had both options selected.

The duration of the fit note issued was stated in 89 (94.7%) cases. This ranged from 1 day to 91 days, with a mean of 21.63 days and a median and mode of 14.0 days.

Table 12. Descriptive statistics for the fit notes received from all GPs

Fit notes		N	%
Number in sample (n=94):	Not fit	62	66.0
	May be fit	25	26.6
	Neither option selected/blank	6	6.4
	Both options selected	1	1.1
Number of fit notes with a single modification (n=16):	Amended Duties	8	50
	Phased return	5	31
	Altered Hours	2	8
	Workplace Adaptations	1	0.1
Number of fit notes with more than one modification (n=9):	*Any combination of the above four modifications*	9	36
Number of fit notes with comments (n=27):	'May be fit' notes	21	77.8
	'Not fit' notes	4	14.8
	Neither option selected/blank	1	3.7
	Both options selected	1	3.7
Completion of the reassessment section (n=94):	Not completed	37	39.4
	Will not need to assess patient	27	28.7
	Will need to assess patient	13	13.8
	No review section on form	17	18.1

The most common single work modification selected by GPs was 'amended duties', which was selected in 8 cases (50% of single work modifications). The second most common single work modification selected was 'phased return', found in 5 cases (20% of single work modifications). 'Altered hours' was selected in two cases, and 'work adaptations' was selected in one case.

Fit Note Comments

The comment section of the fit note was completed in 27 (28.7%) of the fit notes, of which 21 (77.8%) were 'may be fit' notes and four (14.8%) were 'not fit' notes. One (3.7%) of the fit notes with a comment had neither of the options selected and one (3.7%) had both options selected.

The content of the comments was analysed with the same categories used as for the fit notes collected from the employer organisations (see Table 4, section 2.1.3). The frequency of categories identified and an example of each are shown in Table 13. Some comments covered more than one category. The most frequently identified category was 'work-related advice' (23 fit notes) followed by 'functional effects of a patient's condition' (11 fit notes), and 'additional information on health condition' (8 fit notes).

Table 13. Frequency of categories with examples of comments per category

Category	Examples of GP comments	Number of fit notes
Work-related advice/recommendation/instruction	'If this is possible patient benefits from a set regular shift which starts preferably later during the day, for example 11am onwards'	23
Functional effects of a patient's condition	'Ongoing stress, needs to focus on one phone line at a time to build up confidence, also needs to see occ health'	11
Additional information on health condition	'After elbow surgery has recovered will need to consider phased return'	8
Clinical management/intervention	'Advised to rest from hospital'	3
Date for RTW suggested/indicated	'Plan rtw 14/11/13 with some working from home'	1

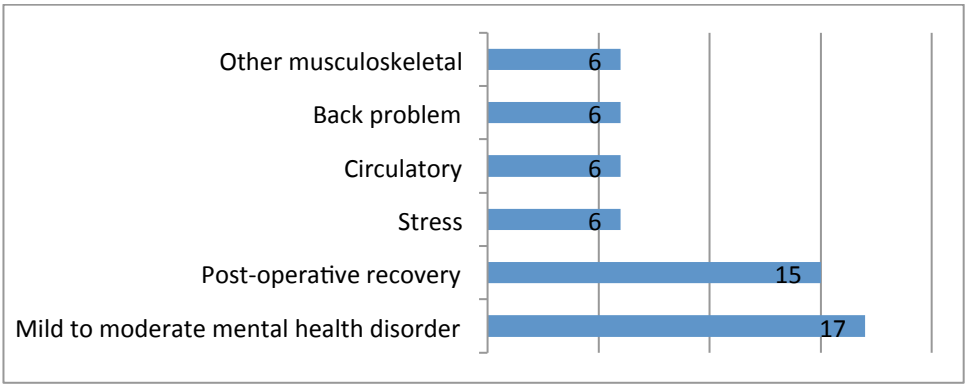
Re-assessment

The review section of the fit notes, indicating whether or not the GP would like to assess the patient again, was completed as required in 40 (42.5%) of the fit notes. In 27 (28.7%) of these cases the GP recorded that they did not need to assess the patient again, and in 13 (13.8%) cases that they did. In 37 (39.4%) cases the review section was left uncompleted, and in 17 (18.1%) cases the review section was missing altogether due to the GP using a different fit note format.

Conditions

The specific conditions stated on the fit notes were categorised according to a taxonomy used by the Department for Work and Pensions.[24] Figure 6 shows the six most frequently specified conditions. The most common condition was 'mild to moderate mental health disorder' (18.1%), followed by 'post-operative recovery' (16.0%).

Figure 6. Number of fit notes issued for the six most frequently specified conditions



Questionnaire data

A total of 93 questionnaires relating to fit notes were received. Sixty-two (89.9%) of these related to 'not fit' notes and 24 (34.8%) related to 'may be fit' notes. Six (8.7%) related to fit notes where neither option had been selected, and 1 (1.4%) related to fit notes in which both options had been selected.

Questionnaire data for 'not' fit notes (n=62)

Return to work outcome

In 38 (61.3%) cases the GP knew what had happened to the employee following the issuing of the fit note, the most common situation being that the employee had received another 'not fit' note' (n=18, 29.0%) or had returned to normal hours and duties (n=9, 14.5%).

In 21 (33.9%) cases the GP did not know what had happened to the employee following the issuing of the fit note.

In two cases (4.8%) the GP did not give a response to this question.

Communication between GP and workplace

In one case (1.6%) it was reported that the GP had contacted the workplace regarding the employee's return to work and in 61 cases (98.4%) that they had not. In the one case it was actually the patient's psychiatrist who had written to the workplace.

Similarly, in one case (1.6%) it was reported that the workplace had been in contact with the GP practice regarding the employee's return to work, and in 61 cases (98.4%) that they had not. However, in this one case it was actually the patient who had contacted the practice on the employer's behalf to check the dates on the fit note.

In no cases had Occupational Health been in contact with the GP practice about the employee's return to work, although in two cases (3.2%) the GP was unsure as to whether this contact had taken place.

In two cases (3.2%) it was reported that another agency had contacted the GP practice about the employee's return to work. In one case this was a request from an Insurance Company to complete a form, the other related to correspondence with the patient's consultant.

Usefulness of the 'not fit' notes

Questionnaire responses (n=62) made in regard to the usefulness of the 'not fit' notes are illustrated in Figure 7.

On reflection, I completed this fit note satisfactorily

- In 56 (90.3%) cases the GP either agreed or strongly agreed with this statement.

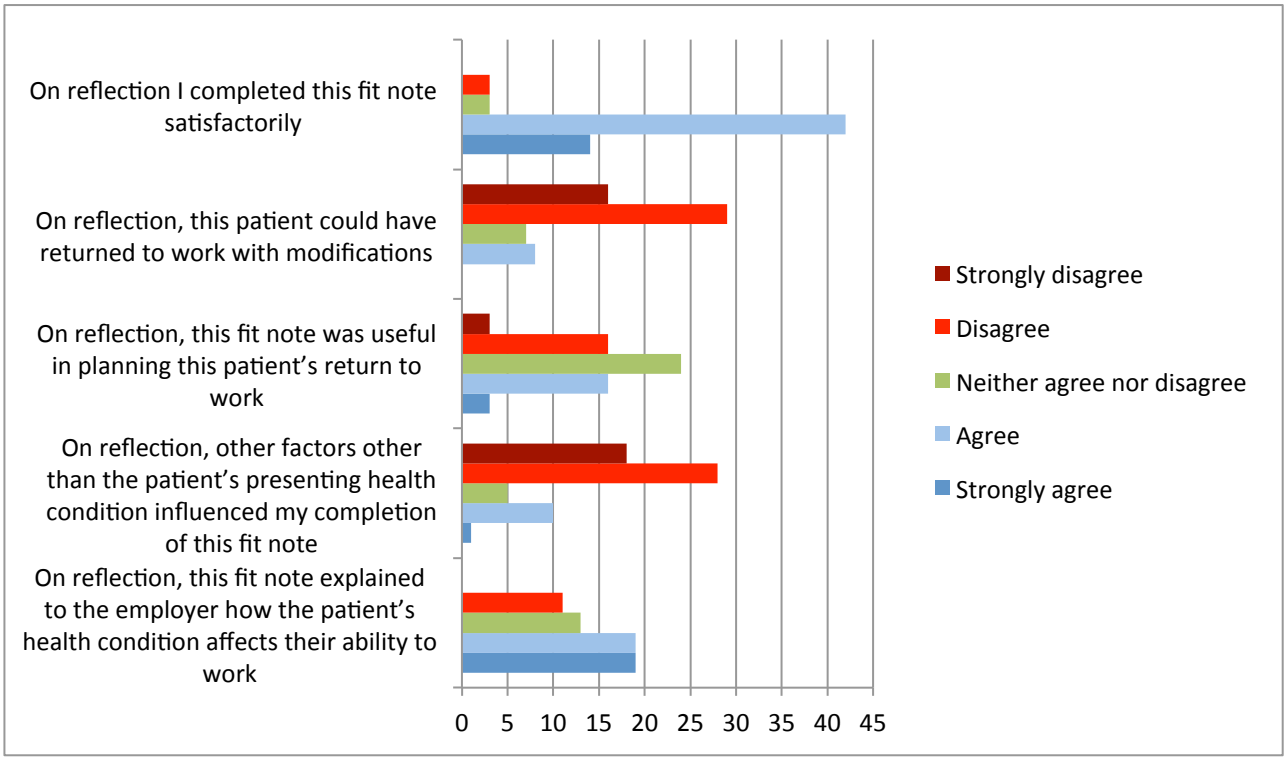
On reflection, this patient could have returned to work with modifications

- In the majority of cases (n=45, 72.6%) the GP disagreed or strongly disagreed with this statement. In eight (12.9%) cases the GP agreed that this could have been the case, and in 7 cases (11.3%) the GP neither agreed nor disagreed.

On reflection, the fit note was useful in planning the patient's return to work

- In in 24 (38.7%) cases the GPs were neutral on this issue. An equal number 'agreed or strongly agreed' as 'disagreed or strongly disagreed' (n=19, 30.6% in each case).

Figure 7. GP questionnaire responses regarding the usefulness of 'not fit' notes



On reflection, factors other than the patient's presenting health condition influenced my completion of this fit note

- In almost three quarters of cases (n=46, 74.2%) the GP disagreed or strongly disagreed with this statement. Eleven (17.7%) agreed or strongly agreed.

On reflection, this fit note explained to the employer how the patient's health condition affected their ability to work

- The greater proportion (n=38, 61.2%) agreed or strongly agreed with this statement. Eleven (17.7%) disagreed.

Questionnaire data for 'may be fit' notes (n=24)

Return to work outcome

In 17 (70.8%) cases the respondent knew what had happened to the employee following the fit note. Six (35.5%) of employees had returned to normal hours and duties, four (23.5%) returned to normal hours and modified duties, one (5.9%) returned to modified duties and hours, and one (5.9%) returned to modified hours and normal duties. Three (17.6%) were issued with a 'not fit' note and two (11.8%) returned to work but the respondent did not know the details.

Communication between GP and workplace

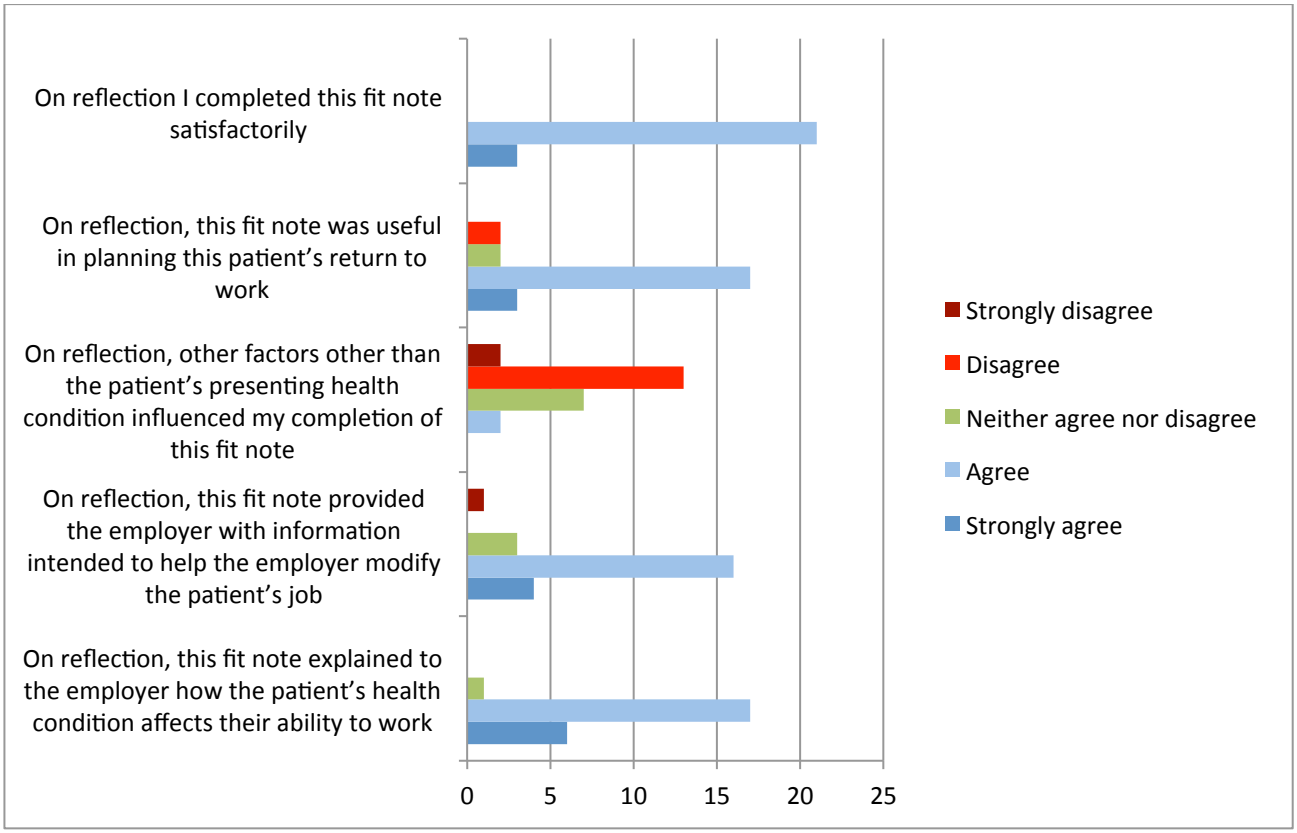
There were no cases in which either the GP had contacted the workplace regarding the employee's return to work (or vice versa), or Occupational Health had contacted the GP practice regarding the employee's return to work.

In two cases (8.3%) it was reported that another agency had contacted the practice regarding the employee's return to work – this involved correspondence with the Nottinghamshire Fit for Work service to whom the patient had been referred by the GP.

Usefulness of the 'may be fit' notes.

Questionnaire responses (n=24) made in regard to the usefulness of the 'may be fit' notes are illustrated in **Figure 8.**

Figure 8. GP questionnaire responses regarding usefulness of 'may be fit' notes



On reflection, I completed the fit note satisfactorily

- In all cases the GP either agreed or strongly agreed that they had completed the fit note satisfactorily.

On reflection, this fit note was useful in planning the patient's return to work

- The majority of GPs (20; 83.3%) agreed or strongly agreed, two (8.3%) were neutral, and two (8.3%) disagreed with this statement.

On reflection, factors other than the patient's presenting health condition influenced my completion of this fit note

- In more than half of cases (n=15, 62.5%) the GP disagreed or strongly disagreed, seven (29.2%) were neutral, and two (8.3%) agreed with this statement.

On reflection, this fit note provided the employer with information intended to help the employer modify the patient's job

- The majority (20; 83.4%) agreed or strongly agreed, and one (4.2%) strongly disagreed with this statement

On reflection, this fit note explained how the patient's health condition affected their ability to work

- The majority of respondents (23; 95.8%) agreed or strongly agreed, and none disagreed with this statement

Questionnaire comments

A total of 96 comments were made by the GP participants in response to three questions regarding the completion of their fit notes.

Due to overlap of content between the responses to each question, the comments were analysed as a whole.

Analysis of the comments revealed three main categories. These categories and sub-categories, and the number of comments per category are shown in Table 14. Each comment might cover more than one category. Six statements did not relate to any of the categories above and were excluded.

Table 14. Number of categories identified by analysis of the GP questionnaire comments

Main category	Sub-category	Number of comments per category
Comments regarding completion of the fit note	Could have provided more information	29
	No further information required or applicable	14
	Reasons for issuing a 'not fit' note	12
	Uncertainty as to whether completed satisfactorily	12
	Reasons for not providing more detail	5
	Fit note issued for other reasons than health	4
	Did not complete the fit note fully	2
	Could have considered issuing 'may be fit' note	1
Comments regarding outcome of the fit note	Outcome not as anticipated	5
	Statement regarding return to work status	4
Comments concerning the roles of stakeholders	Role of GP in completing fit notes	6
	Apparent need for greater support in facilitating return to work in primary care	4
	Role of the patient in the fit for work decision	4
	Role of employer in applying fit notes	3
Other: Statements not relating to any of the categories above		6

The greater proportion of comments made by GPs referred to how they could have provided further information on their fit note. This information might refer to: the patient's diagnosis; prognosis; cause duration

and severity of the condition; treatment including duration; advice on modifications; information on the functional effects of the condition; using lay terminology and recording the patient's occupation.

Fourteen comments referred GPs belief that there was no further information that could have helped the patient return to work, or that this information was 'not applicable' (these were all related to 'not fit' notes).

Twelve comments referred to GPs' reasons associated with issuing a 'not fit' note. These included the fact that it was a 'first' note; the patient was 'avoiding' work; the patient was very anxious; there was family ill-health; the patient had already self-certified.

Twelve comments referred to GPs' uncertainty as to whether they had completed the fit note satisfactorily. This included not knowing, or being unsure as to whether more information could have helped the patient return to work, uncertainty about how to refer to work-related stress, whether a 'fit note' was still required, whether both 'may be fit' and 'not fit' note options could be used together, judgements about amended duties.

Six comments referred to GPs views about their role in fit note completion. This included the fitness for work decision not being seen as the GPs' role; the challenge of long-term/continuation fit notes; questioning GPs awareness of the 'may be fit' option; the use of national guidance for sickness absence following surgery to avoid the need for fit notes.

Five comments referred to reasons for not providing more detail on fit notes. These were: not knowing time frames; patients not wanting their employers to know about their condition; doubts about the diagnosis; that detail wasn't required on a 'not fit' note.

Five comments referred to where GPs had not anticipated the return to work outcome of their patient. In two cases the patient had not returned to work as expected and was receiving further fit notes from other GPs in the practice, another was a patient with acute back pain that the GP had thought would be 'self-limiting' but who remained off sick, one had returned to work but had not received the expected support from her employer, and another who had returned to work despite the GPs expectations.

Remaining comments included: GPs reporting that they would appreciate being able to access a second opinion, uncertainty about how else GPs could communicate with employers, the fitness for work decision being led by the patient, that there were other non-health related reasons for issuing fit notes, GPs realising that they had not completed whether it was a 'not fit' or 'may be fit' option, or the reassessment section.

GP interviews

Interviews took place at the GP participants' surgeries between November 2013 and May 2014. Seven interviews were conducted by one researcher, and four by a second researcher. The duration of the interviews ranged from 25 to 46 minutes (mean 34 minutes). Five main themes were identified from analysis of the GP interviews. These and their sub-themes can be seen in Table 15 and are described in the text with quotations to illustrate each theme.

Table 15. GP interviews: Main themes and sub-themes themes identified as a result of thematic analysis

1. Views and attitudes to the fit note
a. Overall opinion
b. Doubts concerning the GP role
c. Perceived lack of guidance and standards
d. Sick notes vs. fit notes
e. The 'may be fit' option
f. Telephone consultation
g. Electronic fit notes
2.Completing the fit note
a. Detail on the patient's condition
b. The comments section
c. The re-assessment section
d. Dates and duration
3. The consultation
a. Patient role in consultation
b. Inconsistency and variation in the fit note consultation
c. The impact of self-certification on fit note issue
4. Communication with the employer
a. Perceptions and experiences of employers and occupational health
b. Increasing communication with employers
5. Changing GP behaviour in fit note completion
a. Reflection may be useful in changing behaviour
b. Training and education in fit note completion
c. Guidelines
d. Changing patient knowledge and understanding of the fit note

1. VIEWS AND ATTITUDES TO THE FIT NOTE

a. Overall opinion

GPs considered the fit note an improvement, and fully supported the principle of facilitating return to work. The fit note was seen as a potentially useful tool in encouraging patients and employers to consider work adjustments. The 'may be fit' option was seen as a clear message that gradual returns to work should be expected, and provided authority and structure. The format was generally acceptable and it was seen as important that it was not too complicated. The requirement to specify return to work date helped to identify a clear goal and focus for the patient:

> *I think they are a much better option than the previous sick note because the main reason I think is that it used to be all or nothing. And this gives you the option to let people get back to work gradually, which was one big omission that I used to find. (GP_6)*

b. Doubts concerning the GP role

However, not all considered that issuing fit notes was the role of the GP and several would prefer not to have responsibility for them at all. Many felt they did not have the time, skill or capacity to make effective use of the fit note and that they had 'more important things' to deal with. Some felt that they had to accept what the patient said at face value, and that it was not an effective means of communicating with employers because it was by nature a one-sided tool:

> *I think that it's probably something that is probably in the wrong place with GPs. I think it fundamentally misunderstands what GPs do. I don't think we have either the time or the skills - so the capacity to do the sorts of in depth discussions that we need to do about someone's occupation in the context. It fundamentally changes the structure of the traditional general practice consultation. So I'm not terribly in favour of them.(GP_4)*

c. Perceived lack of guidance and standards

In some cases fit notes were perceived to be unnecessary for example in 'cut and dried' cases such as elective surgery where there was perceived to be an expected set period of absence. More ambiguous conditions such as 'back pain, breathing problems and stress' were examples of those that they found difficult to manage. GPs frequently used the terms 'difficult' and 'uncomfortable' during the interviews in reference to the note:

> *Generally I feel a little bit uncomfortable with them as a GP, I felt - I sometimes find for some acute stuff it's quite easy to sort out. If it is a viral infection or if they're depressed or something like that, that's fine. But it's when it becomes one of these long term sick notes or I guess it's to do with a musculoskeletal injury then it becomes a bit difficult to know really what's appropriate for them to do and not to do. (GP_9)*

The need for guidelines and standards were identified as necessary for a more consistent approach.

d. Sick notes vs. fit notes

GPs frequently used the term 'fit note' to refer to 'may be fit' notes, and the term 'sick note' to refer to 'not fit' notes. Some were unclear what to do now that there was no longer a 'fit for work' note:

> *For me, it's called 'fit note' but actually some of them is they're 'not fit', do you know what I mean? So it would better to have two categories, the sick notes, which is what they used to be called, and the fit note which is the new one… I would say, because to call it a fit note, when you're saying you're not fit work doesn't make sense. We still call them sick notes because actually that's what you're saying; it's a note to say that you're too poorly to work. (GP_7)*

e. The 'may be fit' option

GPs found the 'may be fit' option and the modification tick boxes helpful for the negotiation and discussion of work issues with patients. There was however a perception that encouraging people to return to work because work was good for their health was sometimes misinterpreted by the patient as a lack of empathy.

The choices of modifications were generally seen as adequate, although some GPs were reluctant to recommend amended duties as they felt they did not know enough about what these might entail. GPs also felt that 'workplace adaptations' required more specialist knowledge. There was some uncertainty about the meaning of the options and the opportunities they offered:

> *Sometimes I have trouble distinguishing between them, so "work adaptations", that's easy isn't it? Altered hours – "altered hours and a phased return to work" – oh no, altered hours are permanent altered hours isn't it, under duties? Yes, so I suppose that's a bit obvious really isn't it, it's just me being a bit stupid. Yeah, the phased return to work would be a gradual thing – altered hours would be permanent altered hours, permanent amended duties wouldn't it? (GP_10)*

GPs had varied opinions as to why comparatively few 'may be fit' notes were being issued. Reasons included that it was traditional practice to judge a patient as either 'fit' or 'not fit' for work and that there was insufficient time in the consultation to address patients' work requirements.

Other reasons were that GPs did not have the relevant training; believed that local employers were unable or unwilling to consider modifications; that patients refused them; that if they were issued, it was usually following one or more 'not fit' notes; that patients were already negotiating modifications themselves so a 'may be fit' note was not required.

Some GPs were unclear as to whether the fit note could be used as a 'not fit' and 'maybe fit' note at the same time. In their view a 'may be fit' note might not be appropriate at the time of the consultation, but might be in the near future so combining both options was seen as a sensible use of the note.

f. Telephone consultation

The option to conduct a consultation over the phone was perceived as a helpful initiative by GPs as in some cases they felt able to judge whether or not they needed to see the patient. This could save what they perceived to be unnecessary consultation time. Not all thought it was appropriate for the first consultation and views were mixed as to their use in repeat consultations:

> *As long as there has not been any significant change and we are writing the same things. And as long as we haven't expected them to have gone back to work by now. If that was the case, if it was chronic and it's expected, you know we can chat with them over the phone. (GP_8)*

g. Electronic fit notes

Some GPs felt that the ease of completing a computerised form, led to a more detailed, higher quality fit note and facilitated continuity of care between GPs. Templates could potentially be useful in prompting the GP to complete each section. However some were frustrated that there was less flexibility in how they were used, for example there was no option to enter a future date on the fit note (not allowed according to the DWP Guidelines) or a facility for patients to sign the fit note. In some cases, certain sections were missing, such as the section on whether or not the GP wanted to assess the patient again before they returned to work.

Some GPs considered that there should be a standard template. It seemed that templates might be similar, rather than standardised: Some GPs appeared to be creating their own templates, others continued to complete the paper copy and were seemingly unaware of an electronic version or whether they could print off a copy for the patient:

> *It's not on my template, is it? I don't think - Let's just grab a patient and just.. (looks on computer screen). No it's not on my template, so I've missed that little bit off in my template. So maybe if I were to change my template, it would prompt me to do it more often. (GP_3)*

Computerised versions were not available to all GPs and were seen as potentially useful, although not necessarily a priority. Some GPs were issuing paper fit notes then entering the details onto a template within the computerised medical record. However, completion and accuracy was not necessarily guaranteed:

> *The problem is you do it by hand and you forget to record it. That happens all the time. (GP_10)*

2. COMPLETING THE FIT NOTE

a. Detail on the patient's condition

GPs varied in the amount of detail they provided on the patient's condition. Some gave very little, thinking that the less they said, the fewer implications it might have, both for the patient and themselves. They considered it might not be helpful to or necessary for the employer to have too much information on the condition:

> *My principal is as little as possible, and that's really if I'm doing any report, really. You've got to find a balance. The more you offer, the more it can get the patient into deep water and me into deep water because you end up having to justify these things. (GP_3)*

For others it might depend on how they felt 'that day', and who would read the fit note, as to how much detail they would include.

> *If I'm writing to an employer what's the point of writing a lot of medical information to him which he doesn't understand or might misinterpret. (GP_4)*

Detail was more likely if the condition was a simple physical injury, such as a fracture: Some recognised that the employer might benefit from more detail, but were still unsure about how much was 'safe' to provide: Others recognised the needs of employers in understanding the meaning of what was written and avoiding medical 'jargon'.

GPs might be deliberately vague in some cases, although there was some uncertainty as to whether lack of clarity was permissible and a recognition that vagueness was not particularly helpful to the employer. However issues of confidentiality could limit GPs in providing a complete picture, for example if patients were signed off due to family ill health. For others, the detail on the condition was mainly completed automatically by the READ code entry system.

Some GPs felt it was important to involve the patient in the decision as to what to write. It wasn't seen as an easy decision. Patients might challenge what was entered, for example if they felt that they needed further justification for sick leave: Others reported acceding to the patient's wishes, in order to not only maintain a relationship with that patient, but due to fear of the consequences. GPs might be deliberately vague about the condition if they felt that more detail might impact on relationships at the workplace, if patients did not want their employers to know about their health condition, or were unsure who might have access to the information:

> *She gets very worried about what – if she does take any time off sick, what's put in there – but that's partly related to when she rings in for her own time off before she needs a sick note that they have to leave it on an answer machine which is in an office, which other people can hear. (GP_6)*

GPs also recognised that their own beliefs and attitudes about disclosure could influence how they completed this section of the fit note. They also were not sure how helpful their information would be. This GP had provided more detail on the condition during the study, but still questioned the extent to which this information would be useful:

> *In the last couple of months I've put stress, due to family situations, or back pain due to problems at work, or perceived problems at work, might be things like that, rather than just non-specific back pain. To whom, that's the question. Who is that helpful to? I mean, arguably it's the employer but then the employer's not in a position – is in even less of a position than me to decide whether a patient's fit enough to work. (GP_3)*

GPs admitted that they wrote fit notes for non-medical reasons such as bereavement, at least initially, and there was uncertainty as to whether this was appropriate.

b. The comments section

Many GPs reported that they appreciated the space for comments to provide more detail, or elaborate on the work modifications, however others hadn't noticed it, or thought it unnecessary and too large:

> *I tend not to use it. I think it's wasted space, because it is quite a big box but it doesn't get used. (GP_5)*

Even if it was perceived as useful, GPs reported that they did not necessarily use it or provide a great deal of detail, or realise that it was a requirement to comment on 'may be fit' notes. They were uncertain as to what they were expected to write in the comment box and varied in their understanding of the phrase 'functional effects of your condition'. Some did not feel sufficiently confident to comment, feeling that they needed to have an in-depth knowledge of the patient's job. Others were unaware of the wording:

> *I've never even read that! But it's not often I add a comment. 'Functional effects of your condition'. Yes, well it's not very clear, is it? I would say it's not very well worded and I suspect what they mean is how does this condition affect you. I don't know whether it's really necessary. (GP_5)*

Few GPs used the comment box to provide more information on 'not fit' notes. They thought this might be due to the layout of the note (the comment section is enclosed in the same box as the work modification options) or because they did not feel it to be relevant. Some however could see that it might be helpful to the employer to know why the condition was preventing the patient from working.

c. The reassessment section

Some GPs thought that the reassessment section was frequently missed because of how the fit note was designed, and suggested improvements such as a tick box or a default question. Others had not noticed it. However, several GPs did not complete the section because they didn't think it was necessary:

> *I find this unhelpful, this section here "I will or will not need to assess the patient" I have always found that quite irrelevant, really to be honest….. They just go back automatically, that is why I always find that a bit of useless bit really to be honest. (GP_9)*

Some thought it could lead to unnecessary appointments, and deliberately did not complete it and left it to the patient to decide. There was uncertainty as to whether they should provide a 'fit to work' note if a patient wanted to return before the expiry date: Some GPs had not realised that patients could return to work before the expiry date without being re-assessed, or referred to 'open' and 'closed' certificates, a feature of the previous 'sick note'.

d. Dates and duration

The majority of GPs felt confident in completing the dates section, however others were less so, in particular exactly which date the absence started and the return to work date:

> *You know what? I think I have a mental blockage on , so 'From' and 'To', I'd - sometimes I get – I'm not a hundred percent clear on the return dates. Whether that would that be their last date of sickness - or is that their first date that they're fit to go back to work? (GP_11)*

3. THE CONSULTATION

a. *Patient role in consultation*

GPs described the extent to which they involved, and in many cases, relied upon the patient during the fit note consultation. They might consider contacting an employer regarding a patient's return to work, but only at the patient's request. Some GPs involved the patient in the decision about how the fit note was completed, but still had to accept what the patient told them:

If the GP left the timing of any discussion of sickness absence to the patient, they might then have insufficient time to deal with it effectively:

> *Sometimes it's difficult because you've already had a long consultation and then they mention the sick note at the end. "I'll need a sick note for my work." Well, you don't have time to start exploring their work at that time. It's impossible; you've got the next patients to see. So either you call them back, or you just sign the form. (GP_1)*

GPs described the importance of their role as patient advocate but also a reluctance to anger or upset patients if they held a conflicting view, particularly with long-term sickness absence. Lengthy sickness absence was perceived to be more common in mental health conditions, when patients had been referred for a specialist opinion.

Use of the modification options was often dependent on the subject being raised by the employer or patient rather than the GP who often did not feel confident to offer specific advice. In some cases it seemed that GPs prompted the patients to ask them for a fit note:

> *Yes, obviously we do have consultations which are purely for "I need another fit note", which are quick appointments and we try to get them onto phone calls really now. But, sometimes, you know sometimes you also say "do you need a fit note?" just to remind them but most patients know when they want one. (GP_8)*

Having a 'not fit' note might be seen as aiding recovery, more particularly in mental health conditions where having time off work was more likely to be seen as part of the solution. However, some GPs would suggest modifications that the patient may not have considered, such as altered or reduced hours.

It was perceived that some GPs might be able to negotiate and manage the return to work discussion more effectively than others. This GP described her own method of approaching the prospect of return to work with patients:

> "*Well I tell you what, I'll write you a short length of time and next time we'll look towards you going back to work". So that it's not quite so sort of abrupt but they know that I'm – hopefully anyway - they know that I'm not going to be a complete soft touch next time (GP_10)*

b. *Inconsistency and variation in the fit note consultation*

Participants described how GPs varied in their understanding, completion and management of the fit note even within the same practice:

> *I think I'm a little less easy going than other members of the practice maybe - I don't have any audit for this but I could imagine one or two of the others, colleagues, partners, being a little bit more happy than even I am to give sick notes, fit notes, but that's just – I don't know. (GP_3)*

This could be due to individual preference, time and the location of the practice:

> *The explanation about the diagnosis, I normally put it next to 'diagnosis' in the first box so I think it's just preference. Sometimes people use the comments box for that. It depends on how busy that GP is. It depends on whether that's a permanent GP or a locum GP. It depends on the type of patients we will see. For example, if you work in an area that the majority of your patients are not working or majority of your patient might have social and psychiatric problems, then obviously you issue more*

and your threshold for issuing a fit note might be lower compared to a person who works in a country area - most patients are professional and working, you rarely get a request for a sick note. (GP_2)

The general assumption was that most GPs devised their own method, however this could lead to difficulties in providing a consistent approach, particularly as *'many people come back for repeat notes to different doctors'* and tracking the fit note on the medical records system relied on accurate coding by each GP. Difficulties were also experienced if the initial fit note had been issued in hospital but was not recorded on the same system.

c. The impact of self-certification on fit note issue

Some GPs referred to the fact that many patients had already been absent from work by the time they consulted their GP which may have affected their mind-set about their work capacity.

There were doubts as to whether patients and/or employers were aware of the rules regarding self-certification. Opinion and practice differed as to whether GPs thought they were able to – or should - write a fit note for patients if they were consulted within the self-certification period, or whether patients should be charged a fee:

Usually the patient says, "I need a note for work." And there's the conversation of, "You've not been off for a week so you don't need a note" (GP_6)

The patient shouldn't have to come for a private sick note and pay £10 or whatever it is for that. I don't know where that came from, or under what circumstances you actually use a private sick note. (GP_1)

GPs also described how they might not be aware of the extent of a patient's sickness absence history as there was no system of documenting self-certification at the practice.

4. COMMUNICATION WITH THE EMPLOYER

a. Perceptions and experiences of employers and occupational health

GPs indicated uncertainty as to whether employers took much notice of recommendations made on the fit note. Many thought that employers wanted very little information other than to confirm the legitimacy of their employee's absence, and to indicate when the employee would be returning to work:

I guess, a justification as to why they can't work really, you know–(GP_9)

or to 'cover' themselves if the employee wanted to return to work:

So my understanding of that is that people sometimes want to go back to work, but then the employer will worry about that and demand a note saying you are fit to go back because they are worried about their insurance. (GP_10)

There was a perception that the size of the organisation might impact on the detail desired from the GP, for example that larger organisations would want more details because occupational health sere more likely to be involved. However others thought large employers would conduct their own assessments of fitness to work through occupational health, but that smaller organisations might need more information on the fit note.

Some perceived that employers might know very little about the fit note, for example that patients could return to work without a 'fit' note or that employers might tend to ask the employee to continue consulting the GP as the cheaper option:

I don't understand all the work rules and stuff with Occupational Health but I'm sure sometimes employers have to pay for that Occupational Health review, maybe they're a bit reluctant to and it's easier for, you know, a patient to keep seeing a GP and have an assessment (GP_9)

GPs described how they received very little feedback from employers on the usefulness or outcome of their fit notes– unless there was a problem. More feedback would be welcomed to help in future consultations as the patient may not provide the full picture.

GPs described how they were sometimes required to write patient reports for employers, which many viewed negatively. There was a perception that employers might use the request for a GP report to put pressure on employees to return to work. Many GPs felt ill-equipped to advise on fitness to work in these reports, rarely re-assessed the patient. Again, GPs were unlikely to be informed of the outcome:

> *I look into their records and see what they've had done and see what recommendations we've made or the hospitals have made and give them the appropriate information. (GP_5)*

GPs reported that some employers sent the patient back to their GP for a 'not fit' note if they were unable to make the required accommodations. Some perceived that employers were unwilling or unable to take responsibility for risk assessments if employees returned to work before the fit note expired.

GPs described feeling that they needed to support patients if they were concerned that the patient was being bullied into returning to work and thought that some employers held negative attitudes towards mental health problems. They perceived that employers could cause increased stress as a result of their management procedures, and that employers should offer more support in the workplace for these conditions:

> *The patient then ends up with more stress because they've been called for occupational health assessments and then been put on warnings etc. from work. So that actually causes more problems to them (GP_1)*

b. Increasing communication with employers

GPs had mixed opinions as to whether there could be more communication with employers. Some felt there was no need, or focused on the resource implications, the interests of the GP and also the potential threat to their advocacy role. Few had received any communication from employers other than requests for reports and would rely on the patient or employer to initiate it. They wouldn't necessarily reject the approach and some might consider initiating it:

> *They never contact us, so we don't have a chance to communicate with them. That's helpful if they contact us. It doesn't have to be an expensive medical report all the time. It can be just two/three lines or it can be after consulting the patient, a simple telephone call to explain. We can call them back, of course. As you know GPs are very busy, they cannot accept calls during working time but we can accept times to call back. As long as the patient has consented to that we can call back and we can discuss. It can be in front of patients, which is going to be a small sort of meeting between doctor, patient and employer. It can be very helpful; a ten or twenty minutes appointment, we can call the employer, the patient is here, the patient can hear whatever we discuss with the employer, the patient can comment, the employer can comment and the doctor can comment (GP_2)*

Some methods, such as email, might be considered less achievable than others because of confidentiality and data protection issues. However, disadvantages of relying on the employee to be the intermediary were observed:

> *but of course I can't communicate directly with the employer most of the time mainly because of the confidentiality issues. So it tends to be all through the patient which is fine, but if they're a bit anxious or not very assertive, or not able to – or if that's part of the problem, that work is part of the problem - then it can be difficult for them to do that negotiating with their employer. (GP_10)*

Others had been able to refer to local services to provide this communication:

> *That's where I've found this service that the NHS has been providing locally, that has been quite helpful, the Notts Fit for Work, because there is an opportunity to get an OT for the patient rather than for the employer, who can help them with the transition. So that's been another thing that I sometimes would use. (GP_6)*

5. CHANGING GP BEHAVIOUR IN FIT NOTE COMPLETION

a. Reflection may be useful in changing behaviour

Some GPs reported that reflecting on their fit notes in the study had changed their understanding and completion of fit notes. In hindsight they had observed that the content was inaccurate, unclear or not sufficiently detailed. Some realised that they weren't aware of, or hadn't read, some of the sections properly. Some had started to include more comments for employers, more constructive comments and more detail on the condition and how it affected patients' ability to work:

> *I am tending to put more comments. I put more information for employers in the comments sections. I'm actually putting more things now. That's the key question - how the condition actually affects the ability to work. So that was quite difficult. That's something that I've changed, obviously.(GP_1)*

However this change in practice might not necessarily be sustained, partly because 'old habits die hard' and also because they had no evidence of how effective their fit notes were.

Some GPs talked about how improving their completion of fit notes was a gradual process. It was still 'early days' and that it would take time, and frequent reminders for GPs to change their habits.

b. Training and education in fit note completion

None of the GPs had any occupational health experience or qualification. Few reported having made use of any online resources. Two had attended the RCGP education programme in work and health. Their experiences were positive, although it was not clear how much of the programme was directed towards the fit note as they were still uncertain how to use it. Two GPs had attended a Practice Learning Time (PLT) event led by one of the Fit for Work Pilot Services which were perceived as useful, but insufficient.

None of the remaining participants had received any training related to work and health. Two had vague recollections of a website.

Some thought that fit note training was more important than others, many considered it unlikely that they would access training that involved their own time and money, or simply weren't interested:

> *It's not the sort of thing I would go on. I've got a million and one other things I'd prefer to learn, spend an afternoon learning than that, I'm afraid. Sorry.(GP_7)*

When asked whether training might also involve employers, views were again mixed. Some thought that it might be an opportunity for both to hear the other's view: Others didn't feel it was within their remit, or was practical unless a large proportion of their patients were employed by one or two organisations.

One of the GPs who had attended the RCGP training saw a benefit to involving employers and valued the opportunity to discuss practice with other GPs, which rarely happened:

> *If you don't know what the people on the other side of the wall are doing, then you can't address the issues perhaps, or you know, you may be sending messages that they don't understand or aren't helpful…often as an experienced GP, some of the best learning episodes are when you sit round with other GPs and discuss how you do it. So many things in general practice, you're in your room on your own.(GP_6)*

c. Guidelines

The majority of the GPs were either unaware of the DWP fit note guidance or had not reviewed it since the fit note was introduced. Some thought it important, others not:

> *No, I wasn't aware of it. Do we need guidance? (GP_5)*

Standards and guidelines could support their consultations and lead to greater consistency in patient management:

some GPs just issue that (not fit note) because they felt under threat but if there are guidelines and standards you can give that to the patient, "This is not me, this is the guidelines. This is the set of standards that stop me." (GP_2)

d. Changing patient knowledge and understanding of the fit note

GPs varied in how aware they thought patients were of the change in the fit note. Most GPs thought that they were aware, but were not certain as to how they had gained this knowledge. Others disagreed because they thought the changes to certification were quite subtle.

Some GPs reported raising the subject in the consultation and saw it as their responsibility. Some thought it should come through their employer, by inclusion in induction programmes. Others had doubts as to whether employers knew enough about it, or that it was the responsibility of the DWP to better inform the general public:

It's probably a governmental thing isn't it? It's not really ours, and it's not really the employers either, because neither us, nor we, have set it up. The Department for whatever—they've set it up haven't they, so it's probably up to them make people aware. I mean how would that happen? Through public campaigns or, I don't know, leafleting through their employer? (GP_10)

2.4 PHASE ONE: DISCUSSION

Summary of Phase One data collection

Data was collected from the following sources:

Employers: *Thirteen organisations were recruited to the study from which 827 anonymised copies of fit notes were collected. Representatives from each organisation responsible for managing the fit notes were asked to complete a questionnaire concerning the outcome and usefulness of a proportion of these fit notes. A total of 498 questionnaires were completed. Face-to-face individual interviews were conducted with 21 of these representatives to explore their perceptions and experiences of fit notes.*

Patients: *Eleven employed patients were recruited to the study who had been issued with a fit note by their GP. Each completed a questionnaire concerning the outcome and usefulness of their fit note. Face-to-face individual interviews were conducted with ten of the participants to explore their perceptions and experiences of fit notes.*

GPs: *Eleven GPs were recruited to the study from whom 94 anonymised copies of fit notes were collected. The GPs were asked to complete a questionnaire concerning the outcome and usefulness of each fit note. A total of 93 questionnaires were completed. Face-to-face individual interviews were conducted with each GP to explore their perceptions and experiences of fit notes.*

Introduction

This chapter summarises the main findings from the phase one study and highlights the topic areas generated for the phase two consensus study.

Overall awareness and understanding of the fit note

Our phase one findings suggest that, more than three years after its introduction, the fit note is of limited use in helping employed patients return to and remain at work. Although the employer and GP participants were aware of the fit note and why it had been introduced, the patient participants' understanding of it was limited or inaccurate. Employer organisations and GPs might be expected to have a reasonable understanding of the fit note and how it is intended to be used, yet our findings have demonstrated that this was not the case.

Overall opinion of the fit note

In principle, the three main stakeholder groups supported the concept of the fit note in facilitating timely return to work. However there were a number of actual and potential obstacles identified that need to be overcome for it to be implemented as intended. For example, many GPs saw responsibility for the fit note as a role that had been forced upon them and felt that they had neither the time nor the expertise to deal with it; it was seen as a low priority. Patients saw it as a good idea, but its effectiveness would be dependent on the workplace and employer. Employers generally viewed fit notes as an improvement on sick notes, but felt they would be more useful if they were completed and used more effectively by GPs.

Fit notes and sick notes

The interview findings from this study demonstrated that the term 'fit note' is neither commonplace nor widely understood. Those patients who knew about the 'may be fit' option were still unclear about whether it was still necessary to be signed as 'fit' for work. GP participants frequently referred to 'not fit' notes as 'sick notes', and to 'may be fit' notes as 'fit' notes, and some queried what they should do without having the option of issuing a 'fit for work' note. Employers also regularly referred to sick notes rather than fit notes and were doubtful if employees were aware of the difference either. Fit notes were still being used to sign people as 'fit' for work.

In the trial of the draft fit note,[11] the GP participants were provided with the additional assessment option of 'you are fit to work'. In the consultation on the draft regulations for the fit note, there was no consensus of opinion amongst the respondents as to whether this option should be included and it was removed.[4] The reasons were that: workers do not have to be 100% fit to be in work; the option was unnecessary as GPs would have to indicate whether or not they need to assess their patient's fitness for work again; a meeting with the Association of British Insurers had confirmed that a 'fit for work' statement was not needed for Employers' Liability Compulsory Insurance reasons. However, the findings of this study suggest that stakeholders are not aware of this reasoning, and that the term 'fit note' has therefore led to some confusion. This may affect not only the use of the term in practice, but also the findings of research studies about the 'fit note' - participants may be interpreting the term in different ways. For example, in their study of employers' and employees' views about return to work with chronic pain, Wainwright et al.[17] refer to patients being eligible for the study if they had 'needed a sick note or fit note within the last year'. Although the authors report that the fit note was perceived to be helpful by participants, it is not clear whether, in reality, they had been issued with a 'may be fit' note.

- In view of these findings, statements were included in the Delphi study concerning the use of DWP guidance by GPs and employers, training in fit note use, and the use of the term 'fit note'.

Electronic fit note (eMed)

An electronic certification system was first recommended in 2008[9] with the purpose of allowing GPs to compare standards of practice and enable employers to identify patterns of absence. It was also suggested that the system could be used to promote quicker and easier communication between GPs and employers, with the potential for fit notes to be transferred electronically. The DWP states that the electronic fit note, or 'eMed' should be integrated into GP practices' IT systems, enabling GPs to complete the fit note on their computer, save the details to a patient record and print a copy for the patient.[28] The eMed was expected to be in use from July 2012 and to have been rolled out to all GP practices by early 2013. However, in our study the majority of fit notes (80.4%) were handwritten. Employers in the most recent survey conducted by the EEF[20] also report that computer-generated fit notes are not commonplace. Shiels et al.[24] conducted a large retrospective study of fit notes, but the GP participants used specially commissioned carbonised pads rather than electronic fit notes, so it was not possible for the study to assess the uptake of the eMed.

In our study only 162 (20%) of the fit notes collected from participating organisations were computer-generated. Although 121 of these followed the same format as the paper copy, 40 used a variety of different electronic formats, some of which had sections missing or with different section headings. The reasons for this are not known, although it has been suggested that GPs may be avoiding costs by continuing to use the paper version.[29] In an editorial, Gabbay[30] refers to the study by Sallis[11] as 'the recent DWP-funded electronic fit note pilot', yet the paper by Sallis et al. reported on the pilot of the draft fit note, not the electronic fit note. The electronic version of the fit note was piloted in Wales as a proof of concept study and focused on the technical and IT challenges, not the content or quality of the forms. The results of this pilot have yet to be made publicly available.

GPs in our study thought that completing the fit note on computer rather than by hand potentially led to a more detailed, higher quality note which could better facilitate continuity of care between GPs in the same practice. However, some appeared to be creating their own templates, were unaware of the electronic version or simply used the template to record what they had written by hand for the patient. The 'condition' section might be populated automatically from the READ codes, providing no additional details. The eMed was not necessarily viewed as a priority.

The electronic fit note may improve legibility but there is no guarantee that it would improve the content and advice[25] and indeed a recent survey has reported that employers think that it has not improved the quality of the information.[31]

- In view of these findings, statements were included in the Delphi regarding the standardisation, completion and promotion of electronic fit notes

The fit for work consultation

It was apparent from the GP interviews that telephone consultations were a popular option for GPs. Some patients also appreciated this option as it meant that they could collect the fit note from the practice at their convenience. However, others would prefer a face-to-face consultation for reassurance. The process depended on good phone connections. It was unlikely that patients would see what was written on the fit note until they collected it from the surgery and this process seemed likely to facilitate continuations. It was unclear whether patients were given a choice as to their preferred consultation method. It is not known how the method of consultation affects discussion of the patient's job. Roughly 12% of GP consultations are conducted by telephone, a four-fold increase since 1995, yet little research has been undertaken to measure the effectiveness and cost consequences of this method.[32] A recent study has indicated that telephone consultations might increase the number of contacts, with similar costs to usual care.[32] Concerns have been expressed about the impact of telephone interviews on the quality of communication compared to face-to-face.[33] Telephone assessment is reported to be effective for healthcare management[34] and case management in return to work,[35] but little is known about the impact of telephone consultations on the quality of fit notes. It would seem unlikely that GPs would be able to conduct a physical assessment when using a telephone consultation and that it would restrict the opportunity to assess functional ability.

The findings of our study suggest that not all GPs are discussing patients' jobs with them during the consultation. This supports the findings of Chenery[22] where, although 71% of respondents agreed that the fit note was helpful, only 59% of the total sample actually recalled speaking to their GP about their job and 11% of respondents reported not speaking to the GP at all before they received their first fit note.

Patients also reported that GPs differed in how they managed the fit note consultation. Some patients would have preferred to see the same GP who was more likely to have remembered their situation.

GPs indicated that they would either like to be able to access a second opinion of a patient's fitness to work, or that they would rather another professional took responsibility for fit notes.

A number of studies have shown that, although it is part of their contract, GPs are ambivalent about their role in sickness certification.[6;36] In the UK, this may be exacerbated by the apparent increased work demands on general practice. A recent briefing by the British Medical Association reports a 24% increase in GP consultations since 1998, combined with a decline in practice income and increased costs of running a practice.[37] However, previous research findings have been equivocal about the role of other healthcare professions in issuing sickness certificates[6;38;39] and the impact and effectiveness of the newly introduced Allied Health Professions (AHP) Advisory Fitness for Work Report[40] has yet to be evaluated.

GPs in our study seemed to assume that many patients have access to occupational health, when in reality as few as 13% of organisations are likely to provide this.[41] Our findings suggest that there is some lack of awareness among patients/employees as to whether their organisation provides an occupational health service, what it offers, or whether they have direct access. It would be useful for GPs to ask, and for employers to inform their staff, about service provision.

From the findings of the interviews it seemed that there was a general understanding that employees did not need to consult their GP during the first seven days of sickness absence as they could self-certificate during this period. If they requested a fit note during this time there was a belief that the employee would be required to pay a fee. It seemed that this was an area that requires further clarification – self-certification is the equivalent of a 'not fit' note, which might be more likely to facilitate another 'not fit' note through the GP, or delay the patient from receiving necessary work-relevant advice. In addition, repeated use of self-certification is not recorded by the practice, so the GP does not necessarily have a complete history of a patients work health.

- In view of these findings, statements were included in the Delphi study concerning how the fit note consultation might be better managed and who else might conduct it.

Information on the patient's condition

Frequency of conditions reported

In our study, we used the same taxonomy as that used by the DWP[24] to classify the condition stated on the fit note, although we classified 'stress' separately due to the high proportion of fit notes that had recorded this condition. According to the DWP guidance, stress is not perceived to be a health condition, yet it was the fourth highest condition stated on the fit notes collected from the employers, the third highest on those collected from the GPs, and was the condition recorded on 27% of the patients' fit notes. The three most common conditions recorded on the fit notes collected from employers were mental health disorders, back problems and other musculoskeletal problems. These mirror the most common conditions reported by Shiels et al. [24] and Chenery[22] and suggests our sample was representative.

Details provided

In the qualitative findings of our study, employers reported that GPs sometimes recorded conditions that employers did not perceive as a health problem and used medical terminology or jargon. The employers wanted to know whether or not the condition might be caused, or aggravated, by work.

In the patient interviews it appeared that the GP often made the decision about how to complete this section, and that the patients were not always in agreement; it was important to them that they felt the recorded condition sufficiently justified the fit note to the employer. In the patients' opinion, employers would not necessarily understand the condition or terminology used on the fit note, and would rely on occupational health departments and/or the internet to try to gain a clearer understanding.

In the GP interviews the decision as to what and how much detail to provide on the condition depended on a variety of factors: who they thought was likely to read it; how it would be interpreted; whether the fit note was written for other reasons than ill health; the GPs desire to maintain a certain relationship with the patient; perceived lack of confidentiality in the workplace; their own beliefs and attitudes about what was 'safe' to disclose; the method of completion. There was uncertainty about what the GP should report and how to make that decision. Nevertheless, in the questionnaires, on reflection, some GPs reported that they could have provided more detailed information on the patient's diagnosis and could have used lay terminology.

The DWP guidance gives very little detail on how this section should be completed other than stating that the GP should 'give an accurate as diagnosis as possible, unless a you think a precise diagnosis would damage the patient's wellbeing or position with their employer'. However, it does also advise that GPs should only issue fit notes for the patient's own health condition, advice which GPs in our study did not follow. Similarly, in their questionnaire survey of GPs, Hann and Sibald[16] report that 77% of respondents felt obliged to give sickness certificates for reasons 'that are not strictly medical'. Few UK organisations offer, for example, paid carers' leave in comparison with Scandinavian countries such as Denmark.[42] Failure to recognise such issues may be unlikely to result in any positive changes to the current system. In the fit note pilot study[11] the vignettes used referred to patients with back pain and depression and did not explore fit note completion for 'non-medical' factors such as family problems or stress. As a result of these findings, statements were included in the Delphi study to help GPs better explain the patient's health condition to employers and any relationship it might have with the patient's work.

The 'may be fit' option

There was little evidence that GPs were using the fit note to advise that a patient 'may be fit' to return to work. Only 6.7% of fit notes collected from employer organisations had this option selected, and it is likely that the difficulty in recruiting patients who had been issued with a 'may be fit' note to the study was because they are infrequently issued. In 2011 Black and Frost[1] reported that in a study of line managers, 10 to 15 per cent of fit notes were 'may be fit' notes, and as few as 2% in some large organisations. In the study by Shiels et al.[24] only 6.4% of notes had the 'may be fit' option selected and the incidence had dropped from 7.7% in the first month to 6.1% in the last month of data collection. However, their sample included unemployed patients, who might be considered less likely to have been issued with a 'may be fit' note. The survey of employers conducted by EEF[20] reported that a third of companies had not received any fit notes with this option in 2013. It appears therefore that fewer 'may be fit' notes may be being issued now than when the fit note was first introduced.

Data collected through interviews with GPs, and from questionnaire comments, revealed that they found the 'may be fit' and the modification options a useful basis to discuss work issues with patients, although they thought some patients misinterpreted the emphasis on the benefits of working as a lack of empathy on the GPs part. Reasons why the option was not used more frequently were due to 'old habits'; insufficient time in the consultation to explore work issues; lack of relevant training; expectations that employers would not offer modifications; that patients refused them; that patients were too anxious to return to work; that patients were already negotiating modifications. GPs were unsure if they could use both the 'not fit' and 'may be fit' option, and there was still uncertainty about whether a 'fit note' could be issued. The fact that some notes are issued with neither option selected may be a reflection of insufficient training, but is not helpful to the employer. An important finding was that 'may be fit' notes would usually not be considered until after one or more 'not fit' notes. If this is the case, there is a risk that opportunities are being missed to help employed patients avoid any sickness absence by using the 'may be fit' option more proactively i.e. to draw an employer's attention to where preventative action could be taken. This finding is supported by Chenery[22] who reported that, according to employees, 96% of first (or only) fit notes and 81% of secondary fit notes received recorded that the individual was 'not fit for work'.

It cannot be assumed that just because GPs do not often use the option, this does not mean that they are not changing their behaviour regarding sickness absence. People may be returning to work more promptly because of the discussion that takes place within the return to work consultation or because employers are being more proactive. Yet the fit note is regarded as a marker of the quality of the GP consultation.

Chenery[22]suggests that updated fit note guidance might increase number of 'may be fit' notes, but this data was collected after the new guidance was introduced, and it appears to have had little impact.

- Statements were included in the Delphi study to refer to the promotion of the 'may be fit' option in the GP consultation, the use of DWP guidance documents and GP training.

Modification options

In this study, the majority of 'may be fit' notes had a work modification option recorded, a greater proportion than reported in the study by Sallis et al.[11] This may indicate that although 'may be fit' notes are uncommon, GPs are now more confident in advising on modifications, although the GP interviews illustrated that many GPs are unsure of these options, for example thinking that they might be advising on permanent changes to the job.

In common with Sallis, the most common advice option selected was 'amended duties' and yet employers indicated that altered hours were often easier to implement as amended duties were not often available. These findings are supported by a survey of employees[22] who reported that the most common modification made by their employers was modified days or reduced working hours. These findings indicate that GPs need more help in understanding how the modification options could be implemented in the workplace.

- Statements were included in the Delphi study regarding increasing GP knowledge and understanding of effective use of the fit note through specific training.

Comment box

Frequency of use

Our study has shown that GPs are not using the comment box are frequently as intended. The DWP guidance states that the comments box **must** be completed when a GP has assessed a patient as 'may be fit' for work, and that it can be useful to complete if the patient has been assessed as 'not fit'. We found only 12% of all fit notes collected through employer organisations included a comment. The majority, but not all (89%) of the 'may be fit' notes collected through employer organisations included a comment. Of those collected through patients, 27% included a comment, but only 50% of the 'may be fit' notes did. Of those collected through GPs, 29% of all fit notes included a comment; 78% of the 'may be fit' notes did include a comment.

In a previous study of 712 fit notes collected from one GP practice over a six month period, Coole et al.[23] found similar proportions; 72% of the 'may be fit' notes, and 12% of the 'not fit' notes included a comment. In their study of 79,815 fit notes, commissioned by the DWP, Shiels et al.[24] found that of 58,695 fit notes in the sample, 3,670 were 'may be fit' notes. Of these, only 53% had provided free text comments. Thus our study

suggests that GPs are now writing more comments on 'may be fit' notes. Yet the study by Shiels et al. did not report on the comments included in 'not fit' notes, and neither study differentiated between fit notes issued to patients who were in work and those who were unemployed. The lack of use of the comment box on 'not fit' notes has been reported by the EEF in their annual survey of employers.[20]

Content, including 'functional effects'

As regards the content of comments, the DWP guidance[43] provides a checklist for GPs as to what they might include in this section including: activities the patient is unable to do, or that should be avoided or altered; the likely duration of the condition; medical appointments that may impact on work; features of the workplace which may impact on the patients' condition; whether or not the patient might benefit from an occupational health assessment. However, the guidance also states that 'the important information to include is advice about the functional effects of your patient's condition on their fitness to work – and that the GP does not need to refer to their patient's job. In our study, more than half of the fit note comments in the employer sample referred directly to work-related advice/recommendations/instructions, and only 11% referred to the functional effects of the condition. In the GP sample, only 27 of the 94 of the fit notes had included a comment. In these, the greater proportion of fit note comments referred directly to work-related advice, only 11 referred to functional effects. In the patient sample, only one of the eleven fit notes included a comment referring to functional effects. These findings reflect a poor understanding of the term.

In the patient interviews, participants appeared able to describe how their condition affected their ability to work. However, only one GP referred to this in the comments section, and, according to the patient, the GP's description was inaccurate. In the GP interviews, many thought the comments space was useful but either had not noticed it, rarely used it, were uncertain what to include, or felt that it was reliant on them having an in-depth knowledge of the patient's job and/or occupational health training. Interestingly two GPs specifically remarked on the box being a large or wasted space. Yet, in reflecting on their fit notes, GPs commented in the questionnaires that they could have provided more information on the condition, treatment, function, including why the patient was unable to work.

Employer interview participants were keen that where advice was given they would prefer this to be as specific as possible. If patients had more than one health condition, then it should be clear which condition the advice related to. In their questionnaires, employers emphasised the need for GPs to complete the comments section and particularly to explain how the patient's condition had affected their ability to work.

There does therefore seem to be some confusion about what should be entered in the comment box, and descriptions vary in other studies. (For example, Chenery[22] reports that the space is *for the GP to give further advice about what their patient can do at work.* Shiels et al.[25] state that it is *to allow the GP to elaborate on the structured advice or suggest an alternative method of support'*.) This seems to imply that GPs have a choice as to whether to complete it, and do not have to refer to the functional effects of the patient's condition.

The decision not to include a definition of the phrase '*functional effects of the patient's condition'* was discussed in the government's response to the consultation on draft regulations. The reason given was that defining the phrase in the rules would be *'exceptionally complex as this will vary according to each patient's condition'*, Our findings suggest that GPs need more training in this area. The lack of information provided by GPs on patient's functional ability has been reported elsewhere. Norwegian GPs have reported on their difficulty in assessment and communicating on patients function [44;45] and in a study of Swedish sick certificates, only one third of GPs reported on patients' activity limitations despite the introduction of new guidelines and implementation strategies.[46;47]

The findings of our study do not support those of Wainwright et al.[17] that the fit note summarises *'more detailed conversations between employees and GPs'* than the sickness certificate or is '*symbolic of the care that had been put into these discussions'*. It seems possible that the use of the comments section on fit notes, as Wainwright et al.[14] suggest, may not differ greatly to the sickness certificate, where there was a space for 'remarks' which GPs could, and some did, use for suggesting return to work modifications.

Comments and 'not fit' notes

The DWP GP guidance states that it can be useful to complete the comment box if the patient has been assessed as 'not fit'. However, the box is incorporated into the section including the work modification options. The findings of Phase One indicate that the box is infrequently used for this purpose, that GPs do not consider

it necessary, and that the layout does not encourage completion for 'not fit' notes, yet employers would value more information on a range of factors.

- Statements were therefore included in the Delphi to facilitate GPs in completing the comments section in all fit notes, to provide prompts to help in completion and to clarify and encourage GPs to comment on the functional effect of the patient's condition.

Dates and durations

In the majority of cases in the employer fit notes, either a duration had been entered or a 'from' and 'to' date. However, both GP and employer participants reported that they were uncertain whether the 'to' date referred to the last day of absence, or to the first day of work resumption.

In our study, the most common duration of fit note was 14 days. In the study by Shiels et al.[24] the greater proportion of fit notes - around a half - were issued for between one and four weeks. Although it would be a positive outcome of the fit note if periods of sickness absence were to decrease in length, the employer interview findings suggest that they are seeing repeats of fit notes of a shorter duration. For example, rather than one fit note for four weeks, they may be receiving four fit notes of one week duration, which they find difficult to manage in the workplace as they cannot be confident of when an employee might be returning to work. In our study, of the 'not fit' notes collected from employers, just over half (50.8%) were followed by another 'not fit' note. This suggests an area for further research. Employers were also keen to know for how long modifications might be in place for.

- As a result of these findings, statements were included in the Delphi regarding the clarity of dates and durations of fit notes and reduced work capacity.

Reassessment by the GP

The DWP guidance states that the reassessment section of the fit note is mandatory as it gives the patient an indication about whether they can expect to be fit for work when the fit note expires. This helps them and their employer plan for the future. It is also one of the main reasons given for not including a 'fit to work' option on the fit note.[4] However, our study findings show that GPs are not completing this section routinely. Of the fit notes collected through employers, this section had not been completed in almost 60% of cases. It had not been completed in nine of the 11 fit notes collected from patients, or in almost 40% of fit notes collected from GPs.

Employers reported that the completion of this section would indicate how likely it was that patients would return to work after the fit note expiry date. Patients reported either being unsure whether it was possible to return to work before the expiry date, or that their GP had let them decide whether to return for a further consultation. GPs' reasons for non-completion included not having noticed the section, not seeing it as necessary or not wanting to encourage further consultations.

In their study, Shiels et al. (2013)[24] found that this section was not completed in 43.7% of fit notes. Our more recent findings indicate that no improvements have been made in this area, and that further training or education may be required.

- In view of the findings, statements were included in the Delphi study regarding completion of the reassessment section and regular auditing to measure and improve the quality of fit note completion.

Occupational status

The DWP guidance does not indicate that GPs should record their patients' occupational status. In this study, the lack of this information on the fit note is likely to be in part responsible for some of the problems experienced in recruitment. Perhaps the clarity of any audits, service evaluations or research concerning the fit note would be enhanced if this were to be the case. Shiels et al.[24] aimed to report on the proportion of patients unemployed versus those in work, but the participating practices had no consistent policy relating to the routine recording of patient employment information. Completing fit notes for patients who are out of work may require different processes and training to those for patients who are in work. Asking a patient about their occupational status could facilitate the return to work consultation and it would seem incongruous not to record this.

Only one GP in this study felt that, in hindsight, it might have been useful to have recorded the patient's occupation, although whether this was on the fit note or in the GP record was not clear. A recent study by Richards-Taylor et al.[48] further reported on the poor recording of patients' occupations in GP notes, and questioned whether the fit note has value in the monitoring and analysis of sickness absence if patients' occupational status is not recorded.

- In view of these findings, a statement was included in the Delphi study to facilitate the recording of employment status on the fit note.

Management of the fit note at work

According to the DWP guidance, the fit note is the property of the patient. Although employers should take a copy for their records, our study suggests that in practice most organisations are not only keeping the original but do not provide the employee with a copy. However, the opening sentence of the DWP guidance on taking sick leave[49] states that 'employees must give their employer a doctor's 'fit note', which might contribute to this misunderstanding.

There also seems to be a range of methods and timescales for delivering the fit note to the workplace. In practice, the fit note may be read by colleagues, managers, receptionists, administrators, human resources and occupational health staff. These methods seem neither to facilitate efficiency, confidentiality or responsibility. In the case of a 'may be fit' note, it would seem vital that the fit note reaches the workplace as soon as possible, but there were no apparent systems for prompt positive management of the 'may be fit' option.

Some employers indicated in our study that, because they found 'may be fit' options difficult to implement, they might not actively encourage their employees to obtain 'may be fit' notes. Further research is indicated to explore whether this might account for the low proportion of these notes.

The majority of employers were unaware of the DWP guidance and were unclear about the legal position regarding insurance and the advisory nature of the fit note. There was little evidence of education and training for employees as to how they should manage the fit note. Both patients and employers referred to absence monitoring systems and it was apparent that these might discourage employees from returning to work before the expiry of the fit note in case they had a 'relapse' resulting in another episode of sick leave and that work modifications, particularly reduced hours, might impact on their pay. These findings reflect those of Irvine[50] in highlighting the importance of contextual factors in the workplace, such as contractual status, salary, sick pay provision and job control on fit note completion.

- In view of these findings, statements were included to facilitate transmission and confidentiality of the fit note and the use of DWP guidance by employers, and to promote sickness absence procedures that support return to work.

Communication between GPs and employers

We confirmed that the fit note is the primary means of communication between the GP and the workplace other than any additional information that the patient may provide to the employer about the GP consultation. Otherwise, communication with the GP was through reports requested by occupational health staff. Requests for reports made by occupational health staff took place in around 20% of 'may be fit' notes and 10% of 'not fit' notes. However, their value was brought into question. Employers/occupational health complained that the quality of the reports was often poor, that they often took several weeks to be returned, and that the fees were variable and unreasonable. GPs are not keen on completing reports because they feel they do not have the skill set required, yet they are not obliged to do this private work. GPs complain that they do not usually receive any feedback from the employer following these reports.

Employers and patients – and some GPs - considered that the use of phone and email by GPs and employers could lead to greater dialogue. However the complexities of ensuring patient consent and confidentiality would have to be addressed, and contact details would need to be included on the fit note with the GP address.

- In view of these findings, statements were included in the Delphi concerning the cost and timeliness of medical reports and the potential for communication by email and phone.

Education, guidance and training in using the fit note

Written guidance

When introducing the revised statement, it was stated that there would be 'a communications campaign' to ensure doctors, employers and patients/employees were aware of the change'.[4] However, there is little evidence of the effectiveness of this, or whether the campaign was evaluated.

The DWP issued on-line guidance documents for GPs[43] and hospital doctors,[51] patients and employees,[52] occupational health,[53] and employers and line managers[54] when the fit note was introduced in 2010. In their report on a survey of GPs, Hann and Sibald[16] suggested that revised guidance for all stakeholders might improve awareness of using the fit note to its full potential. This revised guidance was published for patients and employees, GPs and employers and line managers in April 2013 and again in 2014 for GPs - however, our findings indicate that most stakeholders are unaware of it and thus it has had little impact on practice. These findings support studies published previously by Wainwright et al.[14] who reported on GPs' lack of awareness of on-line resources and of time to read the guidance. Prior to the fit note, in 2002, the DWP issued guidelines on the 'sick note' but a study by Roope et al.[55] demonstrated low levels of awareness and use of these. A systematic review of the sickness certification process concluded that 'guidelines without training are obviously ineffective'.[36]

An e-learning tool is also available through the Health Working UK website,[56] but again in our study GPs did not refer to using it although the idea of on-line resources seemed to appeal. Wainwright et al. suggested in their study that GPs wanted more interactive on-line training. However, a study evaluating the effectiveness of an e-learning training module for hospital doctors in sick note certification was limited by low uptake[57] and concluded that further research was needed in this area.

GP training

In their response to Dame Carol Black's Review,[9] the government stated that the GP fit note would be supported through the widening of the National Education Programme for GPs. This would aim to improve GPs' knowledge and confidence when dealing with health and work issues and the revised medical certificate, allowing GPs to focus on what individuals can do rather than what they cannot.[3] Subjectively, GPs attending the NEP for GPs have reported finding it useful,[58] however an objective evaluation of the Programme and its impact on the quality of fit notes has yet to be conducted/published. The programme comprises a half day optional workshop which GPs currently have to pay for and attend in their own time. Reports indicate that uptake is less than anticipated - a survey conducted by the EEF noted that in 2012 only 3,500 had received face-to-face training (of a possible 41,350 GPs).[31] Hann and Sibald[16] found that only 10% of GPs surveyed had received training in health and work in the last 12 months and the extent or content of this training was unknown. Those who had received training were more likely to believe that patients had to be fully recovered to return to work, a belief held by 20% of the respondents. This suggested that there were deficiencies in the training and demonstrated that one fifth of GPs did not understand the key message underpinning the fit note.

Our findings suggest that the two GPs who had attended the NEP workshop considered it useful, but that it did not cover fit notes in detail and was likely to be accessed only by those with a particular interest. GPs in our study indicated that training in fit note use needed to be ongoing in order to effect change, because as Welsh et al.[13] reported it may be difficult to change 'a lifetime of practice'. Other studies have reported differing views amongst GPs as to further training in sickness certification generally.[6;59;60] The value of training for GPs in occupational medicine has been highlighted as an area requiring further investigation.[61] Some studies, for example, have demonstrated that specialist GPs and those working in occupational health issue sickness certificates with shorter duration,[62,63] whereas others suggest that those with additional qualifications prescribe more days sick leave.[61,64]

In reflecting on the fit notes they had issued, most of the GPs in our study considered that they had completed the notes satisfactorily, yet several sections had not been completed and some GPs, on reflection, did feel that there was other information that they could have included. A questionnaire survey of 5,455 Swedish physicians Lofgren[65] found that although the majority of respondents indicated a need for more knowledge and skills in handling sickness certification, few stated that they needed more skills in filling out the certificates. Our study suggests otherwise.

In their survey of employers,[21] the CBI report that only 10% of respondents were confident that doctors are sufficiently trained to use the fit note, while only 5% consider that doctors have sufficient understanding of the workplace to make full use of the fit note. In our study most employers considered that joint fit note training for employers and GPs would be beneficial, but GPs were less keen.

Employer/employee training

Although GPs can access a national programme of information there is no equivalent for employers or employees. DWP guidance documents are available for employers and employees but the majority of participants in our study were unaware of them, and there was little evidence of specific training in the fit note. It seems that, alongside the fit note, employees/patients are the main conduit of information between the GP and the workplace and yet no one body appears to be responsible for ensuring that they are aware of the fit note, and understand how it can be used. Our findings support those of Lalani et al.[18] that employers also need training in the use of the fit note and that opportunities are needed to promote better understanding and dialogue between the stakeholders.

- In view of these findings, statements were included in the Delphi study referring to the use of DWP guidance and training in fit note use for all stakeholders.

Limitations of Phase One

In this first phase of the study a considerable amount of both quantitative and qualitative data was collected from all three stakeholder groups from which a series of statements on fit note use were generated for Phase Two.

The main limitation of this phase of the study was that we were unable to recruit the intended sample of patients. This was despite applying for and implementing an amendment to increase the number of GPs issuing study material to patients and extending the recruitment period, and making regular contact with the GPs and practice managers. We do not know the reason for the recruitment difficulties but suspect that some GPs were forgetting to pass on the information packs to patients, that patients were not motivated to participate, or that they found the information too complex. It may also be due to patients' concerns about drawing attention to their health condition and ability to work, and fears as to whether this judgement might be brought into question. This might be a particular worry if the patient feels that their condition may not 'warrant' sickness absence according to fit note guidelines. The finding suggests that GPs may not be best placed as gatekeepers to recruitment in fit note research and consideration should be given as to whether it might be more effective to engage organisations in the recruitment of employed patients. Future studies in this field will need to take these issues into consideration.

Recruitment of interview participants was based on the available resources and timeframe of conducting the study and it is possible that data saturation was not reached. We were also unable to collect as many 'may be fit' notes as intended. Although having a longer duration of data collection might have increased the sample, the overall small proportion of 'may be fit' notes collected through the employers in our study indicates that this is unlikely to have made a substantial difference. In addition, we did not take into account any differences in the gender of the participating GPs. Previous research has suggested that male and female doctors approach fitness for work matters differently[66], and this was not addressed in our study. Furthermore, although the study was able to recruit more than the intended sample of organisations, the proportion of those with occupational health provision may not be reflective of the actual proportion of employers with such provision in the UK. Finally, although data was collected across three counties, these were in one region in England, and we therefore cannot draw any conclusions regarding the generalizability of our results.

CHAPTER 3. PHASE TWO: CONSENSUS STUDY

3.1 MODIFIED DELPHI STUDY

3.1.1 Aim

In order to produce a set of recommendations on the ideal use of the GP fit note, and in the absence of other relevant literature, we aimed to reach a consensus as to the content of these with a group of experts in the field. These recommendations were subsequently presented to stakeholder groups in a final phase of the study to explore the extent to which the recommendations might be implemented in practice (see section 3.2).

3.1.2 Methodology

The consensus method was the modified Delphi technique. The Delphi technique was developed by the Rand Corporation in the late 1940s as a means of reaching a consensus of expert opinion on the likely impact and aftermath of nuclear war.[67] It has subsequently been adopted in medical, nursing and health services research. In a Delphi study a questionnaire or interview schedule is presented to a panel of 'informed individuals' in order to seek their opinion or judgement on a particular issue.[68] Individual responses can be solicited with the potential threat of peer pressure removed.[69] Several 'modifications' of the technique have been described but in essence the modified Delphi method is an anonymous, multi-round, consensus-building technique used to generate, analyse and synthesise expert views to reach a group consensus position. There is no universal agreement on an acceptable level of consensus, however Keeney[70] suggests this should be decided before commencing the study, and recommended at least 70%.

The process usually involves a minimum of three rounds, as described by Jones.[71] In the first round either relevant individuals are invited to provide opinions on a specific matter, based on their knowledge and experience, or the team undertaking the Delphi expresses opinions on a specific matter and selects suitable experts to participate in subsequent questionnaire rounds. These opinions are grouped together under a limited number of headings and statements drafted for circulation to all participants on a questionnaire. Participants rank their agreement with each statement. The rankings are summarised and included in a repeat version of the questionnaire. Participants then re-rank their agreement with each statement in the questionnaire, with the opportunity to change their score in view of the group's response. The re-rankings are summarised and assessed for degree of consensus. If an acceptable degree of consensus is obtained the process may stop and final results fed back to the participants. If not, the third round is repeated. Participants are told that they need not conform to the group view. There is no complete agreement about when to terminate a Delphi survey, and it has been argued that 'if no consensus emerges, at least a crystallizing of the disparate positions usually becomes apparent'.[72]

Method

A series of statements were generated by the research team based on data collected in the first phase of the study and on published literature. Statements were reviewed and revised by the research team together with a member of the steering group and presented to members of an expert panel. Participants were informed that the purpose of the study was to reach a consensus on:

- The content and management of the ideal fit note
- How dialogue between the stakeholders is best facilitated
- The training needs of GPs and employers

Participants were informed that the statements did not necessarily reflect the views of the research team.

In the first round, a series of statements were presented to the participants. The statements were grouped under five main subject headings:

- General format and application of the fit note
- Completion of the fit note
- Management of the fit note
- Communication about the fit note
- Training

Alongside each statement was a drop-down box with four response options:

- Strongly agree
- Agree
- Disagree
- Strongly disagree

Participants were asked to select one of the response options for each statement and to insert any comments regarding the statement in an adjacent free text box. Links to all of the most recent fit note guidance documents published by the Department for Work and Pensions were attached to the Delphi documentation at each round.

Participants were asked to respond to the statements within approximately two working weeks. The research team analysed the results and removed statements where participants had reached consensus (which was defined as ≥75% agreement).

In the second round, participants were sent a series of statements including those where consensus had **not** been achieved in the first round, together with re-worded or additional statements generated from comments and responses in round one. These statements were discussed and reworded by four members of the research team. The file included the participant's previous score for each of these statements and the proportion of each response option selected by the other participants. Each participant was then able to compare their response with these anonymised responses and consider whether they might wish to change their initial response in the light of the responses of others. They were again invited to add a free text comment for each statement.

Participants were asked to complete and return the excel file within approximately two working weeks. The research team then again analysed the results and removed statements where participants had reached consensus (≥75% agreement).

The third round followed the same procedure as the second round.

Sampling

A list of potential panel members was drawn up, generated by the research team and members of the steering group. These represented employers, government departments, trades unions, patient organisations, occupational health, general practice, allied health professionals delivering work-focused interventions and academics from the field of work and health. Individuals were approached by email/letter. Individuals were considered to be appropriate and/or relevant if they had professional experience of/expertise in any of the following: contributing to the development of the fit note, researching/evaluating the fit note, writing fit notes, managing employees issued with fit notes, representing patients and employees issued with fit notes, rehabilitating patients issued with fit notes. A total of 51 individuals were identified. They were sent an introductory letter and/or email about the study. Participants were informed that they would not be identified to each other. Further information explaining both phases of the study and the Delphi procedure was sent to those who expressed an interest.

3.1.3 Results

Participants

Of the 51 potential panel members approached, 20 agreed to participate. Of this group, one withdrew prior to data collection and two then failed to respond to the survey. Therefore a total of 17 individuals participated in the study.

Round One

A total of 53 statements were included in the first round of the Delphi. All 17 participants responded. Consensus was reached for 37 statements. Details of the statements are shown in Figure 9.

Figure 9. Consensus statements from Delphi Round One

GENERAL FORMAT AND APPLICATION

1. Electronic/computer-generated fit notes should be standardised.
2. Electronic/computer-generated fit notes must exactly match the hard copy fit notes.
3. Fit notes should include a section stating whether or not the patient is employed.
4. The electronic/computer-generated fit note should have drop-down prompts for the GP, giving examples of the information they are expected to provide.
5. The comments section should be separate from the work modification tick boxes to encourage GPs to comment on ‘not fit’ notes as well as ‘may be fit’ notes.
6. GPs should be able to access a second (independent) opinion of a patient's fitness to work.
7. The DWP should actively promote the use of electronic/computer-generated fit notes.
8. The DWP should actively monitor the use of fit notes.

COMPLETION OF THE FIT NOTE

9. Fit notes should be completed electronically.
10. Each section of the fit note must be completed.
11. The content of each section of the fit note must be discussed and completed with the patient's knowledge and agreement.
12. If a patient has more than one condition affecting their ability to work, information and advice on the fit note should clearly distinguish to which condition this refers.
13. If medical terminology is used on a fit note, then a lay person's version should also be provided e.g. CVA (stroke).
14. If a patient's health condition is work-related (partially or fully) the GP should specify this on the fit note, with the patient's consent.
15. If a patient has had, or is undergoing surgery, and with the patient's consent, the GP should use the fit note to advise on expected post-operative complications and restrictions.
16. GPs should clarify the duration of recommended modifications on a fit note where possible.
17. GPs must complete the comments section of the fit note on both ‘not fit’ and ‘may be fit’ notes.
18. GPs must ensure there is no ambiguity as to the return to work date on the fit note.

MANAGEMENT OF THE FIT NOTE

19. GPs must ask all employed patients whether there is anything about their health condition that makes it difficult to work, and if so, what this is.
20. GPs should state how the patient's condition affects their ability to work (i.e. the functional effects of the condition) on both ‘not fit’ and ‘may be fit’ notes.
21. GPs must conform to the most recent fit note guidance published by the DWP.
22. It should be possible for patients to access the same GP for ongoing fit note consultations
23. GPs should ask the patient the extent of their employer's occupational health provision and involvement when completing the fit note.
24. The option should be available, with patient consent, for fit notes to be emailed to the employer.
25. Employers must conform to the most recent DWP fit note guidance.
26. Organisations must have a timely mechanism for dealing with ‘may be fit’ notes.
27. Employers should ensure that sickness absence monitoring schemes do not discourage employees from returning to work before the expiry of their fit note, if they feel able.
28. There should be a defined period within which GPs complete reports requested by an employer or the employer's occupational health provider.

COMMUNICATION ABOUT THE FIT NOTE

29. Fit notes should include GP contact details (phone, email) to facilitate discussion of the patient's return to work should the employer wish to do so, and with the employee's consent.
30. Employers should contact the GP by phone or email, with employee consent, if they have questions about the employee's fit note.
31. Employers must ensure strict confidentiality in their management of fit note information.
32. Where necessary, and with patient consent, GPs should communicate with their patient's employer to seek more information on the employee's job and possible modifications.

TRAINING

33. GP fit note training should be incorporated into official GP training events (e.g. Protected Learning Time).
34. GP fit note training should be mandatory.
35. Employers must inform their workforce about how their organisation manages the fit note.
36. Employers must inform individuals as to any impact that work modifications advised on a fit note might have on their pay.
37. Training in the use of the fit note should include GPs, employers and patient/employee representatives so that each can hear the others' viewpoint.

Round Two

A total of 36 statements were included in the second round of the Delphi. These consisted of:

- Six unchanged statements where consensus had not been reached
- Ten re-worded statements where consensus had not been reached and where comments indicated that further clarity was required
- Twenty new statements generated as a result of comments made in the first round

All 17 participants again responded. Consensus was reached for 22 statements. Details of the statements are shown in Figure 10.

Figure 10. Consensus statements from Delphi Round Two

GENERAL FORMAT AND APPLICATION

1. Completion of all fields of the electronic/computer-generated fit note should be mandatory.
2. Electronic/ computer-generated notes must require the GP to select either the 'may be fit' or 'not fit' option.
3. GPs should have the option of selecting both fitness to work options (‘not fit’ and ‘may be fit’) if they qualify these choices with clear dates, duration and advice.
4. It is for the employer in conjunction with the employee, to consider and act on - or reject - the advice that they receive.
5. Other healthcare professionals with relevant training and competency should be able to complete fit notes.
6. If a patient has another job with different demands, the GP should complete the fit note to cover each job.
7. GPs need to understand the details of their patient's work tasks in order to comment on the 'functional effects' of the patient’s condition.

COMPLETION OF THE FIT NOTE

8. If a patient's symptoms are aggravated by work, then the GP should specify this on the fit note, with the patient’s consent.
9. With the patent's consent, information on planned tests and treatment interventions impacting on the patient's ability to work should be included on the fit note, with timescales where known.
10. Where possible, and with the patient consent, GPs should include information on the fit note as to the likely duration of reduced work capacity.
11. GPs should avoid using non-specific advice on work adjustments on a fit note e.g. light duties.
12. GPs should have the most up-to-date DWP fit note guidance available on their website and/or at their surgery.

MANAGEMENT OF THE FIT NOTE

13. Patients should not be discouraged from consulting their GP about a health problem that impacts on their ability to work during self-certificated sickness absence.
14. GPs should be able to write a fit note during the self-certification period, free of charge.
15. The use of email to send fit notes to patients' employers should be piloted before a final decision is made.
16. The DWP should provide more detailed guidance to employers on best practice in the management of the fit note through their organisation.
17. Employers should have the most up-to-date DWP guidance available for employees on their website and/or at the workplace.
18. Reports requested from the GP by an employer or the employer's occupational health provider should be completed within two weeks of the request being made.
19. Where reports are requested from the GP by an employer or the employer's occupational health provider, there should be a standard fee.

COMMUNICATION ABOUT THE FIT NOTE

20. Patients should be the primary channel of information between their GP and employer concerning the fit note.
21. Records of any contacts made between the employer and the employee's GP, should be sent to the employee (with the employee’s consent).
22. Employees should be consulted as to which members of staff within their organization will see the content of their fit note.

Round Three

A total of 14 statements were included in the third round of the Delphi. These consisted of:

- Five unchanged statements where consensus had not been reached in Round 2
- Seven re-worded statements where consensus had not been reached and comments indicated that further clarity was required
- Two new statements generated as a result of comments made in Round 2

Sixteen participants responded. Consensus was reached for eight statements. Details of the statements are shown in Figure 11.

Figure 11. Consensus statements from Delphi Round Three

GENERAL FORMAT AND APPLICATION

1. Fit notes should include a section stating whether or not the patient is employed/ self-employed/ unemployed
2. The review section should be amended to a default statement ' I will not need to assess your fitness for work again at the end of this period' with the option to amend this if required.
3. There should be local audits of fit notes to ensure that fit notes are completed according to most up-to-date DWP guidelines.
4. Other healthcare professionals with relevant training and competency, who complete fit notes should be Any Qualified Providers who have clinical data sharing set-up locally with GP systems.
5. GPs should provide as much information about the health condition on the fit note, relevant to their return to work, as the patient will consent to.

COMPLETION OF THE FIT NOTE

6. When completing a fit note, the option of 'may be fit' should always be considered initially.

MANAGEMENT OF THE FIT NOTE

7. Patients who seek consultation with their GP about a health problem affecting their ability to work should be able to request a face-to-face consultation.
8. Employees should contact their employer to discuss a 'may be fit' note within two working days of being issued with one.

Consensus statements

The total number of statements across the three rounds where consensus was reached was thus 67. These are shown in Figure 12.

Figure 12. Delphi statements where consensus was achieved

GENERAL FORMAT AND APPLICATION

1. Electronic/computer-generated fit notes should be standardised.
2. Electronic/computer-generated fit notes must exactly match the hard copy fit notes.
3. Fit notes should include a section stating whether or not the patient is employed.
4. The electronic/computer-generated fit note should have drop-down prompts for the GP, giving examples of the information they are expected to provide.
5. The comments section should be separate from the work modification tick boxes to encourage GPs to comment on not fit notes as well as maybe fit notes.
6. GPs should be able to access a second (independent) opinion of a patient's fitness to work.
7. The DWP should actively promote the use of electronic/computer-generated fit notes.
8. The DWP should actively monitor the use of fit notes.
9. Completion of all fields of the electronic/computer-generated fit note should be mandatory.
10. Electronic/ computer-generated notes must require the GP to select either the 'may be fit' or 'not fit' option.
11. GPs should have the option of selecting both fitness to work options (‘not fit’ and ‘may be fit’) if they qualify these choices with clear dates, duration and advice.
12. It is for the employer in conjunction with the employee, to consider and act on - or reject - the advice that they receive.
13. Other healthcare professionals with relevant training and competency should be able to complete fit notes.
14. If a patient has another job with different demands, the GP should complete the fit note to cover each job.
15. GPs need to understand the details of their patient's work tasks in order to comment on the 'functional effects' of the patient’s condition.
16. Fit notes should include a section stating whether or not the patient is employed/ self-employed/ unemployed.
17. The review section should be amended to a default statement ‘I will not need to assess your fitness for work again at the end of this period' with the option to amend this if required.
18. There should be local audits of fit notes to ensure that fit notes are completed according to most up-to-date DWP guidelines.
19. Other healthcare professionals with relevant training and competency, who complete fit notes should be Any Qualified Providers who have clinical data sharing set-up locally with GP systems.
20. GPs should provide as much information about the health condition on the fit note, relevant to their return to work, as the patient will consent to.

COMPLETION OF THE FIT NOTE

21. Fit notes should be completed electronically.
22. Each section of the fit note must be completed.
23. The content of each section of the fit note must be discussed and completed with the patient's knowledge and agreement.
24. If a patient has more than one condition affecting their ability to work, information and advice on the fit note should clearly distinguish to which condition this refers.
25. If medical terminology is used on a fit note, then a lay person's version should also be provided e.g. CVA (stroke).
26. If a patient's health condition is work-related (partially or fully) the GP should specify this on the fit note, with the patient's consent.
27. If a patient has had, or is undergoing surgery, and with the patient's consent, the GP should use the fit note to advise on expected post-operative complications and restrictions.
28. GPs should clarify the duration of recommended modifications on a fit note where possible.
29. GPs must complete the comments section of the fit note on both ‘not fit’ and ‘may be fit’ notes.
30. GPs must ensure there is no ambiguity as to the return to work date on the fit note.
31. If a patient's symptoms are aggravated by work, then the GP should specify this on the fit note, with the patient’s consent.
32. With the patent's consent, information on planned tests and treatment interventions impacting on the patient's ability to work should be included on the fit note, with timescales where known.
33. Where possible, and with the patient consent, GPs should include information on the fit note as to the likely duration of reduced work capacity.
34. GPs should avoid using non-specific advice on work adjustments on a fit note e.g. light duties.
35. GPs should have the most up-to-date DWP fit note guidance available on their website and/or at their surgery.
36. When completing a fit note, the option of 'may be fit' should always be considered initially.

Figure 12. Delphi statements where consensus was achieved (contd.)

MANAGEMENT OF THE FIT NOTE

37. GPs must ask all employed patients whether there is anything about their health condition that makes it difficult to work, and if so, what this is.
38. GPs should state how the patient's condition affects their ability to work (i.e. the functional effects of the condition) on both ‘not fit’ and ‘may be fit’ notes.
39. GPs must conform to the most recent fit note guidance published by the DWP.
40. It should be possible for patients to access the same GP for ongoing fit note consultations.
41. GPs should ask the patient the extent of their employer's occupational health provision and involvement when completing the fit note.
42. The option should be available, with patient consent, for fit notes to be emailed to the employer.
43. Employers must conform to the most recent DWP fit note guidance.
44. Organisations must have a timely mechanism for dealing with ‘may be fit’ notes.
45. Employers should ensure that sickness absence monitoring schemes do not discourage employees from returning to work before the expiry of their fit note, if they feel able.
46. There should be a defined period within which GPs complete reports requested by an employer or the employer's occupational health provider.
47. Patients should not be discouraged from consulting their GP about a health problem that impacts on their ability to work during self-certificated sickness absence.
48. GPs should be able to write a fit note during the self-certification period, free of charge.
49. The use of email to send fit notes to patients' employers should be piloted before a final decision is made.
50. The DWP should provide more detailed guidance to employers on best practice in the management of the fit note through their organisation.
51. Employers should have the most up-to-date DWP guidance available for employees on their website and/or at the workplace.
52. Reports requested from the GP by an employer or the employer's occupational health provider should be completed within two weeks of the request being made.
53. Where reports are requested from the GP by an employer or the employer's occupational health provider, there should be a standard fee.
54. Patients who seek consultation with their GP about a health problem affecting their ability to work should be able to request a face-to-face consultation.
55. Employees should contact their employer to discuss a 'may be fit' note within two working days of being issued with one.

COMMUNICATION ABOUT THE FIT NOTE

56. Fit notes should include GP contact details (phone, email) to facilitate discussion of the patient's return to work should the employer wish to do so, and with the employee's consent.
57. Employers should contact the GP by phone or email, with employee consent, if they have questions about the employee's fit note.
58. Employers must ensure strict confidentiality in their management of fit note information.
59. Where necessary, and with patient consent, GPs should communicate with their patient's employer to seek more information on the employee's job and possible modifications.
60. Patients should be the primary channel of information between their GP and employer concerning the fit note.
61. Records of any contacts made between the employer and the employee's GP should be sent to the employee (with the employee’s consent).
62. Employees should be consulted as to which members of staff within their organization will see the content of their fit note.

TRAINING

63. GP fit note training should be incorporated into official GP training events (e.g. Protected Learning Time).
64. GP fit note training should be mandatory.
65. Employers must inform their workforce about how their organisation manages the fit note.
66. Employers must inform individuals as to any impact that work modifications advised on a fit note might have on their pay.
67. Training in the use of the fit note should include GPs, employers and patient/employee representatives so that each can hear the others' viewpoint.

Statements where consensus was not achieved

Statements where consensus was not achieved (n=6) are shown in Figure 13.

Figure 13. Delphi statements where consensus was not achieved

GENERAL FORMAT AND APPLICATION

1. The term fit note should be used to refer to both 'not fit' and 'may be fit' notes.
2. There is a case to rename the fit note.

COMPLETION OF THE FIT NOTE

3. Dates and durations entered on fit notes should be adhered to but may be subject to change.
4. If a patient does not wish to disclose their health condition, the GP should enter a statement to this effect on the fit note in the section referring to the patient's condition, with the patient's consent.
5. Fit notes should only be issued for a medical condition.

COMMUNICATION ABOUT THE FIT NOTE

6. Where possible, and with the agreement of the employee, information should flow directly between their GP and the employer.

Free text comments

Free text comments for each statement were summarised. As many of these referred to respondents' opinions as to whether it would be possible to implement the recommendations in practice, these were reported with the findings of the achievability study in the following section.

3.2: ACHIEVABILITY STUDY

3.2.1 Aim

The aim was to ascertain the practicality of implementing the modified Delphi study recommendations.

3.2.2 Method

The 67 consensus Delphi statements were presented under the five section headings described in Section 3.1. Participants were invited to comment on whether the recommendations were achievable, and what might hinder or facilitate their use in practice. Expert participants were given the option of commenting on each section, or separately on each recommendation.

Sampling

A list of 15 potential participants was generated by the research team and steering group of employers, government departments, trades unions, patient organisations, general and medical practitioners and occupational health organisations who were believed to have the knowledge and experience to comment on the recommendations. These experts were identified at both national and local level. Participants from the Delphi study were also invited to participate again. All were approached by email.

Data analysis

Free text comments from this study were combined with relevant comments from the Delphi study. These were synthesised and the key practical recommendations summarised.

3.2.3 Results

Of the 15 potential participants, one declined, five did not respond and nine agreed to participate. A further three participants from the Delphi study also agreed to participate in this study. Thus a total of 12 participants were included. Comments referred to the achievability of the proposed recommendations, respondents' personal opinions and organisational views.

1. Standardisation and the electronic fit note

Standardisation of the electronic fit note was thought to be achievable by most. Issues raised were:

- whether electronic fit notes currently do and/or should have a standard template, format or content and the extent to which this matches the paper copy.
- this could be facilitated by agreement/co-operation between GP IT suppliers and the expiry of the supply of paper copies.
- this could be hindered by: locums not being authorised to use the system; systems being unsuitable, unavailable or unreliable; if fit notes are completed by other professions; particular circumstances requiring paper copies e.g. home visits.

2. Changing the method of fit note completion

a. Mandatory fields

Making all fields of the electronic fit note mandatory was considered achievable by most. Issues raised were:

- some versions of the electronic fit note already have some mandatory fields.

- this could be facilitated by revised DWP guidance; software prompts; the option of stating ‘not applicable’ (e.g. to accommodate matters of patient consent/confidentiality).
- this could be hindered by increasing the number of sections.

b. Incorporating a ‘default’ response for the reassessment section

There was overall agreement that changing the review section to a default statement (I will not need to assess your fitness for work again at the end of this period) is achievable. Issues raised were:

- whether this is actually a default response already on the e-fit note or whether it would require a change in the GP IT specification - which would be difficult and costly to carry out.

c. Incorporating drop-down prompts for GPs on the electronic fit note

This was considered achievable by most. Issues raised were:

- it could be facilitated by prompts that were clear, simple, comprehensive and carefully selected.
- it could be hindered by the cost to the state of the required changes to be made by software companies.
- some felt that it should only be used in addition to comprehensive training and guidance on fit note completion and should not replace the free text option or deter individual tailoring of fit notes.

3. Altering the layout of the fit note

Separating the free text comment section from the work modification options was seen as achievable by most. Issues raised were:

- some difference of opinion as to a) whether this is already in place or whether a change in the regulations would be required as it would entail an alteration to the template and b) whether the DWP guidance already supports this recommendation.
- use could be facilitated by GP education and inclusion in DWP guidance documents.
- increased complexity could reduce completion of the comment section.

4. Recording employment status on the fit note

The majority of respondents thought that including a section on the fit note to record whether or not the patient is employed/self-employed/unemployed was achievable. Issues raised were:

- It could potentially increase the time and complexity of the consultation, or when GPs write a continuation note following a message rather than a consultation.
- It could be facilitated by making it a mandatory field.
- As the fit note is a legislated document, a change in the law would be required.

5. Completing the fit note

a. Patient involvement and agreement

There was overall agreement that it should be achievable for patients to be fully aware of what the GP has written on the fit note and the reasons for completion. However there were differences of opinion as to whether patient agreement is achievable. Issues raised were:

- This could hinder objectivity, not be possible, or would lengthen the consultation, and that it should only be carried out ‘where relevant’.
- It could be hindered by telephone consultations, as the patient does not see the fit note until they collect it from the practice.

- There were views that a) this is not only achievable but should already be routine practice, and b) that the patient should sign the fit note and receive a copy.

b. Information about the health condition

There were differences of opinion as to whether it was achievable for the GP to provide as much information about the health condition, relevant to their return to work, as the patient will consent to. Issues raised were:

- The main focus of the fit note is considered to be on function and advice rather than providing details on the diagnosis or condition; thus it should be seen as an option and not an expectation.
- It could be facilitated by GP training on conducting functional assessments.
- It could be hindered by limited consultation time.

c. Lay terminology

It was seen by most responders to be achievable that if medical terminology is used on a fit note then a lay version should also be provided. Issues raised were:

- This would be facilitated by including the recommendation in DWP guidance documents.
- Some believed that this was unrealistic and unnecessary or should be at the GPs discretion.

d. Commenting on the functional effects of the condition

There were differing opinions as to whether GPs need to understand the details of their patients' work tasks in order to comment on the 'functional effects' of the patient's condition. Issues raised were:

- This could be facilitated by better GP training, encouraging GPs to ask patients about their work tasks and the provision of a generic functional task list.
- It could be hindered by lack of time in the consultation, the reliability of the patient's report, when English is not the first language, the complexity of the job, the perception that GPs need occupational health training to do this.
- It is contrary to current DWP guidance.

e. The 'may be fit' option

Most respondents believed it to be achievable that the 'may be fit' option should always be considered initially when completing a fit note. Issues raised were:

- Some believed there are circumstances where this is inappropriate, e.g. 'short term' illnesses, following major surgery.
- It could be facilitated by inclusion in the DWP guidance notes and interpretation of the term 'may be fit'.
- It could be hindered by concerns about increase in workload.

f. Work-related/work-aggravated health conditions

Most respondents believed that if a patient's health condition is work-related (partially or fully) or aggravated by their work, it is achievable for the GP to specify this on the fit note, with the patient's consent. Issues raised were:

- It could be facilitated by the use of a tick box and inclusion in DWP guidance documents.
- Judging a condition as work-related/aggravated is subjective and that the GP may not be best placed to judge – the term 'work-relevant' may be preferable.
- Concerns about a significant increase in reporting of work-related conditions, especially for mental health issues.

g. Advice on work adjustments

There was a difference of opinion as to whether GPs should avoid using non-specific advice on work adjustments on a fit note, e.g. 'light duties'. Issues raised were:

- It is not the role of the GP to offer specific advice as this is the role of occupational health.
- It would be facilitated by better GP training and the GP's understanding of the patient's work.
- It would be hindered by the time limits of the consultation.

h. Completion of the comment section in 'not fit' notes

There was a difference of opinion as to whether it would be achievable that GPs must complete the comment section on both 'not fit' and 'may be fit' notes. Issues raised were:

- It could be facilitated by better GP training, and revising the DWP guidance.
- It would be hindered by potentially lengthening and complicating the consultation, and by patients not wishing to disclose too much information in the initial period of absence.

6. Fit note completion by other healthcare professionals

There were differences of opinion as to whether it would be possible for other healthcare professionals with relevant training and competency to be able to complete fit notes. Issues raised were:

- It would require a change in the law, and in regulations concerning the delivery, content and assessment of training.
- It would be facilitated by healthcare professionals having access to patient records to gain a full picture of the individual's health.
- There was a view expressed that prior patient consent should be obtained.

7. The fit note consultation process

a. Asking all patients about health and work

There were differences of opinion as to whether it is achievable for GPs to ask all employed patients whether there is anything about their health condition that makes it difficult to work. Issues raised were:

- It would be facilitated by better GP training.
- It could be hindered by patients who are unwilling to disclose, or who perceive that they have a condition which affects their ability to work but in reality does not.
- There were concerns that this might result in more patients being 'signed' and should only be considered where 'relevant'.
- There was a view that this is part of routine history taking and that the same should be asked of unemployed patients.

b. Face-to-face vs. telephone consultation

It was seen as achievable by most respondents that patients who seek a consultation with a GP about a health problem affecting their work should have the option of a face-to-face or telephone consultation, and that this is included in the current DWP guidance. Issues raised were:

- It would be hindered by not all GPs offering telephone consultations, and by resource issues.
- There were also views expressed that a) it should be the GP who decides which is the appropriate option and not the patient b) that a face-to-face consultation may also 'improve the patient experience'.

c. Use of email to transmit fit notes

There were differences of opinion as to whether it would be achievable for fit notes to be emailed to the employer, with patient consent. Issues raised were:

- It would be hindered by the fact that it is not in the current GP IT system contract and the costs such a change would entail.
- There were concerns about issues of consent, confidentiality, accuracy of email addresses, adding to the GP workload, whether this would take away the responsibility from the patients.
- There was however a view that it could enable more direct and timely communication in some circumstances where employees are less proactive, or where there are obstacles to communication such as language barriers
- It was agreed that this method should be piloted before any decisions were made.

8. Workplace management of the fit note

a. Confidentiality in management of fit note information

The majority of responders thought it achievable for employers to ensure strict confidentiality in the management of fit note information. Issues raised were:

- The recommendation would be facilitated by clarification of the terms ‘strict’ and ‘employer’.
- There was a view that employees should know about policies concerning the confidential management and distribution of fit notes before the need arises.
- There were differing opinions as to whether employees should be ‘informed’ or ‘consulted’ as to who sees the content of their fit note. It was perceived to be the responsibility of organisation to address this in their sickness absence policies and procedures. Employees should be assured that fit notes are held securely, and who has access.

b. The management of ‘may be fit’ notes

Most respondents considered it achievable for organisations to have a timely mechanism for dealing with ‘may be fit’ notes and that employees contact their employer to discuss a ‘may be fit’ note within two working days of being issued with one. Issues raised were:

- This would be facilitated by organisational sickness absence policies reflecting the process and timescales for accommodating adjustments and by greater clarity of the statement.
- There was a view that this may not be possible depending on the specific industry and days worked by the patient and should not be mandatory.

c. The impact of sickness absence monitoring schemes

Most respondents considered it achievable for employers to ensure that sickness absence monitoring schemes do not discourage employees from returning to work before the expiry of their fit note, if they are able.

- This would be facilitated by the organisation addressing this issue in their sickness absence policies and procedures, and by educating employers and employees that the note is advisory – if the employee feels well enough and follows work procedures to report an earlier return to work then this is acceptable.

9. Communication with employers about patients’ fitness to work

a. Email/phone communication between GPs and employers

There were differences of opinion as to whether it would be achievable for GP contact details (phone, email) to be included on the fit note to facilitate discussion of the patient’s return to work: Issues raised were:

- It could be hindered by perceived obstacles of patient consent (if direct communication were being made), GP time/workload and GP role.
- There were concerns about potential confidentiality breaches and that, according to the DWP guidelines, the GP is not required to issue job-specific advice.
- Such communication could also incur a cost to the employer as GPs could charge for the provision of additional information under the terms of their contract.
- GPs are under no obligation to check emails daily and may not see a reply from an employer. Therefore the use of these methods should not be expected as routine, although may be useful in some specific cases.
- If contact were to be made, accurate records with copies sent to the patient would be seen to aid trust. The keeping and provision of records is achievable, but may be a resource issue for both employer and GP.

b. Communication through GP report

There were differences of opinion as to whether it is achievable for GP reports requested by an employer or the employer's occupational health adviser, to be completed within two weeks of the request being made, and if there should be a standard fee. Issues raised were:

- It would require further legislation.
- There were views expressed that a) timelines are helpful to guide the GP, and that this is good practice, but compliance would be hindered by heavy workload demands and more important clinical priorities and b) that GPs do not necessarily have the ability to produce useful reports.
- There were views expressed that a) not all employers will pay b) employers might withhold payment for inadequate reports c) requests and reports can vary in complexity.
- The quality of reports might be improved by providing GPs with more guidance as to the content of reports, or standard proformas.

10. Monitoring fit note use

Most respondents believed it to be achievable for the DWP to actively promote and monitor the use of e-fit notes, and that their use should be audited and published, and for local audits to be conducted. Issues raised were:

- Monitoring could be seen as intrusive, or limited in its usefulness as it would only report on quantitative data rather than free text comments.
- This could be facilitated where audits were not punitive or increased GP workload, and by the DWP setting a date by which all fit notes should be computer-generated. Monitoring could be facilitated by the audits being conducted by the Care Quality Commission and/or the Royal College of General Practitioners.

11. Training/education in fit note completion and management

a. GPs

Many respondents thought that GPs should conform to DWP fit note guidance and that fit note training should be incorporated into official training events, but there were differences of opinion as to whether this should be mandatory. Issues raised were:

- It was already part of Good Medical Practice that GPs stay up to date, or that training was primarily as an issue for 'new starters' (Foundation / Voluntary Training Scheme).
- Training could be facilitated by sufficient resources and the support of bodies responsible for GP education, or by Clinical Commissioning Groups.
- Uptake of training could be facilitated by audits of existing training e.g. by RCGP or CQC and the provision of on-line modules.
- Use of the guidance could be facilitated by the availability of training; better training; a penalty for non-take up.

- Guidance cannot be mandatory.

b. Organisations

Most respondents thought it was achievable that organisations should conform to DWP guidance and for organisations to inform their workforce as to how they manage the fit note, however mandation was considered unrealistic. Most also thought it achievable for the DWP to provide more detailed guidance to employers on best practice in the management of the fit note through their organisation.

- This would be facilitated by more detailed DWP employer guidance and the resources required to produce it.
- There is a view that the DWP may not be best placed to give this guidance.

c. Employees/patients

Most respondents considered it achievable for GPs to have the most up-to-date DWP fit note guidance available on their website and/or at the surgery and available for the patient to see. Issues raised were:

- There was a view that the information should be accessed through the DWP website rather than that of the surgery, and that dissemination is the role of the DWP.

The majority of respondents believed it to be achievable for employers to have the most up-to-date DWP fit note guidance available on their website and/or at the workplace. Issues raised were:

- There were views expressed that a) this information should be accessed through the DWP website, b) that the DWP material may not be suitable.
- It could be facilitated by better training of employers.

d. Joint training

Most respondents believed that ideally other key stakeholders should be included in fit note training, and that this should include occupational health professionals, but that it may not be practical.

3.3 PHASE TWO: DISCUSSION AND CONCLUSIONS

Summary of Phase 2 data collection

Delphi study:	*A modified Delphi study was conducted with seventeen stakeholders who were presented with a series of statements generated by the research team. These were based on the findings of Phase One and on published literature. Consensus of ≥ 75% was reached for 67 of 73 statements.*
Feasibility exercise:	*Consensus recommendations were sent to a further reference group of twelve stakeholders for comment on the feasibility of applying the recommendations in practice.*

Introduction

This chapter summarises the main findings from the phase two study and discusses the factors associated with changing practice in fit note completion and use.

The results demonstrated consensus for the majority of recommendations on best practice fit note use, and most of the recommendations were also considered achievable in practice. However, comments made by participants in both the Delphi study and the achievability exercise identified a number of key issues and concerns that may impact on implementation of the recommendations. These are discussed below under broad topic areas.

Fit note and legislation

Any changes to the fit note would require a change in the law, so for example, adding a section on employment status, or separating the free text comment box from the work modification options. The completion of fit notes by other healthcare professionals would also require legislative change, as would any change to the GP contract such as arrangements regarding medical reports requested by employers.

Software

The electronic version would facilitate legible, comprehensive and effective fit notes. However, although a standard design and output should be achievable, practice resources, inconsistencies and compatibility problems in IT systems are impeding implementation of the eMed. Any updates or improvements to the eMed will incur further costs, and require additional funding.

What are GPs expected to ask their patients about their job?

The findings of the consensus study indicate that there are unresolved issues about the extent to which GPs are expected to ask their patients about their work tasks. The DWP guidance states that GPs do not need to understand the detail of their patients' jobs, yet they are expected to be able to suggest how that job – or indeed 'any work' - might be modified. There also seem to be different perceptions as to the meaning of the term 'functional effect' and the extent to which this relates to work, underlining the need for training and possibly a clearer statement about the term.

Communication

In this consensus study there was agreement reached for several of the recommendations which aimed to increase and improve communication between employers and GPs, including the transmission of fit notes by email. However, many comments referred to the impracticality of implementing these recommendations. Obstacles included issues of GP workload, patient consent, confidentiality, legislation and resources.

The impact of the Health and Work Service on the fit note

The findings of this study would seem to lend support to the role of new Health and Work Service [73] in helping employees return to work after more than four weeks' sickness absence. However, they also indicate that there may be significant difficulties in keeping GPs well-informed regarding eligibility and referral methods and implementing reliable and efficient software systems to facilitate this. There is also a risk that GPs will be less inclined to consider the 'may be fit' option in the knowledge that they can refer the patient to the Health and Work Service after four weeks of issuing 'not fit' notes.

The limits of the GP consultation

A recurring theme from the comments made in this phase referred to GPs' limited consultation time and their increasing workload. For some, patient's work ability is not perceived to be a priority, and the fit note is not considered to be a key part of their workload. It would appear vital therefore that changes impacting on the fit note consultation are seen as facilitatory rather than punitive.

Tension between mandatory completion of fit note fields and patient consent

The comments made illustrate the tension that exists between whether GPs 'must' or 'should' follow particular rules and recommendations regarding the fit note, how they decide what is 'relevant' and the role of patient agreement and consent. There was some reluctance about mandatory fit note fields, and yet, as was suggested, a GP can always enter 'not applicable' if completion of any field is not considered appropriate by the GP and patient. There is support for auditing of fit notes which could be facilitated by mandatory fields.

Role and responsibility of the patient/employee

The patient/employee is seen as the main conduit of information between their GP and employer, and according to the DWP guidance, the fit note is the property of the patient. This has the benefit of avoiding issues of consent and confidentiality in providing that information to the employer. However, the patient/employee is least likely to be informed about the fit note and how they can make best use of it. Such information would be ideally gained prior to the onset of work-relevant health problems, but who is responsible for delivering this information, and the costs involved, need to be addressed.

Education, guidance and training

It was suggested that some of the recommendations considered to be achievable might be facilitated by their inclusion in the DWP guidance documents, but unless guidance is disseminated more widely and effectively, this may be of little benefit. It is unclear whose role and responsibility it is to disseminate guidance – to employees as well as employers and GPs - and who should fund this. Making guidance available on websites is useful, but does not appear to be well-accessed.

It was also suggested that further training of GPs and employers would facilitate the implementation of several of the recommendations, but again there are issues of roles, responsibilities and resources to be addressed, particularly if training is to be made mandatory. It would appear that the provision of joint training, where GPs, employers (including occupational health) and employees might learn from each other's experiences and perspectives, whilst attractive in theory, has considerable practical issues to overcome.

The role of organisations in managing the fit note

Comments made in phase two have demonstrated that in order to achieve many of the recommendations, employers need to take a more active role in promoting good practice in fit note management through their sickness absence policies and procedures. The current DWP guidance for employers does not acknowledge key aspects such as managing confidentiality, the effect of absence policies on return-to-work - and indeed the DWP may not be best placed to provide this guidance.

What is understood by the term ‘fit note’?

Two of the statements where consensus was not achieved in the Delphi study concerned the use of the term ‘fit note’. The term is a misnomer – in reality there is no such thing as a ‘fit note’, however it was not possible to reach consensus on whether the term ‘fit note’ should refer to both ‘not fit’ and ‘may be fit’ notes, or whether there is a case to rename the fit note. Greater efforts need to be made to explain the term, and to ensure that research, service evaluations and audit, clearly define whether ‘not fit’ or ‘may be fit’ notes are being studied.

What counts as a ‘condition’?

Another statement not reaching consensus was whether fit notes should only be issued for a medical condition, and the management of stress seems to deserve a special mention here. The study has demonstrated that there are uncertainties about whether stress ‘counts’ as a condition worthy of a fit note. This seems to be a grey area within the current DWP guidance. For example, in one illustrative case study, an employee is experiencing stress due to a poor relationship with her manager. The guidance states that, as the individual does not have a health condition, she cannot be issued with a fit note. However, in another case, the guidance advises that it would be appropriate to write ‘distressed due to bereavement’. Employees do not seem to be able or willing to access help through the workplace, and thus the condition may have become quite entrenched, or the individual acutely distressed by the time they access their GP. The condition is frequently referred to as one requiring intervention in the evaluation of the Fit for Work Service pilots.[74] It would appear therefore that organisations need better strategies to address ‘stress’, that GPs need better training in managing fit notes for this condition, and that greater clarity is required as to whether such conditions are acceptable reasons to issue a fit note.

Limitations of Phase Two

The strength of this phase is that it was possible to produce a series of recommendations for best practice in fit note use agreed between the main stakeholder groups at a comparatively high level of consensus. Although the Delphi panel was relatively small, no one group was over-represented which could have been a risk factor for systematic bias.[71] However, representatives of stakeholder groups are not necessarily ‘experts’ and panel members may be expert in the theory of the fit note, but not the practical application. The existence of a consensus does not mean that the opinions expressed are correct, and there is a risk of deriving collective ignorance rather than wisdom. However, these potential biases were helped by having a panel that included practitioners as well as academics, and by conducting the achievability exercise with a different group of participants.

Chapter 4. FINAL CONCLUSIONS

The study demonstrated that consensus could be reached for many aspects regarding the content of the ideal fit note, and has produced recommendations for good practice in their completion, timing, transmission and application. It has identified ways in which dialogue between the stakeholders might be promoted, and potential training requirements.

Although most of the recommendations were considered achievable in practice, a number of obstacles to implementation were identified. These included: legislation governing the fit note and GP contracts; the costs and complexity of IT systems and software; the limitations of the GP consultation; the lack of dissemination and uptake of guidance; insufficient clarity of terms; issues regarding patient/employee consent and confidentiality; unclear roles and responsibilities for the funding and delivery of education and training and the further evaluation of practice.

The fit note is not achieving its aims and is unlikely to do so without increased investment of time, money, commitment, and further legislation.

Impact of the study findings

This study has considerable implications for return to work issues. In order for this study to facilitate change in fit note practice, the findings need to be disseminated to the key stakeholders. Strategies for this knowledge transfer are outlined below. However, the success of these strategies is dependent on funding and on the desire and determination of those concerned to implement the findings.

Recipients of knowledge:

Government departments
GPs
Employers/organisations
Patients/employees
Occupational Health practitioners

Methods of knowledge transfer:

Press releases, briefing notes, flyers
Electronic dissemination of the study report to a wide range of stakeholder groups and organisations including:

- The study participants
- The Department for Work and Pensions
- The Royal College of General Practitioners
- The Trades Union Congress
- Patient organisations
- The Federation of Small Businesses
- Chartered Institute of Personnel and Development
- The Confederation of British Industry
- The Faculty of Occupational Medicine
- The Health & Safety Executive
- Key informants and experts in the field of Work and Health
- Local, national and international colleagues of the research team and steering group

Publications in peer reviewed journals
Presentations at local/national stakeholder meetings
Articles in specialist magazines and websites

Future research

The study has highlighted a number of areas for future study. Key areas and examples of research questions are:

Training and education in fit note use e.g.

- What methods are most appropriate for different stakeholder groups?
- What is the potential for joint training for stakeholders?

Promoting good practice in fit note use by employers/organisations e.g.

- What can organisations do to facilitate the appropriate use of fit notes by their employees?
- How can confidentiality of fit note data best be protected?

Completion of fit notes e.g.

- Can other healthcare professionals issue fit notes?
- What is the impact of telephone consultations on the completion and quality of fit notes?

Fit note communication e.g.

- How can direct communication between GPs and employers be facilitated?
- What is the potential for electronic transfer of the fit note?

Appendix

Sample fit note:

Statement of Fitness for Work - For social security or Statutory Sick Pay

Patient's name: Mr, Mrs, Miss, Ms

I assessed your case on: / /

and, because of the following condition(s):

I advise you that:

- ☐ you are not fit for work.
- ☐ you may be fit for work taking account of the following advice:

If available, and with your employer's agreement, you may benefit from:

- ☐ a phased return to work
- ☐ amended duties
- ☐ altered hours
- ☐ workplace adaptations

Comments, including functional effects of your condition(s):

This will be the case for

or from / / to / /

I will/will not need to assess your fitness for work again at the end of this period.
(Please delete as applicable)

Doctor's signature

Date of statement / /

Doctor's address

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