User research into referrals to expert work and health services:

Final Report of Phase 2 research

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Executive Summary

This report summarises the Phase 2 findings of a short, qualitative study commissioned by the DHSC and delivered through the NIHR Policy and Research Unit in Health and Social Care Systems and Commissioning (PRUComm: https://prucomm.ac.uk) on behalf of the DWP and DHSC Joint Work and Health Directorate to explore:

> **What are the user needs of GPs from publicly available work and health services for workers (employees and the self-employed)?**

Introduction and Background

The relationship between work and health is well known (Waddell and Burton, 2006, Gov.uk, 2019). Employment is a key determinant of health where good work is generally beneficial for physical and mental health, and vice versa (Waddell and Burton, 2006, Black, 2008). General Practitioners (GPs) are often the first point of contact for people wishing to discuss work and health matters, particularly when requesting time off work for ill-health. In this role, GPs have responsibility to decide on an individual's capacity and fitness for work, and for completing the Fitness for Work Statement (or fit note) if necessary.

Evidence shows that referring people to Occupational Health (OH) type, work and health services at this stage may be beneficial in reducing unnecessary worklessness and preventing work absence (Gov.uk, 2019). However, there are limited numbers of such publicly available services in England and over half of UK workers do not have access to OH services through their employment. This deficit is important because the need to mitigate the loss to the UK labour force of ill health related worklessness, economic inactivity, and the associated costs to individual's health and wellbeing, is a current policy priority (House of Lords, 2022, The Guardian, 2022, Gov.uk, 2023).

Evaluations of previously available national and local publicly offered work and health services such as the national Fit for Work service in England and Work Well Early Help Manchester (Batty *et al.*, 2022) showed favourable outcomes, finding high service satisfaction among patients/employees and GPs. However, evaluations also highlighted the need to raise awareness and increase engagement among relevant stakeholders, in particular those referring to any available services, predominantly GPs. Our study, during 2022, consisted of two Phases:

- **Phase 1,** small pilot study interviewing 6 participants to test the feasibility of the research and to develop and refine the research questions (Coleman et al, 2022).
- **Phase 2,** semi-structured interviews with 16 GPs to address the study aims.

This report represents the findings from **Phase 2** of the study.

Study aims, objectives and research questions

This study was conducted to explore; 'what are the user needs of GPs from publicly available work and health services for workers (employees and the self-employed)?' Findings from Phase 1 and understandings of what is known about GPs previous referral behaviour to publicly available work and health services, were incorporated into the research questions:

RQ1. What are the most effective ways to raise awareness of, and engagement with, publicly available expert work and health services, amongst GPs and other healthcare professionals?

RQ2. What are the barriers to, and enablers of, GPs and other healthcare professionals making referrals to expert work and health services?

RQ3. How can expert work and health services be tailored to meet the user needs of GPs and other healthcare professionals?

Theoretical Framework – The COM-B Model

An adapted version of the COM-B (Capability, Opportunity, Motivation-Behaviour) psychological behaviour theory (Michie et al, 2011) was used to provide a framework to organise (including informing research questions and interview schedule), structure and analyse this research. This model is a framework for understanding behaviour, in this case GPs behaviour in referring patients to work and health services, through three interacting components: Capability, Opportunity and Motivation. The COM-B model is a helpful mechanism by which to expose the enablers and barriers for GPs in referring to work and health services, including how to increase engagement with, and what type of, services would meet their needs.

Design and Methods

This phase of the study was conducted over a period of six months from June to December 2022 and employed a qualitative methodology. The study encompassed:

- A rapid, light-touch, desk based literature review to explore what is already known about GPs experiences of, and referrals in to, specialist work and health services/occupational health type services.
- Sixteen semi-structured interviews with GPs across England from a range of geographical locations and practice sizes, and representing a breadth of experience in primary care from newly qualified to over 30 years practising as a GP. Experiences of engaging with work and health/OH type services ranged from none to high. Recruitment was through convenience sampling with existing contacts, snowballing and advertising on social media. Interviews were conducted using online platforms and lasted on average an hour.
- Analysis included use of global, organising, and basic themes identified during Phase 1 and updated for Phase 2, which helped to describe opinions around the provision of publicly available work and health services, facilitators and the barriers to such services, and motivations for service referral.

Findings

The study provided a wealth of findings despite the small cohort of GPs involved. Overall, engagement with the idea of work and health services was high among the participants, and all reported the importance of the link between work and health and vice versa. Findings of note include:

- In the absence of services, nine participants mentioned signposting patients onto the Additional Roles (ARs) staff in general practice such as Social Prescribing Link Workers or Care Co-ordinators, or appropriate 3rd sector Voluntary Community and Social Enterprises, as well as also referring onto the Mental Health and Physiotherapy ARRS workers.
- This suggests an increasing reliance on the more 'softer' skills of the Social Prescribing Link Workers and Care Navigators in being able to address or sign post on for issues not considered clinical (e.g. debt, food poverty etc.).

- Participating GPs were divided about their role in supporting people with work and health matters. This elicited a strong response between those who thought OH matters should be part of their role and those who viewed they should not.

The main findings of the study are summarised in relation to each of the research questions as follows:

RQ1 - What are the most effective ways to raise awareness of, and engagement with, publicly available expert work and health services, amongst GPs and other healthcare professionals?

- In-person contact with the provider was proffered as the best way of raising awareness amongst all healthcare professionals – not just GPs.
- Promotional material on the services such as banners, posters and leaflets were considered helpful.
- Many GPs were reliant on information about services being communicated via colleagues or from email/Newsletter communications from the Clinical Commissioning Group (CCG), Primary Care Network (PCN), Practice Managers and more recently, from the Integrated Care Boards (ICBs) (which have replaced CCGs) and the new AR staff.
- Available local directories of services could often be out of date which proved frustrating.
- Alternative ways of raising awareness of services included pop-up message on online clinical systems (EMIS, SystemOne), training sessions in clinical meetings and the addition of a tick-box for referral to work and health services on the fit note.
- Awareness was associated with the longevity of services – longer standing services were more well-known and trusted.
- Participants advised that training on work and health matters forms a minimal component of medical education and training, and thus felt it important to increase this to improve awareness and engagement.

RQ2 - What are the barriers to, and enablers of, GPs and other healthcare professionals making referrals to expert work and health services?

- ***Enablers*** – The referral process should require minimal effort and time (simple) for busy GPs and be a quick, slick, online referral mechanism. The capacity for patient self-referral would be beneficial.
- Provider side factors perceived as enablers of an ideal service are: short waiting times, clear remit and criteria for referral, easy to refer into (including self-referral), quick to access to clinical treatment (especially for mental health conditions) and occupational expertise, and not having unintended consequences (e.g. impact on benefits). Respondents would also appreciate feedback on and from patients.
- Having an advisor from the service in practice or visiting was also considered important. The immediacy of referring to an in practice advisor (including the ARs staff) was perceived as beneficial for all stakeholders.
- Accessibility for patients was cited as key – geographical siting of services and/or the provision of remote services, was seen as important to reach the widest number of patients.
- Confidence in a service was also an important enabler according to participants. Lack of familiarity with /longevity of a service would inhibit GPs referral to them.
- ***Barriers*** included the lack of services, services with long wait times, ill-defined referral criteria, lack of capacity, and the location of the services.
- The lack of longevity of services was seen by respondents as inhibiting their ability to refer, related to a lack of trust in service function and availability.

- Opinions on the usefulness of the fit note were mixed: some GPs mentioned the fit note as an opportunity to make referrals and to opening up conversations about work and health, and in allowing people time off work/reduced duties. Whereas other GPs were less positive, being concerned about the high workload burden of providing fit notes and of patients falling into a 'fit note cycle'.

RQ3 - How can expert work and health services be tailored to meet the user needs of GPs and other healthcare professionals?

- Building on existing models of work and health services which were considered successful by participants.
- Locally commissioned services, appropriate to local population demographics, employer and economic context, were viewed as being the most appropriate way of organising services.
- Services that provide access to specialist OH work and health advisors was evidenced as being a user need of GPs for referral, support and advice.
- Different services for different conditions, would be more appropriate and beneficial for both GPs and their patients. A 'one size fits all' service was considered not sufficient to help people with differing needs for example between those with acute conditions or long term conditions.
- Over half of respondents mentioned they would like a service to act as a facilitator or advocate between the patient/GP, and employer and other stakeholders such as the Job Centre.

Discussion and Implications for Policy

Overall, the ability to refer to publicly available work and health/OH type services would be welcomed by the GPs in this study. They felt that access to specialist OH type support and advice would be of benefit to themselves and in supporting their patients to remain in, or return to work. However, findings suggest that participants referral in to any available service is contingent on a combination of factors being met/in place.

Participants who had previously engaged with work and health services (six participants) drew on their experiences, which were overwhelmingly positive. For these participants - the interaction of *capability* to refer in the form of knowledge/awareness of services, the *opportunity* in the form of having available resources/services and the *motivation* in terms of wanting to help their patients and having confidence in the services provided - combine to evidence positive referral *behaviour*.

Consensus was found across the data from all participants in describing similar characteristics and elements of both the type of services, and ideal referral mechanisms, they would wish to be developed. Beneficial aspects of having an available work and health service mentioned by participants included: the ability to refer patients on to other professionals considered 'work and health experts'; mitigating some of the responsibility felt in advising on matters often considered outside of a GP's sphere of expertise; and time and cost saving benefit to GPs associated with patients being seen by alternative services or by someone employed specifically for this role by the practice/PCN.

GPs also suggested that for services to be effective they should be locally commissioned and delivered, quick and easy to refer into, sustainably funded, and appropriate to the needs of their patient population and their differing conditions, local economic and employer context.

The following policy recommendations are suggested:

- **RQ1 - Awareness:**
    - Increase awareness of work and health matters at an early stage during Medical School through increased education and training for healthcare practitioners.
    - Utilise the ICB/PCNs in raising the visibility of new and existing services (including those provided by voluntary, community and social enterprises) to healthcare practitioners.
    - Develop an accurate directory or database of services, both nationally and/or locally, available to all healthcare providers.
    - Encourage providers of services to visit practices to promote their services and provide workshops on how to refer into and the benefits of, the service.
    - Introduce pop-up messages on online clinical systems to remind GPs of services available.

- **RQ2 - Barriers and enablers:**
    - A list of desired features of both services and referral mechanisms is outlined in the Findings section (RQ2) above and discussed further in the Findings section of the main report.
    - Services that are proven to be effective should be funded long-term, beyond a pilot phase, so that they are provided on a consistent basis (following systematic published evaluations to share learning), rather than ceasing.
    - Any planned services should consider accessibility, either physically or virtually. Patient use and engagement with services is often contingent upon easy access to their location.
    - A geographical spread of services rather than pockets of services, would enable a large number of patients to benefit.

- **RQ3 -Tailored Service:**
    - Develop services which are locally delivered and commissioned at ICB level and delivered at PCN level, enabling the necessary familiarity with the local economy context and population demographics.
    - Providing an OH specialist, separate to clinical healthcare professionals in the PCN or practices would be beneficial.
    - Avoid a 'one size fits all' approach to the provision of work and health services to ensure appropriate coverage for different types of conditions or return to work needs.
    - Increased DWP and healthcare professional's liaison/training would be helpful.

Further research

As this was a small scale study limited to GPs experiences and perspectives, future research could usefully seek to explore the experiences of other Allied Health Professionals (who can now complete fit notes) and the use of the ARs staff (understanding their role) in supporting patients with work and health matters. This would be beneficial, as would investigating the evidence base for a general holistic type service encompassing biopsychosocial matters in relation to work and health, and what components of such a service would look like.

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Acronyms

ARs	Additional Roles
ARRS	Additional Roles Reimbursement Scheme
CCG	Clinical Commissioning Group
COM-B model	Capability-Motivation-Opportunity Behaviour Model
DHSC	Department of Health and Social Care
DWP	Department for Work and Pensions
GP	General Practitioner
IAPT	Improving Access to Psychological Therapies (also known as NHS Talking Therapies services)
ICB	Integrated Care Board
ICS	Integrated Care System
IPS	Individual Placement and Support
LA	Local Authority
MH	Mental Health
MSK	Musculoskeletal
OH	Occupational Health
PCN	Primary Care Network
RTW	Return to Work
SMEs	Small to Medium sized Enterprises
SPLW	Social Prescribing Link Workers
W&H	Work and Health

1. Introduction

1.1 Overview

Employment is a key determinant of health; good work is generally good for physical and mental health, and being out of work is generally bad for health (Waddell and Burton, 2006, Black, 2008). When a person is absent from work due to sickness, the longer a sickness absence lasts, the more complex the barriers to returning to employment become, and the less likely it is that they will return to work at all. Ultimately this leads to a greater cost to employees and employers, and the wider economy. Evidence also suggests that long periods out of work are associated with poorer mental and physical health, increased use of health services and poverty (DWPa, 2022, DWPb, 2022, Fox et al. 2022, Sorensen et al., 2021). This is especially important given the current rises in cost of living in the UK (Institute for Government, 2022), and evidence that shows there has been a significant loss of workers in the UK labour force as a consequence of long term ill health (ONS, 2022). Although the prevalence of ill health related worklessness was increasing before the Covid-19 pandemic, the pandemic has 'exposed the vital relationship between the economy and health' (Black, 2023). It is also acknowledged that even if people are not fully fit, engaging with work can deliver health benefits. According to Sorensen et al. (2021, p1);

> "*Work plays a central role in determining health. It provides wages and benefits, shapes life opportunities and resources for individual workers, their families and communities, and may enhance wellbeing, resilience and life satisfaction".* Conversely, working conditions "*whether physical exposures, job demands, or psychosocial experiences – may cause or contribute to work-related injury and illness and may increase risk of chronic disease and mental distress*".

Work and health services, such as Occupational Health (OH), can support people with health conditions to remain in, return to, and thrive in work. However, only half of UK workers (employees and self-employed) currently have access to OH services (DWP & DHSC, 2020). The focus of this research is on publicly-available work and health support, rather than employer funded occupational health.

Publicly available services are defined in this context as work and health support that can take a variety of forms / delivery models. Features can include:

- "**Upstream**" support for people managing a health condition to remain in work (including following a sickness absence). Services may also support people to return to work;
- **Light-touch, "biopsychosocial" approaches**, helping individuals to address their holistic health, personal and workplace barriers to employment;
- **Case management;**
- **Signposting** to both clinical services (e.g. mental health services, physiotherapy) and wider, local and/or nationally available services (e.g. debt advice, CV and interview coaching, wellbeing support);
- **Delivery by multidisciplinary teams**, involving clinical and / non-clinical professionals.

Evaluations of previously available publicly available work and health services such as the national Fit for Work service (Gloster et al, 2018) generally found high service satisfaction among participants (patients/employees). However, these studies also highlighted the need to raise awareness and increase engagement among relevant stakeholders, in particular those referring to any available services, predominantly GPs. This research project was designed to understand the needs of GPs as potential referrers to publicly available work and health services.

1.2 Background to this report

This report represents the culmination of a **two phase project** which has been commissioned by the DHSC and delivered through the NIHR Policy and Research Unit in Health and Social Care Systems and Commissioning (PRUComm: prucomm.ac.uk) on behalf of the DWP and DHSC Joint Work and Health Directorate to explore:

> **What are the user needs of GPs from publicly available work and health services for workers (employees and the self-employed)?**

In **Phase 1** of this research (carried out April and May 2022, Coleman et al 2022), six GPs were recruited and interviewed. The research explored the views and experiences of GPs, categorised identified themes according to the Capability-Motivation-Opportunity (COM-B) Behaviour model (Michie, Atkins & West, 2015), and used this structure to identify any under-represented areas of understanding that could be explored further in Phase 2.

The key findings were:

- Engagement with the idea of work and health services was high among the group of participants, and all reported high importance for the link between work and health;
- All respondents spoke about a high workload related to the provision of fit notes, but that they lacked the time, resources and expertise to address the issues related to work and health;
- None were aware of current publicly available work and health services (barring one health specific service for occupational asthma), and most did not feel supported in tackling health issues related to work;
- Respondents reported several potential advantages of work and health services, including both patient and GP benefits, and benefits to the wider community and economy (e.g., less loss of economic productivity, fewer sick payments required);
- Patients would benefit from more dedicated time with service providers, quick access to services that have long wait times through the NHS (or are not offered at all through NHS), and access to specific occupational expertise with resources to address issues;
- GPs would also benefit through time and cost savings associated with patients being seen by alternative services or by someone employed specifically for this role by the practice / PCN;
- Respondents pointed to the importance of such services being: clear in their remit, easy to refer into, quick access to treatment, not having unintended consequences (e.g. impact on benefits) and promoted and supported enough to become standard practice;
- There was a need to understand at what level in the system such services would be commissioned and supported, and the importance of sustainable adequate levels of funding was stressed.

In **Phase 2** of the study these findings were built upon and areas identified from Phase 1 that were under-represented, were explored.

To this end, the findings from Phase 2 of the study are presented in this report. The report outlines what is currently known about the subject from a brief literature review before going on to provide an outline of the COM-B model (Michie, Atkins & West, 2015). The COM-B model was used as a theoretical framework from which to inform and structure the interview schedule and to structure and organise the subsequent findings. The results of the study are then provided before going on to discuss these in relation to the COM-B model and existing literature, and finally proffering some suggestions regarding implications, recommendations and future research.

1.3 Aims and Research Questions

The overall question this research aimed to explore was:

What are the user needs of GPs from publicly available work and health services for workers (employees and the self-employed) with a focus on England?

This research aimed to address the following questions:

1. What are the most effective ways to raise awareness of, and engagement with, publicly-available expert work and health services, amongst GPs and other healthcare professionals?

2. What are the barriers to, and enablers of, GPs and other healthcare professionals making referrals to expert work and health services?

3. How can expert work and health services be tailored to meet the user needs of GPs and other healthcare professionals?

1.4 What the literature says

We conducted a rapid, light touch review of literature during summer 2022 to explore what was available regarding GP referral to specialist work and health services/occupational health services. This sought to identify initiatives that GPs currently have or previously had access to and refer(red) into, evaluations of these services and also research articles that discuss GPs perspectives of referring to work and health services.

In reviewing the literature, we aimed to explore what was already known about '**the user needs of GPs from publicly-available work and health services'.**

The importance of the GPs role in keeping people in work is well documented (Black, 2008, Waddell and Burton, 2006, Morrison, 2011) and was emphasised by changes to the GP sick note system in 2010 which refocused notions around work and health from what a person cannot do, to what a person can do. Since 2010, GPs have assessed for fitness for work via the Statement of Fitness for Work (commonly known as the 'fit note') which was aimed at keeping patients in work wherever possible. Until recently the system has been administered by GPs but paradoxically, it is well documented that there is a lack of knowledge about, and training on, occupational health and work in general practice (Morrison, 2011). Similarly, there is a lack of awareness of what (if any) publicly-available work and health support is available for GPs to refer into.

In April 2022, a new version of the fit note was introduced to replace the 2017 version. On the latest version, the requirement to sign the form by the healthcare professional has been replaced with the name and profession of the issuer (DWPa, 2022). Since July 2022 (DWPa, 2022) fit notes can now be certified by doctors, nurses, occupational therapists, pharmacists and physiotherapists. GP IT systems have been updated across Great Britain to support the legislative changes. This opens up a wide range of professions who are now responsible for having conversations with patients on work and health matters and possibly referring on to work and health services. DWP are now monitoring and evaluating these changes, through commissioned qualitative research and internal quantitative analysis. For clarity, this report focuses solely on GPs which was the remit of the study when commissioned.

1.4.1 Method

A desk based, literature search was undertaken for relevant evidence on general practice and work and health services (including occupational health services). While the primary focus of this study is England, the literature review was widened to include the UK. Titles and abstracts were reviewed and the search was initially restricted to articles published after 2000, although relevant key older papers were also reviewed. Relevant articles were identified and their citations and references were also examined. Alongside academic papers, the review included 'grey' literature encompassing documents and reports from providers of health and work services and other documents specific to the subject matter.

1.4.2 Findings

There are a plethora of private occupational health services however, it is very hard to find publicly-available services that GPs refer into, especially since the nationally provided Fit-for-Work service (DWP, 2014) in England ceased in 2018. There have however, been some examples of publicly available work and health services that GPs can refer into, some of which have been delivered in the past but have since ceased, and some are ongoing. We have searched the internet for examples but our findings are unlikely to provide a comprehensive list of all services that currently exist or have existed in the past.

More generally, searching the internet provided information, albeit sometimes scant, on locally provided services such as *Who Dares Works* in Cornwall. Similarly, the search for academic and grey literature found a limited number of papers and articles explicitly discussing GPs referral into work and health services. Only two papers talked specifically about this (Beckley et al, 2011 and Elms et al, 2005), other papers and articles talked more generally on the subject of OH and healthcare providers. In this section, a brief overview of current and ceased publicly-available work and health services is provided before moving on to provide a short report on some of the findings from the academic literature.

1.4.3 What services exist?

(Please note: information about service availability outlined in this section reflects the position at the time the research was conducted and may not be reflective of the current situation.)

It is difficult to ascertain the extent of current publicly-available work and health services in England because, as outlined above, no centralised directory exists containing this information. From our limited investigations we identified services such as *Working Win* in Sheffield and *Sheffield Occupational Health Advisory Service (SOHAS)*, *Thrive into Work* in the West Midlands and local initiatives such as *Who Dares Works* in Cornwall.

Sheffield Occupational Health Advisory Service (SOHAS 2021)

SOHAS is a registered charity that was established in 1980, with its main objective being to provide support and advice for people whose health is affected by their work and to help and support them to keep their job. Their work is funded by Sheffield City Council, Sheffield Improving Access to Psychological Therapies (IAPT) (also known as NHS Talking Therapies services), Sheffield Health and Social Care Trust and Sheffield Autism Partnership Network. SOHAS advisers work out of 24 GP surgeries with the majority of patients being referred by their GP. The service also get referrals from a number of voluntary and health organisations from across the city.

Working Win – Sheffield

Currently working in partnership with Primary Care Sheffield and referred into by over 70 GP practices. *Working Win* was launched in 2018 and supports people who have a health condition to find and stay in employment. They provide one-to-one support from a dedicated employment specialist and coaching and is based on the Individual Placement and Support (IPS) model of supported employment. Government and council funded.

Black Country Healthcare NHS Foundation Trust (BCHFT) – West Midlands
Provide a suite of employment services across the West Midlands to help people with health conditions find work. There are three offerings such as *Bridges to Work*, for mental health conditions, *IPS services*, *Employment Retention* service for mental health conditions and *Thrive into Work* for any health condition. *BCHFT* Have commissioned the Shaw Trust (a not- for-profit social enterprise providing a range of supportive services for children and adults not just employment focused) to deliver the *Thrive into Work* programmed based on the IPS model. The scheme provides one-to-one support, benefits advice and support to stay in work.

Who Dares Works – Cornwall
Aimed at supporting military services veterans into work. Veterans attend the Active Plus course and have a mentor to help them build confidence to move forward. Specialist support is provided for work-related activities such as taster days and work experience.

WorkPlace Leeds - Leeds
Run by the charity Mind in Leeds and works in partnership with a variety of voluntary, private and public organisations. It is targeted at those with mental health (MH) conditions. It is an IPS service providing specialist employment support and job retention services through coaching, workshops and in-work support. To be referred for job retention services for example, people must be accessing IAPT, specific GPs within Leeds or secondary MH services.

Working Health Services Scotland (WHSS) - is a Scottish Government funded NHS service that provides free and confidential advice and health support for people who are self-employed or working in companies with 250 or less employees and have a health condition or injury which they feel is impacting on their work. The service aims to support them to remain at work avoiding absence. People may be referred to Physiotherapy, counselling or occupational therapy and case managers can provide signposting to services for help and advice on issues such as employment, housing, debt and wellbeing. Referral can be made by patient's themselves, GPs, health professionals or partner organisations.

In-work Support Service (Business Wales Skills Gateway) - provides rapid access to tailored occupational therapy, physiotherapy and psychological therapy services, designed to help employed or self-employed people return to work or manage a health condition in work due to a mental health or musculoskeletal problem. Individuals can contact the service and speak directly to a specialist adviser or a GP or employer (or any other interested party) may signpost an employee towards the service.

Northern Ireland's *Condition Management Programme* (NI Direct) is a 12 week programme of short, work focused, cognitive educational interventions aimed at helping people to understand and manage their health conditions. A multidisciplinary team of health professionals work together to offer help and support to cope with single or multiple health conditions that are causing a barrier to work.

Employment Advisers have been introduced in the IAPT scheme to help clients struggling to stay in, return to, or find work (DWPc, 2022).

1.4.4 Ceased Services

Recent past examples include Greater Manchester's *Working Well Early Help Programme* (GMCA), the national *Fit for Work Service* (DWP, 2014, Gloster et al 2018) (now concluded) and the *Health and Work Support Pilot* in Scotland. Evaluations of the schemes (where available) show high levels of satisfaction with them and their effectiveness in getting people back to work. Challenges to the schemes include ensuring stakeholders are aware of it, setting achievable targets, building connections with stakeholders and ensuring easy referral mechanisms.

Manchester's Working Well Early Help Programme – (Ceased 2022)

This service was well received and feedback from participants of the programme was overwhelmingly positive. Initially targeted at employees of Small to Medium Enterprises (SMEs) and employers but was later extended to newly unemployed people with health conditions/disability. The service was underpinned by the biopsychosocial model, stressing the value of addressing health and wellbeing issues as the precursor to a return to work. Successful and effective partnerships and relationships between all stakeholders across Greater Manchester were fostered. It sought to support a return to sustained employment for individuals with a health condition or disability who have either become unemployed within the last six months or taken medical leave from an existing job (Batty et al, 2021, p1).

Referral pathways into the service came from GPs, Job Centre Plus and SME's themselves. Although uptake of the scheme was disrupted by the Covid-19 pandemic and there were recommendations about building awareness, it was in the main, seen as a success such that it leaves a strong appetite behind for the continuation of a similar service. The ending of the service is viewed as 'a significant gap in upstream support for employees on medical leave that needed to be filled.' (Batty et al, 2022, piii).

Fit for Work scheme – (Ceased 2018)

According to a survey by GP magazine (Paton, 2018) of 425 GPs, carried out by *GPonline,* lack of awareness due to inadequate publicity was the cause for not referring into the Government's Fit-for-Work scheme and that 65% of GPs had not referred a single patient. Of those who had used the scheme, 40% said that no one they had referred had successfully returned to work. An evaluation of the scheme in 2017 whilst in service (Gloster et al, 2018) concluded the same and suggested myriad of other reasons for low uptake such as the lack of tailoring for individuals, conditions and employers as well as not being accessed by the those employers it was intended for, i.e. smaller businesses.

Fit for work Scotland – (Ceased 2018)

Delivered by Scottish Government on behalf of the UK Government, *Fit for Work* was to complement, rather than replace, existing occupational health provision and to fill gaps in existing support (DWP, 2014c). It was to make it easy for both GPs and employers to refer employees into (phone and website access) and consisted of an holistic assessment resulting in a return to work plan, with allocated case worker.

Health and Work Support Pilot – (Ceased March 2020)

Funded by DWP/DHSC Work and Health Unit and the Scottish Government and ran until March 2020 and consisted of two year long pilot projects in Dundee and Fife. An evaluation of the pilot by the Scottish Government (2022) concluded that; '*the evidence suggests the HWS pilot worked to fill an essential gap by providing support targeted at those experiencing health and work challenges. Satisfaction with the pilot services was high, and there were better health and employment outcomes for those people who received full support available under the pilot. Employers and referrers were also positive about the pilot.*' (p6)

1.4.5 GP Perspectives of Referring to Work and Health Services

There is a paucity of literature on the experiences and perspectives of GPs referring to work and health services in England. What literature exists, whether from the UK or internationally, acknowledges the importance of the GP role to work and health but restates the view that occupational health is considered a 'Cinderella subject' (Shanahan et al, 2010, p566) in many medical courses and for many medical students. Indeed the lack of emphasis on and training in occupational health has been highlighted as a barrier to addressing patients OH needs by Elms et al (2005) in their study of perceptions of OH in primary care covering GPs and practice nurses in Manchester and Sheffield.

However, Morrison (2011) notes that it is not just the lack of medical education and training for GPs seen as a barrier to their role in OH. Commenting on the role of GPs in keeping people at work, Morrison discusses the difficult advocacy role GPs undertake often fraught with tension and avoidance of conflict between patients and themselves as perceived gatekeepers to the benefits system/time off work. Flyan et al (2011) in their research with GPs on evaluating the statement of Fitness for Work, also noted the avoidance of conflict and that GPs felt inadequately equipped to deal with it and that they were also unwilling to damage the patient/practitioner relationship.

In the absence of an occupational health advocate for patients, such as with a work and health service, GPs often act as the liaison between patient and employer predominately through the sickness certification system (Money et al, 2010). Yet as Morrison (2011) points out, GPs felt they did not have the expertise or knowledge about the range of employment to take responsibility for making such work and health decisions. Indeed, because of this, the GP is often considered an obstacle in the return-to-work process. For example Beach and Watt (2003) suggest that GPs are '*handicapped by a limited knowledge of their patient's work and a lack of access to workplaces and managers*' (p302) and have conflicted loyalties and confidentialities to their patient which an occupational health practitioner would not.

Thus there have been overwhelming calls for the better use and awareness of the role of occupational health practitioners where they exist in organisations/services, and improving the communication between them and all other stakeholders (employers, healthcare providers) to remove barriers to work rehabilitation and to manage work related health problems (Sawney and Challenor, 2003; Beaumont, 2003; Morrison, 2011; Franche et al, 2005; Stern and Madan, 2012; Patton, 2013; de Kock et al, 2016). Indeed Dol et al (2021) concluded from a systematic review of 14 international articles based on RTW interventions in a range of organisations, that where face-to-face contact occurs with an individual who fulfils the Return-to-Work Co-ordinator function, RTW work rates were increased and time to RTW was reduced. According to Shaw et al (2007, p3) in their systematic review of the role of RTW Co-ordinators in preventing workplace disability; *'this individual may be located in a clinical, corporate, insurance, or governmental setting, and he/she facilitates and supports safe and sustained RTW through proactive communications with the worker, the workplace, and other stakeholders.'* Shaw et al (2007) include 22 studies that indicate that the work co-ordination role is successful and conclude by suggesting that workplace co-ordination shows moderate to large improvements on disability outcomes. However, they point to the nature of the role as being evolving and that there are wide variations in individual advisors competencies such as training, medical knowledge and social problem solving.

Where specialist OH practitioners are available to patients in England, such as when in a pilot Occupational Health clinic based in general practice in Leicestershire 2008-2009, significant benefit maybe seen from a consultation. An evaluation of the service conducted by Beckley et al (2011) concluded that out of 96 patients seen, only five received no benefit from a consultation. Patients and GPs responded positively to the service and acute conditions along with mental health conditions were the most common reasons for seeking workplace help and advice.

Similarly evaluations of the interventions mentioned in the previous section, particularly those where an OH advisor visits practices (Sheffield's SOHAS and Working Well Manchester) also indicate their benefit for patients and GPs alike. A challenge identified with these services seems to be generating referrals, as referral volumes are almost always lower than expected, including from GPs.

1.4.6 Summary

This brief literature review indicates that there is limited research into GPs experiences and perspectives of referring into publicly-available work and health services. According to Elms (2005), this is impacted by their time and inclination to do so and according to Morrison (2011), lack of appetite to engage in what is seen as a specialism. Studies and evaluations therefore point to the need to raise awareness of services, where and when they exist, to increase referrals. Increased communication with specialist occupational health practitioners is similarly advocated. However, this is reliant on services being in place, and to this end, there appears to be a piecemeal approach to services in England which are provided on a local basis. We suspect there are/have been many services and evaluations that we cannot find through internet searching alone.

2. Design and Methods

2.1 Theoretical Framework: Behaviour Theory

In this section, we provide a description of the COM-B model which is the theoretical framework used to structure the research from development of the interview schedule through to informing analysis and organising the findings. Rather than providing a behavioural intervention for GPs (which would require a larger study), the framework has been used as a structural and organising mechanism for both the research and this report.

Referring patients for work and health services is fundamentally a behaviour, carried out by GPs. Therefore, it is appropriate to explore this behaviour through psychological behaviour theory. The 'COM-B model' is a framework for understanding behaviour in which Capability, Opportunity and Motivation interact to generate Behaviour (see Figure 1; Michie et al, 2011). These three factors interact over time as part of a dynamic system with feedback loops, which can be both positive and negative. The model depicts that at any given moment, a specific behaviour will occur only when the person concerned has the capability and opportunity to engage in the behaviour, and is motivated (through reflective and autonomic mental processes) to enact that behaviour over any other behaviours.

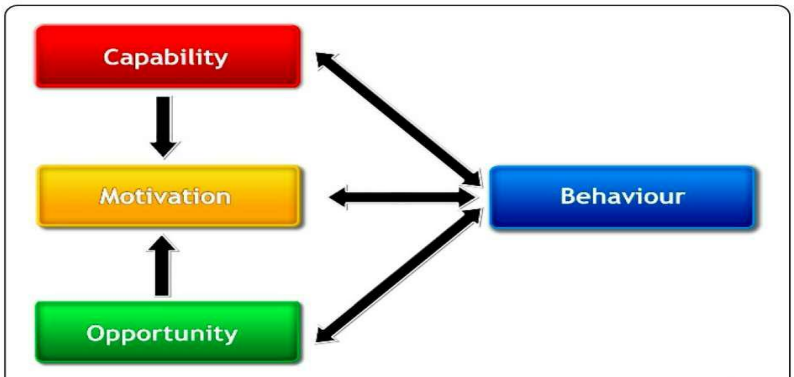

Figure 1 The COM-B system - a framework for understanding behaviour.

Source: Michie et al. (2011)

The construct of capability reflects an individual's knowledge, skills or abilities to carry out the behaviour; this can be either psychological (knowledge, resilience, skills) or physical (strength or stamina). Opportunity relates to the external factors that determine if a behaviour can be carried out; including both physical opportunity (having enough time, resources, or access) and social opportunity (social norms, cultural acceptability). Finally, motivation reflects the decision making aspect of behaviour, and again has two components: reflective motivation (which is decision making through evaluation and planning) and automatic motivation (which is an automatic decision making process, which can be based on impulses or habits).

This framework was drawn comprehensively from previously proposed models of behaviour and behaviour change, and seeks to link this framework with appropriate and effective behaviour change interventions in order to support the implementation of evidence-based practice. Where aspects of the COM components are seen to be reduced, targeted interventions and policies are recommended through consultation with the associated Behaviour Change Wheel (figure 2). This model has been used effectively in previous research to explore referral behaviours of GPs for other interventions (Aughterson et al, 2020; Tuckerman et al, 2020; van Westen-Lagerweij et al, 2021).

This approach has often focussed on the identification of barriers and enablers within the health care system (Eley et al., 2018; Feiring and Friis, 2020; Whiteley et al., 2021), and in the past, has led to the clear identification of resources, system changes, and policy changes required in order to promote GP referral behaviour change.

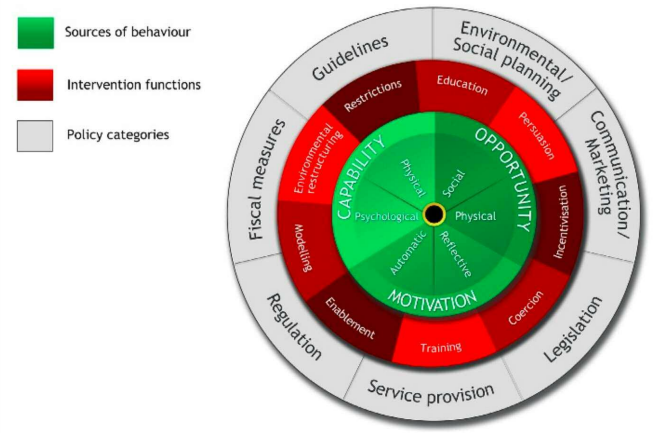

Figure 2 The Behaviour Change Wheel.

Source: Michie, van Stralen & West (2011)

2.2 Methods

In addition to the review of the literature, qualitative methods were employed in this research, and we report here on Phase 2 which aimed to interview 15-20 GPs with differing experience and awareness of health and work services in England. An interview schedule (Appendix A), participant information sheet and consent form were developed based on discussions with Department for Work and Pensions (DWP) and Department of Health and Social Care (DHSC) and lessons learnt from Phase 1 of the research.

The schedule was informed by the COM-B model (Michie, Atkins & West, 2014), and questions were grouped according to the components of the model.

For Phase 2, participants (GPs) were recruited using convenience sampling, via existing links within the research team, links provided by the DWP and DHSC teams and the use of social media (e.g. Twitter, Linked-In, Facebook) to advertise the project.

Qualitative researchers undertook the interviews using videoconferencing platforms (Zoom / Teams). All interviews were recorded with permission of the respondents and transcribed verbatim. Comprehensive field notes were also written up immediately following each interview to enable first reflections in advance of transcripts being analysed.

Global, organising, and basic themes were identified during Phase 1 and updated for Phase 2, and helped the research team describe the beliefs around the provision of publicly available work and health services, the facilitators and the barriers of such services, and the motivation for service referral.

The thematic analysis was structured around the COM-B model (see Table 1). This model provided a structure for thematic analysis of referral behaviours in context. Within this broad grouping structure, specific basic themes were generated to describe the data. Quotes have been used to illustrate findings where appropriate, keeping respondent identity confidential by providing each with an identification code (e.g. GP1, GP10, GP16).

3. Findings

Findings from Phase 2 of the study are reported in this section and results are presented according to the structure of Table 1 below which follows the framework of the COM-B (Capability Opportunity Motivation) theory. Between July and November 2022, 16 GPs were recruited and interviewed. Recruitment to this project was difficult despite utilising multiple contacts and recruitment avenues as detailed above. Reasons for this were reported as lack of GPs time and lack of financial remuneration to do the interview. As a consequence of this the sample may have some self-selection bias towards those who wished to talk about Occupational Health (OH). There was some diversity in terms of prior engagement with work and health services; 10 had limited or no (direct) experience with these services, while 6 had had some relevant experience with work and health services in the last few years or recently. Interviews lasted an average of 45 minutes to one hour.

Twenty-four codes, within eight sub-themes, were identified and categorised according to the COM-B model (Table 1).

Table 1. Coding framework, structured according to the COM-B model.

GLOBAL THEMES	SUB-THEMES	CODES
1. CONTEXT	a. Most recent role in primary care	(i) description of experience, practice, other practice staff
		(ii) particulars of location/practice that impacts utility of services
2. CAPABILITY	a. Knowledge	(i) Understanding of occupational health (broadly but also in specific cases; i.e. causality between work and health issues)
		(ii) Knowledge/promotion of available Work and Health (W&H) services
	b. Skills	(i) Role of GP in referring (including *not* GP role, not OH specialists)
		(ii) Training (previous and required including, knowledge of W&H learning and development opportunities)
		(iii) Identification of appropriate cases and referral stage
3. OPPORTUNITY	a. Resources	(i) Availability of W&H services
		(ii) Use of Additional Roles (ARs)
		(iii) GP time
		(iv) Fit note (including difficult conversations, breaking the cycle)
		(v) Ideal referral process (including self-referral)
		(vi) Provider side factors: wait times, criteria, access/location
		(vii) Ideal service (including employer liaison, different services for acute and chronic conditions, locally commissioned etc.)
	b. Professional influences	(i) Standard practice within organisational structures
		(ii) Awareness of services within organisational structures (including peer-to-peer)
	c. Social influences	(i) Patient knowledge and acceptability of services
4. MOTIVATION	a. Beliefs	(i) Relationship between work, home life and health (biopsychosocial determinants)
		(ii) Employers role
		(iii) Usefulness of W&H services (incl. limitations, need for early referral, short waiting times, relevance to local context, delivery of timely outcomes/benefits for patients)
		(iv) Trust in W&H services (including understanding of, and confidence in, the service)
		(v) Costs to patients of non-referral
	b. Emotions, Impulses, Habits	(i) Altruistic reasons (moral, ethical)
		(ii) Economic motivation (including Quality and Outcomes Framework (QOF)

In comparison to the previous coding framework from Phase 1 of the study (see Appendix B), we note that GPs responses have shifted emphasis towards the Opportunity for referring into work and health services and this is reflected in the increased in codes in this global theme. Some codes from Phase One have been moved or subsumed into other codes i.e., waiting times, ease of referral, where it was felt they were more appropriate and/or relevant for this Phase. For example promotion of services has been added to Knowledge (ii), knowledge of work and health learning has been moved under a new code (ii) Training as again this was felt to be more appropriate. The (i) Role of the GP code has been changed to reflect GPs feelings about this and patient self-referral has been subsumed into (v) ideal referral process.

The following codes were added or removed (not emergent themes from the data) subsequent to this round of interviews;

***Codes added**:* Under Skills: Training
Under Resources: Use of Additional Roles Reimbursement Scheme (ARRS), GP Time, fit note, ideal referral process, provider side factors, ideal service, employer role.
Under Motivation: Employers role, altruistic reasons.

***Codes removed**:* Under Skills: Communication skills with patient.
Under Resources: Ease of referral process, waiting times for services.
Under Motivation: Priority within wider structures and costs to patients, removed referrals to other 'soft services' (now under Additional Roles (ARs), influence of norms or habit, lack of automatic collection.

The change in codes reflects the different interview questions for Phase two, which were informed by and developed from, responses to the first phase interviews. Two themes stand out from this round of interviewing in comparison to the previous phase. These are the use of the new ARs for work and health referrals and the remit of the GPs role. Reasons for the emergence of these new themes include; a) the broader sample of GPs included in the study, and b) the familiarity with the new ARs as they are embedded in Primary Care Networks and general practice as time has gone on. These themes are unpacked in further detail in the following sections.

3.1 Context

The 16 GPs interviewed had a breadth of experience in primary care and some had experience of holding other roles (e.g. academic, GP trainer, army medic, speciality lead positions, secondary care and managerial positions) in parallel to, or during their clinical careers. The length of time GPs had been practising ranged from newly qualified to over 30 years, thus a wide range experiences with regard to work and health and referring patients was captured. Six were located in areas which had been exposed to GP related work and health services (Level of experience - below in Table 2), while 10 were from other areas of England where GPs had little or no knowledge / experience of such services. Table 2 shows some further characteristics of the respondents and their general practices.

Table 2: Respondent Characteristics

(GP ID codes start at ID10 due to previous ID numbers being used in Phase one of the research).

GP	Current contract	Size of practice (Patients) (a)	Rural / urban(b)	Level of experience(c)	Region
10	Partner	7500	Urban	High	North West
11	Salaried	1400	Urban	Low	North West
12	Partner	8600	Urban	High	North West
13	Salaried	5500	Urban	None	North West
14	Salaried	5300	Urban	Low	North West
15	Salaried	8500	Urban	None	Yorkshire and Humberside
16	Salaried	5900	Urban	High	Yorkshire and Humberside
17	Partner	11000	Urban	High	North West
18	Salaried	(d)	Mixed	None	East Midlands
19	Salaried	(d)	Mixed	None	East Midlands
20	Salaried	10000	Urban	None	South West
21	Partner	20000	Mostly Urban	High	East Midlands
22	Locum	Between 6,000 and 10,000 (e)	Urban	None	West Midlands
23	Partner	9400	Urban	None	North West
24	Salaried	17,000	Mixed	None	South East
25	Partner	12,500	Mostly Urban	High	Yorkshire and Humberside

(a) Approximate figures provided by respondents, (b) Self-defined by respondents (c) Level of experience of Work and health services (High, low, none) (d) Not currently attached to practice (e) Locum so moves around practices

**** Note: The following sections are structured using the same format as the Table 1 columns for example:**

GLOBAL THEMES	SUB-THEMES	CODES
3.2. CAPABILITY	a. Knowledge	(i) Understanding of occupational health (broadly but also in specific cases; i.e. causality between work and health issues)
		(ii) Knowledge/promotion of available Work and Health (W&H) services
	b. Skills	(i) Role of GP in referring (including *not* GP role, not OH specialists)
		(ii) Training (previous and required including, knowledge of W&H learning and development opportunities)

HEADING = Global Theme: Capability, Opportunity and Motivation
Sub Heading = Sub-themes under global theme: i.e., Capability a. knowledge, b. skills,
Third Level heading = Codes – details of themes under sub heading i.e. (ii) Knowledge/promotion

3.2 CAPABILITY

➢ *Capability - a. Knowledge:*

(i) Understanding of occupational health

All respondents recognised the importance of work to health and that the relationship is often reciprocal in nature. Most were also cognisant of the fact that the longer an individual is away from work the harder it becomes to return to work.

Many interviewees emphatically described the wide-ranging benefits of work to health and life more holistically (e.g. social contact, income, purpose, giving meaning, health benefits and structure/routine);

> *'so work is generally good for health. It's good for your physical health, it's good for your mental health and it's good for your wellbeing as well and contributions to society and everything and all that kind of stuff, because we don't just go to work for money, we go for lots of other benefits to ourselves as well.'* (GP22)

> *'it's a two-way thing really, personally I think people are usually a lot more healthy and have a sense of wellbeing if they're at work, and I always try and strive to keep people at work if you can and if that's their wish.'* (GP21)

> *'a lot of patients that I've had that have had problems when they've lost jobs around self-esteem and work and isolation, so, loneliness. And having something that gives you something to get up for, go to work, And, equally, when things are not going well at work, I get a lot of patients who are being bullied at work, who are having a horrible time at work and work is making them ill and that's about mental health.'* (GP15)

While some respondents had past experience of referring to specific publicly-available work and health services, including the Greater Manchester Working Well Early Programme (GMCA 2022), Sheffield Occupational Health Advisory Service and the Fit for Work service (Gloster et al, 2018), only one respondent had knowledge of any currently available work and health service. Indeed those respondents who had experience of referring to a dedicated service remarked that they had not referred since these had ceased some years ago. In their absence, participants discussed sign-posting to other services such as those from the 3rd Sector / Voluntary Community and Social Enterprises and services which focus on helping people with socially determined matters for example debt, benefits, housing or relevant ARs. Services mentioned included Be Well in Manchester, the Citizens Advice Bureau or specific mental health services.

(ii) Knowledge/Promotion of services

Respondents suggested that GPs (and other members of the practice) need to be made aware of what services they could access to aid their patients in relation to work issues. Indeed, just having a service in place was cited as being beneficial by many. A suggestion was made that awareness should be raised not just with the GPs but also with other health professionals within the practice, so that the patient could be treated holistically and referred by any practice staff (not just GPs). Promoting services to patients through advertising in surgeries or leaflets/texts was also suggested as a way to raise their awareness and usage;

> *'I think GPs would be interested in something like that. I think they'd see both the social and the clinical benefit, and if something that was relatively easily accessible either online or by way of a short presentation could be developed, I think we'd get significant buy-in.'* (GP21)

> '*I do remember Fit for Work, but it's one thing changes and it's like, well, what is it now, what is there now, and there might be stuff, I'm sure there is stuff, but I'm just not really very aware of it.'* (GP14)

Not having in-practice advisors or any promotional literature or details of services means, that as some GPs suggested, services get forgotten about or fall off their radar;

> *' it wasn't on my radar. I'm not saying it wasn't there, it may have been there, but I didn't know about it. Perhaps would be my own fault or perhaps didn't advertised to us. I don't know. But I wasn't aware of where to go for further help.'* (GP16)

- ***Capability - b. Skills:***

(i) Role of GP

GPs were asked about what their role should be in supporting people to return to work and this elicited strong opinions with respondents being divided between seeing it as an important part of their role;

> *'So I think we can take a lot of the fear out of people returning to work or trying to stay at work.'* (GP21)

And others questioning whether it should be part of the GPs role at all. In terms of the latter, around half-of the respondents argued that they did not view work and health or OH as part of their role. This was due to many influences not least because of perceptions about not being qualified specialists in this area and that they lacked specific training in OH from which to provide appropriate advice on work and health matters. Concerns voiced here were around GPs being expected to be 'generalists' as the name suggests, and knowledgeable about everything, but this belied the reality of lacking confidence in giving advice seen as out of their field of expertise;

> *'I mean, I find it a tricky role and I think all of my colleagues agree. You know, I feel that we don't necessarily have the…although we have access to the majority of their medical records and we know about their medical health, we're not occupational health specialists and we're not trained in that way.'* (GP10)

> *'And we're not trained, and we're not…we don't know, so yes, we could be giving good advice, but we could also be giving really bad advice… I think it's the government sometimes sees it as a cheap thing of…they've changed it with the contract, they've got a bit about, you need to give employment advice. Well, I'm not covered, from an occupational health viewpoint, I'm not covered.'* (GP11)

A few other interviewees responded that despite understanding the importance of work and health and acknowledging that it is part of their role, they would rather leave the responsibility to someone else in making decisions about a patient's capacity in terms of returning to work. This was especially related to completing the fit note and giving advice for employers;

> *'I wouldn't say we do much on work adaptions. Then would it be our role, if we're not really an occupational health service. That would be…it depends. If it's a big organisation, they should have their own occupational health department which should be doing that work.'* (GP13)

> *'...being the judge of whether the patient is fit to work or not is very difficult… So, I don't like the fact that we have to be the judge of whether the patient is fit to work.'* (GP18)

Some of the interviewees also highlighted the tension between their medical role and those issues which could be considered to be socially determined in nature for example, problems with housing, benefits, deprivation, that impact on health. And in these instances, questioning if the GP is best placed to help with this or indeed if they have the inclination and/or scope beyond the medical remit of their role. While there was an appreciation that work, health and home life can have complex relationships and it is not always clear how work is affecting health and vice versa, some felt that focusing on social determinants impacting health and work detracted from their clinical work, especially given that they have such little time. One respondent who felt that OH is a specialism in it's own right and not necessarily the role of the GP, mentioned that it is not the GPs *'battle to fight'* or *'police'*, when discussing having to complete fit notes for benefits purposes.

> *'Because this is the social determinant of health, it's something that local authority, NHS organisations, all the other people need to come together to solve, it's not the remit of the GP.'* (GP22)

There were questions about whether these matters are better placed to be addressed by other healthcare professionals as this quote suggests;

> *'…is it the GPs role? You know, maybe it isn't the GPs role. Maybe we do need occupational health workers as ARRS roles in general practice and, you know, that would save us the same amount of time but actually, might benefit patients more.'* (GP15)

(ii) Training

Levels of knowledge about training and development around work and health was low, and respondents who had received training about occupational health reported that this was many years ago during medical school. It is currently a very minor element of GP training and the majority of GPs get no additional training after this;

> *'And there's a bit of a perception that we deal with health and that that isn't really so much in the core duties of a GP, and certainly it's not something that's really touched on in medical school I don't think very much at all.'* (GP12)

However, a couple of GPs mentioned receiving training on how to complete the fit note and a few respondents reported that they had obtained OH knowledge from dealing with health and work services before they ceased. Interestingly, one GP was also working as an Occupational Health consultant who through necessity, had set up their own OH company in a very industrial area of England. Three respondents were seeking out their own work and health knowledge by studying for the Diploma in OH. A couple of other respondents suggested that whilst OH training would be beneficial, by-en-large there is little time and/or appetite, to seek out learning and development on work and health matters. These interviewees also lacked awareness of OH training opportunities. This was symptomatic of the fact that the GPs in the study told us they receive a lot of information daily and therefore any information on training opportunities could be missed unless they were specifically interested in work and health matters or it was seen as particularly relevant to their patient population.

Interestingly one GP mentioned that they would like training from the DWP on the benefits system, suggesting that patients were more informed on these matters leaving them in a difficult situation during discussions around work and health as per this quote;

> *'I think it would also be very, very, very useful for GPs to have some training or even training to be available, all my trainees and myself, we never quite understand the benefits and Universal Credit and how many hours you can work while you're on the sick and all that, and we don't know anything about these things, so we never get told, and then the systems all change. And the patients know way more, they very much know what entitles them to PIP [Personal Independence Payment)] and this, that, and the next thing, and they will come in using phrases that you know they've read online as to how to pass their PIP assessment for inability to work, they'll sort of say, I can't plan a journey, it says apparently what you've got to do is tell them you can't plan a journey, and it's just hilarious. So yeah, there's a big thing out there, people researching how to prove themselves to be unfit for work.'* (GP23)

(iii) Identifying cases and referral stage

Those respondents who had not had experience of referring into services answered the question hypothetically about under what circumstances they would refer and at what stage. The majority of GPs felt that they were capable of identifying cases suitable for referral suggesting that it was an expectation of their role. However this was again associated with their confidence to do so based on their perceptions of not being experts in OH matters as discussed in section (b) Skills above. Overall, there was general consensus across the interviews that acting early was optimal and most suggested that the two week point was the preferable stage at which to refer, which is the point that most patients will be seeking a fit note. Moreover, it was frequently mentioned that an early referral was best so as to keep people in work and avoid the risk of sliding into longer-term worklessness and/or the risk of entrenched illness behaviour or a continuous cycle of fit notes;

> *'I think for me, the short-term ones are when you're actually seeing somebody either in first consultation or within a short time of presentation to get them referred and try and keep them in work rather than going off sick, particularly things like mental illness, musculoskeletal problems where you know that the longer they're off, the harder it's going to be to get them back into work'.* (GP21)

Alongside wishing to refer as soon as it was apparent that work was being detrimental to health or that patients were struggling, respondents mentioned that there were other circumstances which appeared to dictate the referral or wish to refer. For example; the nature and type of condition, whether it is acute or long term (if services available), in certain types of industries such as those requiring manual labour (e.g. hospitality or manufacturing), or social reasons such as financial. Organisational and patient barriers and enablers were also discussed here with a few GPs mentioning that they would want to refer when there was no help from the workplace or the patient was struggling with their employer;

> *'I think often people with…workplaces won't let people back rather than think about how they could make the place safe or adapt or whatever, you know what I mean, they're too risk averse to take people back. So I think they would be the people that could be helped, where an occy health service could perhaps liaise with the workplace in order to get people phased back. I think phased return back to the workplace is the most important thing.'* (GP23)

Similarly, others mentioned that patients who self-identify that they would like a referral and those who are keen to return to work, were considered enabling factors. Conversely, lack of motivation from the patient could be a barrier to referral;

'So we're not going to fight against somebody who's not motivated, for example, you know what I mean? We're not going to push for something that they're clearly not capable of doing and we're not going to push for them to get a role in an organisation when the organisation is not going to support them because ultimately it's going to fail.' (GP22)

3.3 OPPORTUNITY

- ***Opportunity - a. Resources:***

(i) Availability of Work and Health Services

There was only one respondent currently referring into a publicly available work and health service. The rest had no currently available services to use apart from local third sector initiatives such as the Citizens Advice, or mental health services as previously mentioned. Some respondents mentioned that awareness of any kind of service would be disseminated through the Primary Care Network (PCN), come via word of mouth or local directories.

Some mentioned the Job Centre as a source of information. However, a large proportion of the GPs in the study mentioned using the new PCN Additional Roles (ARs) in some format.

(ii) Use of Additional Roles (ARs)

In contrast to the first Phase of the study, the use of the ARs to fill the gap where work and health services do not exist or have ceased, was frequently mentioned. The Additional Roles Reimbursement Scheme (ARRS) operates within PCNs and is seen as a means by which to bring extra workforce capacity through funding the employment of ARs in general practice. General practice in England is currently in crisis as it faces multiple challenges associated with an ageing population, falling workforce, increasing demands for services and decreasing real-terms per capita funding (Gerada, 2021). It is also coming under the political and media spotlight due to the pressures of the COVID-19 pandemic on the NHS (Razai & Majeed, 2022). To help, the ARs programme has been introduced to further support primary care by helping to solve workforce shortages and to support workload pressures. This is being done by employing additional staff in both clinical and non-clinical roles. The scheme is running for five years and the goal is to recruit 26,000 'extra' roles into general practice by 2024 (NHSE, 2021). There is currently a list of 17 roles PCNs can recruit from including Social Prescribing Link Workers (SPLW), Care Navigators, First Contact Physiotherapists, Mental Health Professionals, Pharmacists etc. (NHSE, 2022).

Respondents described that it is now common place to refer patients to physiotherapists and mental health professionals and that they are expected to give the appropriate advice regarding work capability. However, what is interesting is the use of care navigators/co-ordinators and social prescribing ARs workers in place of appropriate work and health services with the assumption that they are well placed to help, especially on psychosocial matters which influence medical conditions;

'I don't know how much our social prescribers get involved in that side of things now, because again they do seem to be a go-to person who has a very wide remit of what they can help with, and I think that's sometimes got really involved and possibly interact with it, peoples' employers and they do advise about welfare. Ours are based with [named Service] which is a charity in [specified place] which again they often can provide citizens' advice and finance and welfare help for individuals accessing their services and lots of physical and mental health support too there.' (GP12)

'So, basically the social prescribers and the care coordinators refer on to the appropriate avenues? GP - Yeah. Like I'd refer… I've asked them to see them and then I just let them sort all of that out. I wouldn't really get involved beyond that. Beyond extra medical input, I was already doing. I just delegate that to them and let them sort it out. I mean, they know more about it than me.' (GP13)

Respondents appeared to like the convenience and immediacy of being able to refer to ARs staff who are often in practice and therefore visible and known to them and their patients. These were also perceived as benefits for patients along with the staff's ability to take a holistic view of the situation and being located in practice rather than having to access a geographically different service;

> *'Maybe we do need occupational health workers as ARRS roles in general practice and, you know, that would save us the same amount of time but actually, might benefit patients more.'* (GP15)

Problems with using ARs staff were only mentioned by a couple of GPs such that there could be concerns over the lack of training of ARs staff in work and health matters and that sometimes the SPLWs refer back to the GP, defeating the object of saving GPs time.

(iii) GP Time

In some instances it was not the lack of wanting to support with work and health matters, it was the lack of time required to beneficially help the patient. Sometimes it is quicker to issue a fit note than to try and help further;

> *'The issue is, we just don't have desperately long with each patient to really get down to the nitty-gritty, and as I've already said, I don't feel I've got occupational training as such, but I think understanding their work environment and how their health impacts it and interacts with it is very helpful, and I do think it is an important part of our job.'* (GP12)

> *'you know, I think at present we don't have the skillset to say, you definitely can't…you definitely don't need this. And, therefore, it's kind of easier and because we're under time pressure and because we don't want to have difficulties with the patient because we want to achieve other goals with them and their health, then we generally give them a sicknote.'* (GP10)

(iv) The fit note (Med 3)

One possible way in which GPs can help with issues pertaining to a patients' work and health is through the fit note; the opportunity of GPs to influence outcomes through this mechanism was explored. Since the completion of Phase one of the study, the ability for alternative groups of allied healthcare professionals to complete fit notes and have discussions about work and health has been introduced (DWP, 2022). Regulations were only changed in July 2022 so it will take time for the changes to embed and impact However, quite a few of the respondents in this phase mentioned that they still have a heavy fit note workload. Only a few GPs mentioned others being able to complete fit notes in their practice such as Advanced Nurse Practitioner and one reported that fit notes were almost exclusively requested via e-Consult in their practice (this is an online portal for patients where they can contact their GP surgery electronically).

GPs in the study were asked if they found the fit note useful for getting people back to work and if it would be beneficial to have a referral to work and health services box on the Med3. Firstly, in terms of the usefulness of fit notes, the response was mixed. Some GPs discussed the benefits in giving people time off and opening up conversations between all parties, especially the employer and employee;

> *'Again I think it's a very individual type thing, I found on the whole it's very good, I think anyone who I've supported through that, previously or recently, do find it very useful actually. Most people want to be in work, and actually taking the pressure off for a while with a sick note that that's coming from me, it's a legal binding document, is helpful, and I also think that it's helpful because we can do phased returns, amended duties. And I think what it does is it prompts that conversation with their line manager and further employment, employers, so it gives them a bit of breathing space and time outside of the normal day's work to go through things and discuss that. So I personally found it quite useful.'* (GP20)

'But for people who are having helpful discussions with their employers and the employer is willing to listen to them, then when I have a discussion with the patient and write some suggestions, then it seems to be helpful in getting them back.' (GP16)

However, there were others who questioned the helpfulness of the fit note being used in situations where time off from work is recommended when perhaps it is unnecessary for example, when the issue is rooted in social factors – will this really help the patient? There were others who mentioned that without engagement with the patient and ideally the employer, the GP will struggle to influence work and health outcomes. This also tied in with the fact that many GPs questioned their role as to whether they should engage in OH matters (see section 3.2) with one perceiving that the system was a way for the responsibility for work and health matters to be shifted to GPs;

'It's not a system for getting people back to work in any way, shape or form. It's basically a way of a doctor taking responsibility for someone being off work, which is a completely different thing, because it says in my opinion they are unfit for whatever. It's not used to its full potential. It's clearly because of constraints of time and clearly because that's how people view it, so it's not useful for getting people back to work at all.' (GP22)

'…you're just signing them off. But what's happening in the meantime? What is that time being used for? That time could be used to develop.' (GP11).

More broadly, it was reported that discussions about work during patient consultations often occurred when a request for a fit note was made. There were a couple of GPs who stressed that they made a point of asking about work in consultations for example by taking an occupational history. Where consideration of work and health issues was necessary during patient consultations (i.e. when writing fit notes), many of the respondents reported difficulties in having these types of conversations with or in engaging with employers or other relevant services such as Citizen's Advice or the welfare benefits system.

This was an area of tension for these respondents who would rather avoid conflict and the complexities of reconciling what they see as best for the patient, maintaining the GP patient relationship, the patient's personal agenda in being off work (especially if due to a socially determined reason rather than medical reason) and navigating the benefits system;

'Well, I've always found it quite difficult as a GP. So on the one hand you have a one-to-one relationship with a patient and so you should be well placed really to support them, to help them to get back to work. But on the other hand, there's almost a slight conflict there, because you're trying to, as a GP, manage people's long-term health, and therefore you're trying to build up a trusting relationship. And when you have to go against what the patient prefers or wants, that can often be quite detrimental to that relationship. So for instance, if you feel a patient needs to get back to work but they don't feel ready yet, but you as a clinician don't think that their health implication is really impacting enough to say that you don't need to be back at work, then it can be difficult to navigate that kind of consultation because it's quite confrontational.'(GP19)

'…simply because, like I said, it's a lot easier to just sign them off, and a lot of it is led by the patient's agenda rather than the actual what's morally or even ethically right. Do you know what I mean?' (GP22)

One GP also mentioned that the old Med-6 form was helpful here in removing the responsibility for these types of conversations. The Med-6 was sent directly to the DWP and was used when the GP preferred to confidentially mention matters regarding a patients diagnosis that they did not want to discuss with them but leave in the hands of the DWP medical officer;

'One thing that we used to do, which I don't think exists anymore was something called a Med-6, and a Med-6 used to be a confidential thing that a GP could fill in where we felt that somebody actually should or could be engaged in some sort of employment, but we didn't want to sort of force the…force the issue with the patient. So, we'd fill that in and send it off and keep filling in Med-3s, but they would then be formally assessed by somebody outside of the practice.' (GP25)

Importantly for this research, there were discussions about patients who get into the 'fit note cycle', where perpetual fit notes are written by the GP whether through lack of time, the desire to avoid difficult conversations, or the fact that there are no services for patients that specifically meet their needs. In this instance having publicly available work and health services were seen as a way to break this cycle. To this end, one GP saw their role as a 'gatekeeper' of fit notes;

> *'…it's very useful to give them the length of the sick note to help prompt return for review and also to prompt them to start thinking about returning to work, so that they don't think it's a never-ending, because we get people coming in, I want another one, I want another one, I want another one.'* (GP23)

Finally, we asked participants if the introduction of a 'referral to work and health services' tick box on the fit note would be beneficial. All bar one of the respondents were positive about this if made possible, seeing it as good way of again opening up conversations with all parties especially employers and in providing extra support for patients (with the caveat that there are trusted services available).

(v) Ideal Referral Process

GPs were asked to describe their ideal process for referring patients to a work and health service. In essence, the simpler the better was preferred.

Components of this included speed and ease of use, referrals by different mechanisms such as electronically and to services based in practice, referrals to ARs staff and self-referrals by patients, as per the following Table 3. Those who had used work and health services previously were keen to highlight how easy it was to refer patients;

> *'I mean, it was great when we had the Working Well because you knew where to send it and it was a really simple (e)referral form, it was really quick and really simple and they sent back really good reports, but it's not commissioned now.'* (GP12)

Table 3: Components constituting an effective referral process

Mechanism	Method	Notes
Quick to use	One click, electronic, automated process	Linked to GP record, able to do while with patient/in consultation
E-referral system	Online via Emis/System One etc.	Form embedded in system, auto populates with patient details. Pop-up notification on system as a reminder
Tick box on e-form	Online via Emis/System One etc.	GP can tick which service needed i.e., physio, MH or others. Free text box if needed
Email referral	Quicker than template/form	In absence of online referral mechanism
Telephone referral	Clinician advice service	Signpost to appropriate service
Fit note	Tick box on Med-3 form	Reminds GP of possibility of referring to services and to have discussion with patient. Tie in with e-referral system
Refer direct to W&H service	Refer electronically and/or to in-practice based advisor from W&H service	Those who had used services praised the ease of referral (see Ideal Service below)
Refer to ARs	E-referral	
Patient self-referral	Ability of patients to self-refer	Bypass the need for GP involvement, saving time for both parties

Generally, GPs mentioned that they would prefer not to have to fill out time-consuming forms or templates for referrals, with most preferring an online solution;

> *'Sending an email to someone is always…generally the quickest… Pro formas are okay but they're just an extra few steps to do. And if we're doing a lot of them, it just gets quite painful that always takes longer.'* (GP10).

> *'I'd refer to social prescriber and they'd sort that out and it would be an e-referral. The easiest way. I guess the less you have to do the better basically.'* (GP13)

When asked, GPs mentioned they were happy for other clinicians or the ARs professionals to refer. Additionally, around a third of the GPs suggested that the ability for patients to self-refer would be very beneficial and preferable with two saying they feel GPs are the 'bottleneck' in the process;

> *'But I don't think someone seeing a work/health advisor, I think if somebody feels that would be beneficial to them then it will be and they don't need me to make the judgment on if that's helpful or not. If someone identifies it as a need, I'm very happy to say that is a need and just get on with it. So having people be able to get into services directly and bypassing me entirely and maybe even bypassing the surgery entirely would be I think ideal.'* (GP16)

(vi) Provider Side Factors

The respondents talked about many different aspects from the provider's side that could be perceived as both barriers and enablers to being a resource for the GPs to refer in to. These included waiting times, knowing the referral criteria, the location of services and capacity. Quick access to services was seen as a major selling point for services, which increased patient interest and willingness to engage in services. Long wait times were seen as detrimental in perpetuating the slide into the fit note cycle and/or long-term worklessness. Clarity of the policy and criteria from providers for accessing the service was also suggested by half of the respondents as being an important determinant in referral behaviour, as this respondent encapsulated;

> *'So I think a policy of I suppose inclusion criteria and exclusion criteria would be very helpful to GPs, because it would positively impact on the ability to say to the patient confidently, I can refer you to this service because of these reasons, or unfortunately you would not meet the criteria. So it will hopefully…hopefully if there were inclusion and exclusion criteria, it would avoid any unnecessary referrals, but actually direct probably more people to the right place.'* (GP20)

(vi.i) Location/ability to access services

This was mentioned by quite of few of the GPs in the context of any service provided being accessible to the widest number of patients. This was discussed in terms of both physical access (geographical location of services) and the ability of patients to access services remotely. For example those patients suffering a physical condition which precludes travel may benefit from a virtual consultation. Access for those with life style conditions, from marginalised communities or with mental health issues was also discussed. One participant mentioned the fact that there are no services to access so this is a moot point;

> *'They [services] might be operating out of a practice which is half a mile away from the practice, just… So I think the geography is important, for the accessibility.'* (GP14)

> '*I'm imagining this wonderful service…that I've never really worked with. I think it is another thing that my patients don't have access to that just result in them ending up on benefits and feeling like they can't work and having no confidence to work. And getting old before their time.'* (GP15)

(vii) Ideal Service - Desired structural features of a work and health service

The most frequent issues that would benefit from work and health services were musculoskeletal (MSK) and mental health. Bearing this in mind, respondents discussed the characteristics of work and health services that they would find most useful, presented in Table 4 below, and that would encourage them to make referrals.

The Working Well Early Help service in Manchester, SOHAs and Working Win in Sheffield, were seen as particular exemplars and respondents who had used these were vociferous in their praise for them as this GP said of Working Well;

> *'Because the access to getting quick, low-grade CBT, or psychological therapy, or counselling, and getting quick physio was remarkable for these patients, and it was really beneficial because then that cycle wasn't embedding them to remain off work for a long time. They were back on their feet and back to work. It was great, it was really, really good. And patients loved it. This is another thing, patients really, really liked it.'* (GP17)

Features of these services included easy referral processes (see Table 3 above), having an advisor in practice, raising awareness of the service, having defined eligibility criteria, easy patient access and short wait times, feedback from the service to the GP etc.

Table 4: Features of an ideal work and health service

Feature	Details	Notes
Easy referral process as above	Or ability to self-refer	Quick, online
Advisor in practice	Having an advisor permanently in, or visiting practice.	Raised awareness, gave GP confidence, relationship with advisor.
Awareness of services	Good practice/outreach engagement.	Regular provider visits. Continued promotion through workshops, posters, leaflets etc.
Knowledge of services	Details of what it does.	Target conditions, evidence based practice.
Appropriate	Based on condition - acute or chronic. One size service does not fit all.	Tiered/different services are required for short-term sick vs long-term conditions.
Defined eligibility criteria	Criteria and guidelines should be simple and memorable.	Provide a clear understanding of what is offered, and who the service is targeted to help.
Easy patient access	Geographical location and virtual access. Timeliness, types of consultations (e.g. online or in-person).	Easy to access locations, consider marginalised populations, those with disabilities, other languages.
Waiting times	Short(er) waiting times for initial contact, but also for treatment (e.g. mental health services, physiotherapy).	
Feedback	From service on patients and by patients. Evidence of success.	Essential evidence for GPs to 'sell' services to patients and raise trust and confidence in using the service.
Removing paperwork	Administering the process after initial contact	Including providing fit notes.
Facilitator/mediator	Would like someone to liaise between GP and employer Frequently mentioned by most of the respondents – whether part of a service or not – considered important.	Tied to GP role in the process – is it their role. Would save time and mitigate possibility of difficult conversations outside of their area of expertise.
Local service	Relevant to local population	Commissioned at place/ICB level, delivered at neighbourhood PCN level.

It was emphasised that new services needed to be adequately resourced to avoid being overwhelmed initially with new referrals. The initial success and quick feedback about patient benefit was discussed as important for getting any new scheme off the ground; once GPs had gained experience and had faith in the service then referrals would naturally continue. Ongoing funding was also mentioned as important and respondents agreed that long term stable funding was required for such a service. In this respect, not having a consistent service to refer to and knowing how likely it is to be in operation, is unsettling and unlikely to motivate GPs to refer;

> *'If you commissioned things for longer and those sorts of services were more stable, then that would make it easier.'* (GP14)

> *'Having…and one of the, it's not a criticism relating to that, but one of the difficulties for GPs and for other primary care referrers is that a lot of stuff that's out there comes and goes. So, and that's…that's because of the way that we support or don't support the recurrent investment in sort of the voluntary sector organisations. But you often find that a service is there for a short period of time, everybody gets excited about it and then it, sort of, because they can't get volunteers or the funding dries up, it's non recurrent funding, that it disappears again. And so, you end up not becoming reliant on stuff that sort of comes and goes in shifts.'* (GP25)

Many stressed that short-term pilots or those set up with non-recurrent funding were not helpful. Relatedly, it was recognised that a sustained period of promotion would be required to establish a new service and build up regular referrals from practices. One respondent who had been involved in the Working Well programme suggested that from experience, information about the service should be delivered multiple times from a variety of sources (e.g. from ICS, PCN, and trusted colleagues) and could be promoted further through 'local champions' as opposed to standard communication methods;

> '*I'm assuming that an occupational health service would be a bigger footprint, a place-based footprint…and, therefore, so how…how…you can put that out in what used to be the old CCG e-mail that goes round to everyone, but I've stopped reading that because it's so badly written and there's…it's repetitive and there's not that much information in it.'* (GP15)

Most importantly, over half of the respondents mentioned the need for a service to act as a facilitator or advocate between the patient/GP and employer. Having to do this as part of their current role was seen as time consuming and potentially confrontational for the GPs in the study. As outlined earlier, some do not feel equipped to engage in these types of conversations and lack the necessary expertise to understand individual job roles and thus patient's work capability;

> *'Well, I think, yeah, you'd need a decent service, a decent work and health service that has, I guess, has the ability to go directly to employers and intervene on a patient's behalf.*' (GP18)

> '*I've found that, I think it's a really good thing to do, but I think it's getting that…it's almost having an advocate really for the person to get that dialogue going with their line manager. So that's a difficult conversation for people because a lot of them don't really know what they can do, and speaking to your boss about that really, it's a bit of a daunting task for a lot of people. So I think if they were being supported by that service, that would be much, much…I think more people would find that they were able to get back to some work a lot quicker actually.'* (GP20)

> *'And just liaise and say, look, we've talked to the GP, this is irreversible, you need to facilitate this. And I think that goes…I mean, GPs would love you, man, if you did something like that, GPs would absolutely love you. That's the sort of ideal world we want.'* (GP17)

(vii.i) Different services for acute and chronic conditions – One size service does not fit all

Many of the respondents discussed to whom such a service should be targeted, and there was consensus that different types of patients would require a different type of service. At one end of the scale were those who had not been out of work long and needed limited help to return to work. While at the other were those patients with long-term unemployment issues. A one size fits all service would therefore be inadequate to address all needs;

> *'I think I suppose the first port of call the GPs are an understandable and useful one. I think for the long-term management people who are chronically on the sick or they don't seem to be improving or we feel that…it does feel like perhaps a separate service could just take those off your hands and deal with them.'* (GP19)

As previously mentioned, it was well recognised by respondents that people who have a job but were temporarily off sick were easier to get back into work compared to the long-term unemployed; however, it was stressed that people who were long-term unemployed were very much in need of services as well but that these would be more challenging cases. It was suggested that early intervention had a role in preventing people on a short break from work from becoming long-term unemployed.

(vii.ii) Commission and support services at the appropriate level

It would be important for such services to be commissioned and supported at the appropriate level. While respondents told us that CCGs had been helpful in facilitating in the past, when Integrated Care Systems (ICSs) became statutory in July 2022 (NHS Confederation, 2022) services will be supported at either the Primary Care Network (PCN) or Integrated Care Board (ICB) level. National or large area services lack local context/knowledge of workforce and employment available. Many of the respondents raised the issue that any work and health services could not be a national 'one size fits all' service. It was suggested that services needed to be commissioned on a scale to benefit the widest number of patients and be cost effective but that a national or large scale service would lack both local context and the required knowledge about the workforce and potentially available employment. A more nuanced local service would better understand local population's needs, the opportunities (work, services) available and the type of employer locally;

> *'There's clearly a wide range of employers, so a large international with a really on it HR department, they may have had the training and know what it's all about, see it's a really helpful thing and not be a thing. The guy who works at the local garage with two others, one boss who's got a total of three employees, then he may not have a clue what it means, and is likely to read what it means in the context of his relationship with his employee.'* (GP16).

> *'I suppose having something to refer to, locally ideally, where I think things work better when you actually know the person or people you're speaking to some extent, so you will get more buy-in and more reassurance that it's worth doing.'* (GP21)

➢ *Opportunity - b. Professional influences*

In this section, we explored questions relating to other factors influencing opportunities for the GP referral decision, such as those from their peers and from the patient. Peer influence has been touched on previously in this report outlining that word-of-mouth about work and health services from colleagues, other healthcare professionals such as the ARs or from the provider, were considered influential in raising awareness of, and confidence in, referring to services. The need for sustained promotion of services from different levels in the system (ICS/ICBs (system) and PCNs (neighbourhood), as well as within and between practices was highlighted.

In particular, the importance of promotion by peers who were trusted colleagues was suggested to be important for building initial engagement and buy-in.

The majority of participants apart from a few exceptions, reported that it is standard in their area of practice to engage with work and health issues with patients, most typically when issuing fit notes. However, it is less common within their workplaces or teams to engage with work and health issues. If this occurred, it was suggested it would again be around fit note issuing or when there were discussions about social determinants impacting health or vice versa. Those who discussed within their practices suggested it occurred at daily, weekly or monthly multi-disciplinary team meetings;

> '*I can't think of a specific example, I think thinking about patients that we would talk about in practice meetings, and sometimes the impact on work might be discussed, there might be a particular work-related issue and… I think it's something we should do more of, I mean, definitely.'* (GP14)

- ***Opportunity – c. Social influences***

Patient knowledge of services and acceptability was mentioned by only a few respondents and for these was considered an influencing factor in their referral behaviour. This finding was to be expected given that there is a lack of services to refer into and thus patient knowledge of services would be limited. In areas where there were services, patient awareness was raised through promotional material in practices and therefore this prompted either a conversation with the GP in asking for a referral or for the patient to go and self-refer. GPs suggested that it was easier to encourage patients (or get buy-in or sell it to patients) to use services if the respondent had experience of using it and hence they could recommend it. For example, this GP's practice is part of the Working Win initiative;

> *'…I recognised the value of it, which is why I was keen to use it where applicable to patients that I was seeing on the ground. So, sort of, when you're discussing that sort of thing with patients, you can get…it makes it easier when you understand what the intentions are and the evidence behind it. It's easier to, not persuade, but to, yeah, to flag it to patients as something that's valuable to them.'* (GP25)

(i) Patient opinion and willingness to engage

Here, the role of patients in the process was emphasised. It was reported that some patients are willing and want to try to get back to work as soon as possible (and these individuals were easy to refer to services), but that others were not, for a wide range of reasons and this impacted the referral process. As previously mentioned, quite a few respondents talked about the need for patients to self-refer to save them time. However, managing patient expectations in terms of waiting times and the scope of the services remit was considered important.

> *'I would like them to be able to go directly, having to come...I'd like the option of referring people myself or sharing the details with people so that they can get in contact. But having to come through me to get anywhere, I am a bottleneck in the process, just because appointments are hard to get'* (GP16)

3.4 MOTIVATION

- ***Motivation - a. Beliefs***

(i) Relationship – biopsychosocial determinants

All respondents believed in the fundamental importance of the work and health relationship, that it is reciprocal in nature and that work is beneficial to health and vice versa. Most perceived of the potential benefits of work and health services for both the patient and themselves, and therefore these were not barriers to referrals.

(ii) Employers Role

The employer's role in the return to work journey was mentioned by all but one of the interviewees who interestingly had lots of experience of referring into a work and health service.

Many were keen to emphasise that the involvement of employers is key in the process and some suggested that perhaps the onus for work and health matters rests with employers such that it is their responsibility to manage. However, as in the case below, many GPs in the study acknowledged that smaller workplaces may not have access to Occupational Health facilities and that receiving a fit note was then a difficult situation for patients, many of whom may continue to work for financial reasons;

> *'But again, I would expect this to be assessed through their occupational health services, really, I would expect their employer to be proactive, pregnancy, long term sick, things like that, we would…so, either they're getting ill and they'd come because they're ill, or they're…things are changing and they will need adjustments, or they've had time off and we need to come up with a strategy, get them back into work.'* (GP13)

> *'And where I work there are lots of dodgy employers who don't employ occupational health people and…and so, you know, a lot…a lot of it is about employment practices that are really dodgy, that actually we're covering the cracks of by providing sick notes and things like that. And…and they would have to listen to occupational services and not just say, oh well, I will need a note from your GP as well as the occupational health person. So, there would have to be a big campaign to employers.*' (GP15)

There were others who discussed the employers reaction to recommendations on the fit note and their capacity to provide accommodations or not and the difficulties that this could cause for both patients and GP. There were many stories where the GP had intervened with the employer over anxieties in returning to work and had provisions made for the employee, for example in increasing breaks etc., or as in this case, smoothing the relationship;

> *'I would often…if a patient's been off for a little while and it doesn't look like things are getting better, and they're telling me that there's a bit of a tension there with the employer, I'll often put things like, has been referred to hospital for this or planning a referral, to show that…or in my mind to try and communicate that we are actively trying to deal with the problem and seeking more help. Whereas if I just put bad back on there for the seventh month on the row, the employer may wonder if this is ever going to change. Whereas in my mind if I write referred to a specialist and it shows some hope I guess.'* (GP16)

> *'So, I mean one of the biggest things I always felt at the start, or the question I asked people were, what did your employer think? Have you spoken to your employer about this? And most people who want to go back to work usually had. And if they had a reasonable employer they would say, they would come to me and say, look my employer is asking, can we have one of the…what are they called...the gradual return to work sick note and saying, you cannot do X, Y and Z. And often it was just a case of me saying, that's reasonable. Here's the note saying that. Because the patient had negotiated with their respective employer.' (*GP18)

(iii) Usefulness of services

However, beliefs in the usefulness of particular services was a strong motivational factor, as was evidence of its success. Confidence in what the service could offer and its longevity was a pervasive argument for GPs in the study as they suggested they would be less inclined to refer otherwise.

Respondents suggested the factors that would make services more useful included (and have been outlined above):

1. Access to specialist occupational health expertise;
2. Early intervention;
3. Short waiting times;
4. Local knowledge of employment landscape;
5. Evidence that it works;
6. Consistent funding.

(iv) Confidence in Work and Health Services

These factors related to the need for GPs to be able to trust services. This included being confident that patients would be contacted in a timely way and not rejected by the service (indeed, being rejected was thought to have significant negative consequences for patients). Of most importance was having evidence that the service worked for patients and was successful. Similarly, patient response to the service was considered paramount. If the service worked effectively and was able to show timely benefits for patients, this feedback would then drive continued engagement without the need for economic incentives. The reputation of the service was therefore an important factor in referral decisions.

Respondents also discussed the desire for valuable information from qualified occupational health specialists, which could be used to feed into fit notes they were issuing or in giving the most appropriate advice.

> *'…usually, you know, to help with your management of the patient. So actually having a service that could just even provide some support and provide expert advice would also be helpful, I think, for GPs. These things come up time to time in practice meetings and someone says, oh I've been asked this question and I don't know, what's everyone else's experience, and nobody knows. Like, to be able to sort of have an occupational position or someone from the occupational medicine field to ask would be beneficial.'* (GP24)

However, some went further to suggest that the provider services should themselves be able to issue fit notes for patients, and that this would have a substantial time benefit for GPs. Indeed, a pilot initiative to this effect was mooted as a possibility with Working Well but did not happen for various reasons (see Batty et al, 2022). Where the Greater Manchester Working Well Early Help Programme had been in place, the coordinated efforts of the Clinical Commissioning Groups (CCGs) were recognised as having an important facilitating role in promoting the service across practices. In practices that had become engaged with this scheme, referrals to the scheme had become standard practice, but this knowledge about the scheme could take time and experience to build up.

➢ *Motivation - b. Emotional factors*

When asked about motivating factors to refer to work and health services, most of the GPs were keen to mention that there was no financial gain for themselves or the practice by referring and that they were motivated by altruistic reasons. Moral and ethical reasons for the greater societal good were consistently mentioned and included referring being seen as benefiting the patient, the GP, wider society and the economy. Many GPs suggested that if patients were adequately supported by an appropriate work and health service and their health improved, they would be less likely to return saving the GP both time and hence money. Seeing tangible benefits to the patient was more of a motivating factor than financial benefit.

> *'So you could say if you improve people's work, you improve their health to work, they would consult less frequently. Probably consult less frequently with the practice. So, I suppose, then you're expending less resources to care for that patient. So, if they're in work, they probably would have less other physical health problems in general. Therefore, generally they'll consult less.'* (GP13)

Economic incentivisation to refer to services was not generally reported to be a significant motivating factor for GPs however a few ventured to say that financial reward might be an incentive;

> *'I'm salaried so they pay me regardless unless they sack me. So, personally no. However the GP surgeries hours included operate largely on hitting targets. So the way to really get GPs attention to attach money to things. Because they're running businesses and if they want to pay the staff and the heating bill, and the lighting, they have to get the money in. So a large part of GP funding is comprised of either hitting quality targets or signing up for additional services.'* (GP16)

'So obviously if things are financially rewarded, it means we obviously do look at it.' (GP12)

'*I suppose having something to refer to, locally ideally, where I think things work better when you actually know the person or people you're speaking to some extent, so you will get more buy-in and more reassurance that it's worth doing. I think the profession beat the drum about wanting financial remuneration, but I don't think that's personally the be all and end all, I think as long as you make it time efficient and succinct, I think people will do it. I suppose the other thing, and there's a political issue about it, is how you make it financially worth peoples' while on lower pay to remain in work than go off sick and claim benefit, or not be penalised for remaining at work.'* (GP21)

The question about whether it would be appropriate to incentivise GPs to refer to work and health services using a Quality and Outcomes Framework (QOF) indicator elicited a strong response. The QOF provides financial reward to practices (not to individual doctors) based on performance on defined indicators and forms a small part of the practice income. There were a few GPs from deprived areas who suggested that it would exacerbate health inequalities in their populations. Some argued that it would not work for time poor and already over worked GPs. However a few contemplated how it could and would work, possibly attached to fit notes and with a strong evidence base behind it. One GP suggested that;

'if that was a QOF target, there'd be a lot more people I think would be probably back in work, which is good all round actually'. (GP20)

4. Discussion

In this section, findings are summarised and discussed both in relation to the COM-B Model outlined in Section 2.1 and to the research questions for the study reiterated as follows:

The overarching aim of the study was to explore and identify:

What are the user needs of GPs from publicly-available work and health services for workers (employees and the self-employed) with a focus on England?

To answer this, this research aimed to address the following questions:

1. What are the most effective ways to raise awareness of, and engagement with, a new expert work and health service, amongst GPs and other healthcare professionals?
2. What are the barriers to, and enablers of, GPs and other healthcare professionals making referrals to expert work and health services?
3. How can expert work and health services be tailored to meet the user needs of GPs and other healthcare professionals?

To note, this is a small scale qualitative study which is limited to the perceptions and experiences of 16 GPs for Phase 2. As such, caution should therefore be exercised in generalising the findings and the Discussion should be interpreted in this context. Findings will also be discussed in comparison to existing literature as outlined in the Literature Review (Section 1.4), before finally concluding with some implications and recommendations for user (GP) needs from work and health services and suggestions for possible further research.

4.1 COM-B Model

Our understanding of the findings for both Phase 1 and Phase 2 of the study have been informed and structured according to the COM-B model described in section 2. As previously mentioned, conducting a study using the COM-B model usually leads to the identification of an intervention for behaviour change but in this instance, has been used solely to provide a framework by which to organise, structure and analyse this research.

However, returning to the COM-B model in relation to the research questions, we can make some speculative inferences from our findings with regard to the motivation and behaviours of GPs in referring to publicly available work and health services. The COM-B model shows that a specific behaviour will occur only when the person concerned has the Capability, Opportunity and Motivation to enact it. It is the interaction of these components that generate the behaviour. Findings in this study show that for this cohort of GPs, referral behaviour is dependent upon the individual components being in place and aligning. This was not possible for the majority of participants as there was no Opportunity in the form of currently available work and health services for them to refer into. Even where the majority would be Motivated to refer for altruistic reasons, without the resources to do so, there can be no behaviour change.

Where respondents had previous experience of referring into work and health services (such as *Working Well* - Manchester) or if they answered hypothetically as though they could refer, then they also implied the importance of the combination of components on their referring behaviour. In these instances the interaction of Capability in the form of knowledge/awareness of services, the Opportunity in the form of available resources/services and the Motivation in terms of wanting to help their patients and being happy with the available services, combined to suggest positive referral Behaviour (where respondents had referred or would refer). For example, looking at the research questions above;

1) *Capability:* Respondents appreciated knowing about services and suggested that awareness raising was most successful through engagement by the service providers themselves. Having a service to refer to would address concerns where GPs feel they are not skilled to advise on OH matters themselves.

2) *Opportunity:* GPs appreciated services being available and discussed provider side aspects that would or could inhibit or enable referral into them, such as having an easy referral process and long waiting times.

3) *Motivation:* GPs would refer into such services if they believed (and had evidence for and trusted) that work and health services were useful, for example if they are locally commissioned and tailored to be relevant to their patient demographics and would be funded over the longer term (not just as a pilot project).

Needless to say that for Phase 2 of this study, findings suggest that experience with previously existing services, or theoretically what GPs envisage to be an ideal service, provided insights into the necessary elements suggestive of what the user needs to affect Behaviour change towards referring. However using the COM-B model as a framework exposed the lack of a necessary resource in the form of available work and health services to be a considerable barrier. This and other findings are discussed below.

4.2 Research Questions

Turning to the research questions, findings are summarised and discussed as follows;

RQ1 - Effective ways to raise awareness of, and engagement with, a new expert work and health service, amongst GPs and other healthcare professionals

This study has shown that engagement with the idea of work and health services was high among this cohort of participants, and all reported high importance for the link between work and health and vice versa. Those who had experience of referring to work and health services such as those mentioned in Section 1.1.4, were keen to impart that having the provider of the service come into the practice to discuss or present workshops to promote their services was the best way of raising awareness amongst healthcare professionals. Indeed the findings from this research mirror that of Beckly's (2011) study on the benefits of having an in practice OH clinic, in that respondents proffered that having an advisor from the service based in the practice or visiting regularly was considered highly facilitative of engagement and hence referrals.

Promotional material such as banners, posters and leaflets left for GPs and patients was also considered helpful. Most of the GPs in the study were however reliant on email/Newsletter communication about services cascaded down through the CCG, PCN and often coming via Practice Managers. More recently, communications were coming from the ICBs (which have replaced CCGs) and the new ARs, as well as word-of-mouth via colleagues or directories (often out of date). This research finds similar to Gloster et al (2018) in their evaluation of the *Fit for Work Service*, that these mechanisms are proven to be ineffective at marketing services. Unless participants are looking for information on services, they are unlikely to be found spontaneously.

Suggestions for alternative ways of raising awareness of services were a pop-up message on online systems (EMIS, System One) during consultations, training sessions in clinical meetings and the addition of a tick-box for referral to work and health services on the fit note (Med-3). Also mentioned here was the longevity of services and the sense that awareness of services was related to the fact that services come and go dependent upon funding. More tangential to this, is perhaps the need for increased education and training in work and health matters for healthcare practitioners at the Medical School stage which would raise awareness of services sooner rather than later. Again this is a widely acknowledged in the literature and noted by many such as Elms et al (2005), Shanahan et al (2010) and Morrison (2011).

RQ2 - Barriers to, and enablers of, GPs and other healthcare professionals making referrals to expert work and health services

There were many barriers and enablers to making referrals to work and health services discussed and some of these were conceptualised as provider side factors. Respondents were asked what their ideal referral process would be to expert work and health services and Table 3 earlier in this report documents this.

Beyond simply having a service in place, the most frequently mentioned enabler was that it would need to have a quick referral mechanism, preferably online and requiring little time and effort on behalf of the GP to enact. A facility for patient self-referral was frequently mentioned as being of considerable benefit to time poor GPs. Services with long wait times, ill-defined referral criteria and lack of capacity were all discussed as potential barriers to referring as was the location of the services. Self-referral to services accessibility to services by patients was seen as a key consideration and the provision of remote or geographically accessible services (such as in the practice) was seen as important to reach the widest number of patients. Again the findings of this study agree with others that show where OH advisors are easily accessible, either sited in practice or visiting, GPs report greater confidence in referring to a known and trusted service (Beckley et al, 2011, Sheffield's SOHAS and Working Well Manchester).

Indeed GPs in this study mentioned they would be reluctant to refer to a service if they had limited knowledge of what was on offer, proffering that they would prefer to have evidence of successful patient outcomes and/or positive feedback from peers who had used the service, to build up their trust in the service.

Being able to refer to a member of the new ARs staff was also described as being helpful in terms of the immediacy in which the GP could refer and the patient could be seen. Indeed the use of the ARs to fill the space where work and health services should be, was consistently mentioned with First Contact Physiotherapists and Mental Health Practitioners frequently being referred to. The findings show there is also increasing reliance on the more 'softer' skills of the Social Prescribing Link Workers and Care Navigators in being able to address or sign post on for issues not considered medical. In fact the increase in GPs seeing patients with health problems related to social determinants (e.g. benefits and life-style related) was mentioned multiple times. This is an area worth considering as an important component in the provision of work and health services which GPs suggest should be 'holistic' in nature. These findings accord with the remit of the Working Well Early Help Manchester programme (Batty et al, 2022) which was based on a biopsychosocial model of care. The programme addressed multiple elements out with purely clinical, impacting on an individual's return to work journey. However, a potential issue with increased use of the ARs could be that the nature and expertise of their role varies between PCNs and practices as evidenced by Baird et al (2022). Similarly, research by Checkland et al (2022) into the development of PCNs, also suggests there is heterogeneity across PCNs with regard to the employment and utilisation of these new staff within PCNs and practices. Roles are used differently according to the needs of the PCN and therefore this variability should be considered.

Commensurate with much of the previous research bemoaning the lack of OH education or training for GPs whilst at Medical School (Morrison, 2011), many respondents reported a lack of confidence in tackling health issues related to work. This could be seen as a barrier to referrals such that they feel that they are not equipped with the specific knowledge and expertise to make decisions, knowing best when to refer a patient if services existed or advice on work and health matters. This could be in terms of the capacity of the patient to do their job with GPs perceiving that it is difficult for them to make assessments about what a person can and cannot do in relation to their role (Flyan et al, 2011. Morrison, 2011). Similarly there were concerns over the quality of advice they could give to patients when they were not trained in occupational health. This led to many GPs questioning whether it should be the role of the GP to attend to these matters at all.

Some respondents spoke about the burden of a high workload related to the provision of fit notes and that they lacked the time, resources and expertise to address the issues related to work and health and frequently had to rely on information from the patient about suitability of work. This could be perceived as a barrier to referral especially if the GP is reluctant to engage in discussions about work and health for fear of conflict, as mentioned by some in this study and which is a well- known phenomenon (Beach and Watt, 2003, Money et al, 2010, Flyan et al, 2011).

Finally, the longevity of services was seen by respondents as inhibiting their ability to refer. There was a perception that services (especially pilot schemes) are unstable and come and go according to availability of funding. Therefore they cannot be relied upon when GPs need to access them nor are there long enough for them to gain experience and hence confidence in them.

RQ3 - Tailoring expert work and health services to meet the user needs of GPs and other healthcare professionals

Respondent's conceptions of an ideal service are presented in Table 4 where most reported several potential advantages of work and health services. A locally commissioned service was considered to be the most appropriate way of organising services which is tailored and specific to population demographics and local economic context. Those with experience of this through Working Well Early Help, Manchester and Working Win, Sheffield were especially vociferous in their praise for a locally provided service attuned to their patient populations needs.

GPs in the study pointed to the importance of such services being: clear in their remit, quick, slick and easy to refer into (including self-referral), quick to access treatment, not having unintended consequences (e.g. impact on benefits). They were keen to discuss patient benefits such as giving them dedicated time with service providers, quick access to services that have long wait times through the NHS (or are not offered at all through NHS), and access to specific occupational expertise with resources to address specific issues.

Again, the ability to access specialist OH work and health advisors was reported by many in this study as being a user need of GPs. As reported earlier in this report, over half of the respondents mentioned they would like a service to act as a facilitator or advocate between the patient/GP and employer and other stakeholders such as the Job Centre. GPs remarked that they often act as the liaison between patient and employer predominately through the fit note system (Money et al, 2010) yet find this a particularly tense and difficult part of their role. This is especially when they feel they do not have the expertise or knowledge about how a patient's condition affects their work and vice-versa. They feel they are not equipped to take responsibility for making such work and health decisions as also discussed by Beach and Watt (2003). The ability of GPs to refer to a work and health service in order for it to take work and health matters out of their hands, would be seen as a welcome benefit for some in this study. GPs would also benefit through time and cost savings associated with patients being seen by alternative services or by someone employed specifically for this role by the practice/PCN, which accords with research which calls for the greater use of OH practitioners to help manage the return to work process (Sawney and Challenor, 2003; Beaumont, 2003; Morrison, 2011; Franche et al, 2005; Stern and Madan, 2012; Patton, 2013; de Kock et al, 2016).

Another of the ways services could be more useful to GPs is the customisation of services to be more sensitive to where patients are in their return to/remain in, work journey. Here segmenting the service into tiers to cater for both acute and long-term conditions was proffered by many respondents who felt that a 'one size fits all' approach to services was neither appropriate nor beneficial to either the patients or themselves.

Acute type conditions such as musculoskeletal ones (MSK) were considered easier to get patients back into work through a timely intervention, than those who had been away from work for longer and would need a different type of support to return. It was emphasised however that new services needed to be adequately resourced to avoid being overwhelmed initially with new referrals. The initial success and quick feedback about patient benefit was discussed as important for getting any new scheme off the ground; once GPs had gained experience and had faith in the service then referrals would naturally continue.

Benefits of a service included both patient and GP benefits, but especially benefits to the wider community and economy (e.g., less loss of economic productivity, less demand for employment related benefits and less demand on GPs time) were also mentioned. This is especially important in today's climate where the impact of the COVID-19 pandemic is being felt with significant loss of workers in the labour force. Recent reports from the Office for National Statistics (ONS, 2022) and Reed and Bailey (2022) have pointed to the fact that there are half-a million people currently missing from the labour force, many through ill-health, that could and would want to work. This is especially prevalent in the over 50's age group as reported recently by the ONS (2022).

4.3 Summary

This qualitative study has provided a rich set of findings albeit from a small cohort, on GPs experiences and perceptions of their user needs from publicly-available work and health services for workers (employees and the self-employed) in England. The data paints a picture which suggests that the GPs in this study would like a locally commissioned and delivered service, nuanced to the needs of their patient population, local economic and employer context and which follows a biopsychosocial framework. Services should be easy to refer into with little demand on GPs time and should provide access to specialist OH provision which they feel supports both themselves and their patients to remain in, or return to, work.

4.4 Implications for policy

Finally for each research question, we consider the implications of our findings and present some recommendations for service provision which meets GPs user needs from publicly -available work and health services.

- RQ1 - Awareness:
    - Ensure that services new and existing (for example those provided by voluntary, community and social enterprises), if not already commissioned by the ICB, raise their visibility by liaising with the appropriate ICB/ICP so that they can be made aware to healthcare practitioners at the PCN and practice level.
    - The absence of a directory of services, either nationally or locally, is a limitation for the DWP, researchers and healthcare professionals alike but a database of this information would be beneficial.
    - Having the provider of the service could come into the practice to discuss or present workshops to promote their services was seen as a good way of raising awareness amongst healthcare professionals.
    - Awareness could also be increased by having pop-up messages on online systems like EMIS and increased education and training in work and health matters for healthcare practitioners at the Medical School stage.

- RQ2 - Barriers and enablers:
    - Recommend security of funding so that services are provided on a consistent basis if proven to be effective (following systematic published evaluations to share learning), rather than ceasing. The provision of a long-term service could help provide longer term biopsychosocial benefits further down the line resulting in benefits to patients, the economy and healthcare provision.
    - As mentioned in the discussion, a consideration for any planned services is their accessibility, either physically or virtually. Patient use and engagement with services is often contingent upon easy access to their location.
    - A geographical spread of services rather than pockets of services, would enable a large number of patients to benefit.

- RQ3 -Tailored Service:
    - Provide a service which is local, commissioned at ICB level and delivered at PCN level. This will enable the necessary familiarity with the local economy context and population demographics. Benefits of this to all stakeholders include: immediacy, shorter waiting times, GPs know and have a relationship with the OH practitioner. The patient would also benefit from seeing a non-medical practitioner for socially determined issues.

- Providing an OH specialist, separate to clinical healthcare professionals in the PCN or practices would be beneficial. There were some suggestions that this could be an OH AR and based in a hub or in practices, or even the Job Centre. One of the benefits of the ARs is that they provide continuity and familiarity for the patient who is therefore more likely to benefit from their support/recommendations and the healthcare professional is likely to build up a relationship with them. For example GP 21 said:

  'because where I work in X, there are plans to create a health and social care hub in the middle of the town, bringing together DWP, the district council, the NHS, that would be an ideal place to locate health and wellbeing coach or workplace facilitator or something, all the services can be like in one building for the first time in my practising career. So it's a golden opportunity for our PCN to do something like that.' (GP21)

- Create a tiered service: A 'one size fits all' approach to the provision of work and health services was suggested by many as being inappropriate for different types of conditions or return to work needs. For example, a two tier service may be more appropriate for different conditions and patients. Acute conditions such as MSK or stress where return to work is easily facilitated should offer different support to a service targeted at those with longer term conditions and/or for those for whom the return to work journey is more complicated and/or problematic. However, care should be taken not to overwhelm a developing service, which would then not benefit GPs or patients.
- Increased DWP and healthcare professionals (especially those who can now administer fit notes) liaison/training would be helpful.

4.5 Further research

Findings from this small scale study (Phases 1 and 2) are limited to GPs experiences and perspectives. Given that there is now an extended list of Allied Health Professionals who can complete fit notes and that there is an increase in the use of the Additional Roles in general practice for work and health matters, further research could usefully seek to:

- Explore the use of the ARs staff in work and health - understanding their role, training, type of referrals to them, and their perspectives and experiences in supporting patients with work and health matters;
- Explore the experiences of other health professionals – such as physiotherapists and mental health practitioners in providing fit notes and work and health advice;
- Explore what happens to people who do not get referred to services compared to those who have received a referral;
- Investigate the evidence base for a general holistic type service covering biopsychosocial matters in relation to work and health and what components of such a service would look like;
- Develop a Directory of Work and Health services that have been / are available for GPs to refer into and capture learning more systematically from evaluations of services undertaken.

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Appendix A: Interview Schedule for Phase 2

DHSC Occ Health Project

Interview Schedule (July – December 2022)

The aim of this interview is to gain understanding of the needs of GPs as referrers to health and work services. We would like to hear your thoughts on the potential value and use of such services, and the key enablers and barriers for GPs if referring to such services. This will help understand the best ways of designing any future work and health services, in a way which meets referrer needs.

For clarity, we will be talking about 'publicly-available services, by which we are referring to:

Work and health support that can take a variety of forms / delivery models. Features can include:

- *"**Upstream**" support for people managing a health condition to remain in work (including following a sickness absence). Services may also support people to return to work.*
- ***Light-touch, "biopsychosocial" approaches**, helping individuals to address their holistic health, personal and workplace barriers to employment;*
- ***Case management***
- ***Signposting** to both clinical services (e.g. mental health services, physiotherapy) and wider, local, services (e.g. debt advice, CV and interview coaching, wellbeing support)*
- ***Delivery by multidisciplinary teams**, involving clinical and / or non-clinical professionals*

Recent examples include Greater Manchester's Working Well Early Help Programme, Northern Ireland's Condition Management Programme, and the national Fit for Work Service (now concluded)

Please answer the questions

- Please could you describe your current / most recent role in primary care?
- Are you a partner or salaried in the practice?
- How many registered patients does the practice have and what other available staff?
- Have you had any specific training in or provide any services related to work and health / occupational health?
- Could you please describe your understanding of the relationship between work and health?

- What, if any, should the role of a GP be in supporting people to return to work?

- As part of your current / most recent role, do/did you provide any referrals to publicly-available/publicly-offered work and health services?

If yes, Follow-up Questions

a. Which services have you referred people to?
b. How frequently do/did you provide such referrals?

c. If you have held previous positions in primary care, have you noticed any differences in work and health service provision across the different positions?
d. How have you gained awareness of these services?
e. How do/ did any organisations (your GP practice / PCN / CCG / ICS) support referrals to publicly-available/publicly-offered work and health services?

If No, Follow-up Questions

a. Are you aware of any such services? If so, where and how?

[**Opportunity**]

- What kind of support - if any - do you need to support patients with health and work problems?

- What wider systems or policies are or would need to be in place to enable GPs to make referrals to publicly-available/publicly-offered work and health services?

Follow-up Questions

a. If already in place, are there any issues with these systems/ policies?
b. If not in place, are you aware of any wider issues which would need to be overcome?

- Where do you get your information on (new) services currently? Any examples of good outreach promotion for GPs?

- Are you aware of any health and work learning and development opportunities, and do you see these as an important referrer "need"?

Probing questions / examples of opportunities

a. Are you familiar with HEE's Health and Work eLEarning programme?
b. Are you aware of the 2019 Health Care Professional (HCP) Health and Work Consensus Statement? What do you think of its four principles for HCPs?

- Please can you describe your ideal process for referring patients to a health and work service.

Prompts:

a. What steps would this include?
b. Who should be able to refer to such services? Just GPs or others (e.g. health professionals, self-referral etc)

[**Capability**]

- Under what circumstances would you want to refer a patient to publicly-available/publicly-offered work and health services?

Follow-up Questions

a. At what stage might you make the decision?
b. Once decided to refer a patient, could there be any issues with carrying this out? Patient consent for referral? (concerned about employment, benefits etc)

Prompts:

a. Work and health services offer services primary care doesn't / long waits in primary care
b. Patients with specific issues /needs (eligibility criteria)

- How useful is the fit note system currently for getting people back to work'? Would it help to have a referral to work and health services as part of fit note process?

- What skills or resources would a GP require in order to appropriately refer patients to publicly-available/publicly-offered work and health services?

Prompts:

a. Knowledge / awareness of such services available and how to refer? How could this be improved? Time during consultations / time outside consultations
b. What time/input is required of a GP after the initial referral? (Feedback loops, follow up)
c. Process / technology (e.g. simple paperwork, digital referral gateway)

- What difficulties (if any) might you encounter / have you encountered with providing referrals to publicly-available/publicly-offered work and health services?

Prompts:

a. Suitable service locally
b. Eligibility criteria for services
c. Patient preconceptions/interest
d. Waiting times
e. Long term funding for the services
f. Few linkages with occupational health and local employers
g. COVID-19 related impacts

- What benefits (if any) would you see/ have you seen with providing referrals to publicly-available/publicly-offered work and health services?

Prompts:

a. Patient getting better support
b. GP time reduced
c. For specific conditions e.g. MSK, MH

***For those with experience of H&W services**:*

a. Do you get any information following a referral? (success, other service referral)

- Are there any patients for whom referring work and health services might be/ is easy?

Follow-up Questions

a. Which patients and why?

- Are there factors outside your immediate organisation's control that would help with or hinder referrals?

Prompt:

a. Specific funding
b. Support in the wider healthcare system (Practice, PCN, CCG, ICS)
c. Support from local champions / trusted colleagues
d. Advertising of the services available
e. Linkages between Primary care and occupational health
f. COVID-19/pandemic

[**Motivation**]

- Is it considered standard practice in **your field/area of practice** to engage with work and health issues?

Follow up Question

a. Or (if available) refer patients to publicly-available/publicly-offered work and health services?

- Is it considered the 'norm' in your **workplace/team** to engage with work and health issues?

Follow up Question

a. Or (if available) refer patients to publicly-available/publicly-offered work and health services?

- Has there been any discussion within or outside your organisation (GP practice / PCN /CCG/ ICS) regarding work and health and/or specific services?

Follow-up Question:

a. Would / has this influenced your attitude or behaviour towards referrals?
b. At what level of the system would such services be best commissioned and supported at (Practice / PCN / CCG/ ICS)?

- Is there any kind of economic motivation for you to engage with work as a factor in patients' health needs / outcomes such as cost/time savings?
    a. And/or to engage with specific work and health services (if available)?
    b. How useful would it be to include health and work as a QOF indicator?
    c. Would economic factors be significant motivating factors?

- What costs for patients could there be if you are not able to refer to a publicly-available/publicly-offered work and health service?

Finally, are there any issues associated with publicly-available/publicly-offered work and health services that we haven't discussed that you thought we would?

Appendix B: Table of themes for Phase One findings

GLOBAL THEMES	SUB-THEMES	CODES
1. CONTEXT	a. Most recent role in primary care	(i) description of experience, practice
		(ii) particulars of location/practice that impacts utility of services
2. CAPABILITY	a. Knowledge	(i) Understanding of occupational health (broadly but also in specific cases; i.e. causality between work and health issues)
		(ii) Knowledge of available Work and Health (W&H) services
		(iii) Knowledge of W&H Learning and development opportunities
	b. Skills	(i) Role of GP in referring (vs self-referral, specialist or workplace referral)
		(ii) Identification of appropriate cases
		(iii) Communication skills with patient
3. OPPORTUNITY	a. Resources	(i) Availability of W&H services
		(ii) Ease of referral process
		(iii) Waiting times for services
	b. Professional influences	(i) Standard practice within organisational structures
		(ii) Awareness of services within organisational structures
	c. Social influences	(i) Patient knowledge and acceptability of services
4. MOTIVATION	a. Beliefs	(i) Relationship between work, home life and health
		(ii) Usefulness of W&H services (incl. limitations, need for early referral, short waiting times, relevance to local context, delivery of timely outcomes/benefits for patients)
		(iii) Trust in W&H services (incl. not bouncing patients back)
		(iv) Priority within wider structures (Primary Care Network (PCN) / Clinical Commissioning Group (CCG) / Integrated Care System (ICS)
		(v) Costs to patients of non-referral
	b. Emotions, Impulses, Habits	(i) Referrals to other 'soft services'
		(ii) Influence of 'norms' or habits of primary care/within practice
		(iii) Lack of automatic collection of occupation by GPs
		(iv) Economic motivation