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Published in:
Physiotherapy

DOI:
[10.1016/j.physio.2022.02.001](https://doi.org/10.1016/j.physio.2022.02.001)

Publication date:
2022

Document Version
Publisher's PDF, also known as Version of record

[Link to publication in ResearchOnline](#)

Citation for published version (Harvard):

Black, C, Shanmugam, S & Gray, H 2022, 'Primary care first contact practitioner's (FCP) challenges and learning and development needs in providing fitness for work and sickness absence certification: consensus development', *Physiotherapy*, vol. 116, pp. 79-89. <https://doi.org/10.1016/j.physio.2022.02.001>

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Primary care first contact practitioner's (FCP) challenges and learning and development needs in providing fitness for work and sickness absence certification: consensus development

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Abstract

Background As yet, the benefit of the Fit Note has not been convincingly demonstrated, although a limited body of research suggests that provision of fitness for work advice and sickness absence certification may be improved with training and case-specific direction. The role of certifying sickness absence in the UK has traditionally been conducted by General Practitioners, but this role has now been extended to First Contact Practitioner (FCP) Physiotherapists in primary care. Therefore, FCPs may offer an ideal solution to the current challenges faced within primary care for those with a musculoskeletal (MSK) condition at risk of sickness absence from their work environment.

Objectives The main aim of this study was to identify the challenges and key learning and development needs of FCPs in response to providing Occupational Health (OH) information in the form of fitness for work advice and sickness certification for patients with MSK conditions within primary care.

Design Consensus was generated using an online modified version of the Nominal Group Technique (NGT) method. A priori consensus threshold of 60% was used in the voting stage.

Participants NGT participants included clinicians with experience in managing MSK conditions in primary care within the FCP model of care. All participants generated, voted, and ranked the items using an online platform.

Conclusions This research adds new evidence regarding the challenges and learning and development needs identified by a group of FCPs working within primary care in consideration of sickness absence certification and fitness for work advice. The items highlighted provide evidence to complement Health Education England's FCP A Roadmap to Practice educational pathway and informs on professional development needs in this area.

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Keywords: First Contact Practitioner; Musculoskeletal Physiotherapy; Musculoskeletal diseases; Primary care; General Practice; Sickness absence; Fit for Work and Occupational Health; Nominal Group Technique

Introduction

The UK's Departments of Health and Work and Pensions, within the White Paper *Improving Lives: The Future of Work, Health and Disability*, outlines the Legislation for extension of Fit Note sickness absence certification for those patients

ill for more than 7 consecutive days to other suitably qualified non-medical Allied Health Professionals (AHPs) along with a set of competencies to aid in its certification completion [1]. The Statement of Fitness for Work (known as a 'Fit Note') was introduced in the UK in 2010 to allow clinicians to provide their patients with advice on fitness for work and to encourage patients to resume some work as soon as they have recovered sufficiently. Despite this, clinicians seem to not provide fitness advice on most Fit Notes and in 2016 the UK Government reported that the Fit Note was 'not fully achieving what it set out to do' [1,2]. For exam-

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<https://doi.org/10.1016/j.physio.2022.02.001>

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ple, mild to moderate severity conditions and illnesses are the commonest diagnoses recorded on Fit Notes, yet only 6% of these are documented as ‘may be fit for work’ [3,4]. It is well known that medical fitness has limited relevance in most employment situations, with many medical conditions and virtually all minor health problems having minimal implications for work. As yet, the benefit of the Fit Note has not been clearly and convincingly demonstrated, although a limited body of research suggests that provision of fitness for work advice may be improved with training and case-specific direction [3–5]. Stakeholders are awaiting further direction from National Government on the confirmed legislation needed for sickness certification authority to be fully realised in practice for AHPs.

The role of certifying sickness absence in the UK traditionally has been conducted by General Practitioners (GPs) in primary care settings, but this role, increasingly, is being carried out by AHPs who work within Occupational Health and Primary care settings. More recently, the UK’s AHP Health and Work report was designed by a working group from the Chartered Society of Physiotherapy, Royal College of Occupational Therapy and College of Podiatry to provide information to the employee and employer on the functional impact of the patient’s reported problem [6]. The role of sickness absence certification and fitness for work is potentially amenable to management within the first contact practitioner (FCP) primary care model. In the UK, this model provides patients with direct access to diagnostic physiotherapists at the top of their clinical scope of practice, to assess and manage undifferentiated and undiagnosed musculoskeletal (MSK) conditions within primary care [7].

FCP roles have been advocated within the National Health Service (NHS) England’s Long-Term Plan [8] and the UK’s Five-Year Framework for GP Contract Reform [9]. The GP Contract pledges central government funding to primary care networks throughout the UK for the implementation of FCP services, despite an apparent lack of supporting evidence or through a clinician led process of identification of training needs.

As these roles will become commonplace in primary care by 2022/23, there is great potential for clinicians to take on the roles and responsibilities traditionally seen as outside their breadth of scope, such as fitness for work and sickness absence certification. This is important as MSK conditions in the UK cause around 28 million days lost in work as the second largest cause of sickness absence overall (nearly 25% of total sickness absence), impacting on organisations output and the UK’s productivity [10]. In addition, MSK conditions are costly themselves and the NHS estimates that they account for £4.76 billion of spending each year [11] and around 20–30% of England’s GP consultations each year [12]. Evidence suggests that MSK conditions are the highest contributor to UK and Global rehabilitation need, affecting adults often in their peak incoming-earning years and are (through low back pain solely) the main reason for a premature exit out of the workforce [13]. Therefore, MSK conditions are major

causes of short- and long-term incapacity, disability, reduced productivity, and sickness absence. FCPs as MSK experts with added roles and responsibility, may be theoretically ideally suited to reduce unfavourable temporary or permanent outcomes for both the employee and employer because of sickness absence.

The adverse health effects of unemployment and worklessness are well recognised, even when adjusting for social class, poverty, age, and pre-existing morbidities. A working age adult who is signed off work, who is absent for 6 months, has only a 50% chance of returning to work, reducing to 25% at 1 year and 10% at 2 years [1]. FCP roles are new and still developing and while there is great potential to influence MSK care and the risk of worklessness as a ‘gatekeeper’ in primary care, they also bring considerable challenges associated with managing work, risk, and in considering the health effects of a ‘Fit Note’. There is a multitude of stakeholders interested in AHPs considering fitness for work advice and sickness absence certification, with explicit mention of ‘making recommendations to employers regarding individuals’ fitness to work’ and ‘knowledge of the AHP Health and Work Report and GP’s Fit Note/Med 3’ in Health Education England’s educational pathway document, ‘*A Roadmap to Practice*’ [7]. Despite this, the traditional role of physiotherapeutic intervention, including assessment, diagnosis and treatment arguably has never consistently included fitness for work advice and in viewing work as an outcome. Lastly, there is a paucity of evidence on the complexity of FCP roles in general, the experiences of FCPs and whether they feel ready and prepared to offer higher breadth of practice information and complex work-related decision making [14].

A key impetus for this study is the fact that there is a lacuna of empirical research exploring whether FCPs feel they have the sufficient skills to assess, manage and influence the specific occupational health aspects pertinent to MSK conditions in primary care. Therefore, the main aim of this study was to identify the challenges and key learning and development needs in response to providing fitness for work advice and sickness certification for patients with MSK conditions within primary care. This study is unique in that the authors believe it considers a topic new to the primary literature and one which will inform FCP practice in this area.

Methods

Design

Researchers used a consensus development methodology that consisted of a novel online modification of the Nominal Group Technique (NGT).

NGT is a research method developed by Delbecq and Van de Ven in 1971, whereby they established a structured, face-to-face meeting, consisting of four key stages: silent generation of ideas, round robin discussion, clarification

tion, and ranking [16]. They developed this technique from their social-psychological studies of decision conferences and programme planning. Since then, the NGT has become an established method for generating ideas, problem solving and reaching a consensus within a group and is used by a variety of disciplines, for instance health, economics and social research, education and within course evaluation, industry, and government bodies [16]. More recently, applications of the traditional NGT include guideline development and research priority setting, identifying preferences for end-of-life care, obtaining patient preference and treatment outcome, and establishing exemplar practice in nursing and pharmacy specialties [17].

Used in these ways, this process offers unique interpretive and textual data to develop and gain consensus from expert FCP's opinion. Research also suggests that nominal groups can generate a higher number and quality of ideas than focus and interacting groups and produces more unique ideas than the Delphi and other group techniques [18]. Its unique structure also limits influences from researchers and group dynamics, allows for equal participation of group members and provides a forum for conflicting values and ideas [19].

Participant recruitment and data collection process

Data were gathered from experts, defined as FCPs involved in the management of MSK conditions in primary care. This was achieved through a non-random, purposeful sampling approach to allow for an in-depth and appropriate exploration of the research topic. Experts provided an exclusive body of knowledge from their own FCP practice context. Participants were recruited online via advertising in the Chartered Society of Physiotherapy's online interactive-CSP Research Network and shared within the FCP Professional Network; all Physiotherapists involved in the delivery of an FCP service were invited to participate. Some individuals assisted in recruitment via snowballing [20] by sharing within their local FCP networks and via social media. The NGT study was also advertised via social media on Twitter (@black_cameron).

Participants were provided with an information sheet, informed consent form, and completed a Doodle™ poll to confirm when they could attend the online nominal group. Based on this, it was decided to run two nominal groups due to the number of recruits and because some clinicians were needed professionally to meet the COVID-19 response. An online digital pre-session information guide and instructions was provided one week before via email, including information on the NGT questions, demographic data questionnaire, a welcome statement and information on meeting joining instructions. Blackboard Collaborate™ was the real-time video conferencing tool used to conduct the online meeting. From the pre-session email, participants started the NGT first step of idea generation by sharing content on their initial ideas on the topic via a digital canvas software (Padlet™). The 2-h structured online nominal groups were conducted involving

structured moderator led discussion to identify items, followed by individual ranking of these items, thereby allowing all experts to contribute equally. The meeting focused on problem-solving and idea-generating strategies to answer the two questions (Fig. 1).

The format of the online meeting consisted of three phases (Fig. 2): 1) discussion and clarification of the question and items relating to FCP practice from the pre-populated Padlet; 2) individual ranking of the importance of each item via an electronic spreadsheet (amalgamated items documented on Google Sheet); and 3) ranking of the 5 most important items anonymously. This was conducted for both NGT questions. Three researchers (CB, HG and SS) facilitated the groups with the question guide provided in Fig. 1. Each NGT was recorded to provide clarification of the items as needed. Groups were convened until saturation occurred, i.e., this occurred when subjectively the group agreed that no new items or insights were identified.

Data analysis

Descriptive analyses were conducted to present demographic data. The level of consensus (% of participants that ranked an item) was defined a priori to be at the 60% consensus level in keeping with criterion for accepted consensus levels within other consensus methods in the published literature [18]. The items generated in the NGT meeting were ranked as mentioned (1 = most important, 5 = least important). Participants could choose not to rank any items that they did not consider relevant to the question. A median rank score and the number of times participants scored a specific item (frequency) were also recorded. The frequency was used to calculate the percentage of experts who ranked an item [21].

An importance score for each item was computed as the average of the reciprocal rankings, this process is proposed by Cho et al. [22] and through a similar rationale to the Expected Reciprocal Rank Evaluation proposed in a different context [17,23]. An importance score (0-1) was ascertained for each item from its mean reciprocal rank (MRR), with scores closer to 1 deemed more important. The MRR is 1 divided by the ranking by each participant – 1 for the item ranked in first place, 1/2 for second place, 1/3 for third place, and so on. For example, if *communication* was ranked first by one participant and fourth by another, the reciprocal rankings would be 1 and 1/4, respectively. If an item was not ranked, it was assigned a zero. The importance given to an outcome was thus measured both by its ranking and by the consistency of it being nominated by the participants. The reason for inverting the ranks is to give more weight to top ranks and less to the lower ranks. Higher values of the score identify outcomes that are more valued by the participants. For example, if all group participants ranked a specific item 1 respectively, this would mean 100% consensus and an importance score of 1. In other words, the group not only fully agreed on the item's inclusion in the final consensus, but also ranked it as the most

It is anticipated that FCPs will be able to provide fitness for work recommendations and sickness certification for patients with MSK conditions within primary care from 2020, with stakeholders awaiting extended legislation for AHPs. In addition, the CSP and NHS have the ambition for FCPs to have conversations with patients about entering/returning to/remaining in work.

Q1. What do you feel are the challenges you face in meeting this multi-stakeholder ambition?

N.B. these could be intrinsic or extrinsic, e.g. systems, time, pathways, training, resources, signposting, culture, professional identity, lack of training.

Q2. What do you feel are your key learning and development needs in response to this ambition?

N.B. these can relate to asking the work question, screening, record keeping, using the AHP Fitness for Work Report, advice etc.

Fig. 1. Questions considered during online NGT meetings.

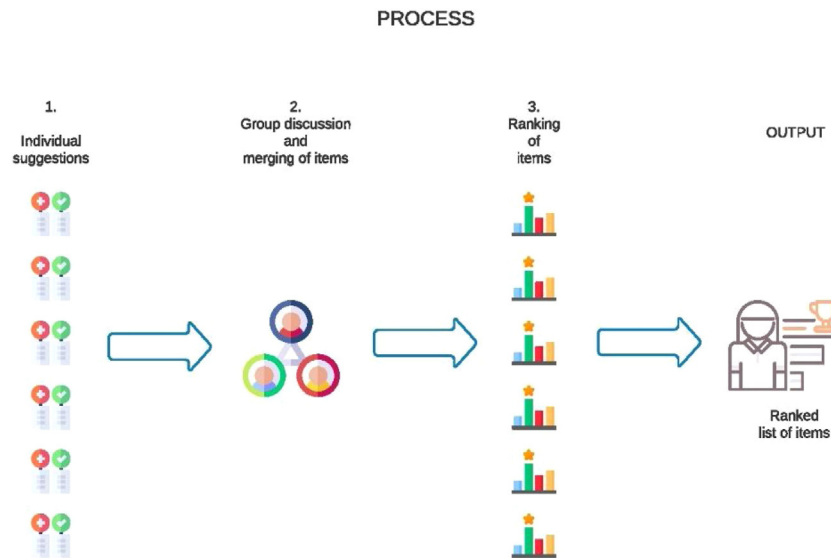


Fig. 2. Online NGT process detailing the stages of the meeting.

Table 1
Number of hours per week worked in FCP role (n = 21 responses).

Hours worked per week	Count	Range (hours)
<10	0	0
11-20	2	14-20
21-36	4	22-32
37 +	15	37.5

important item. It is suggested that items should be assessed in terms of the score as well as the frequency of votes, as this may be more representative of overall group priority of items [17].

Participant characteristics

In total, 21 experts (age range 28-49 years, 75% were female and 25% male) participated across the 2 nominal groups with a mean of 14.5 years’ professional Physiotherapy practice (Table 1). All had been working in an FCP role

for less than 1 year. Of these participants, all identified as first contact practitioners, most were based in England (86%, n = 18); 10% (n = 2) were based in Scotland and 4% (n = 1) in Wales.

A total of 40 items were generated (Fig. 3) in response to the first question regarding the challenges faced when working as an FCP and providing fitness for work advice and sickness absence certification (Table 2). These challenges included the skills, knowledge and training needed to have focussed conversations, intrinsic factors, such as confidence, and extrinsic factors, such as governance and legislative aspects. Nine items ultimately reached the required 60% threshold consensus level (% of participants that ranked an item) ‘Confidence in having challenging conversations about return to work’, ‘FCP training through a Framework similar to GP training’, ‘Lack of knowledge of legislative and legal requirements’, ‘Lack of overall governance, clinical supervision and competencies on a national scale’, ‘Educational requirements of Fit Note [sickness certification] requirements’, ‘Professional liability aspects of Fit Note [sickness certification]’, ‘Patients’ and workplaces’ opinion on FCP vs

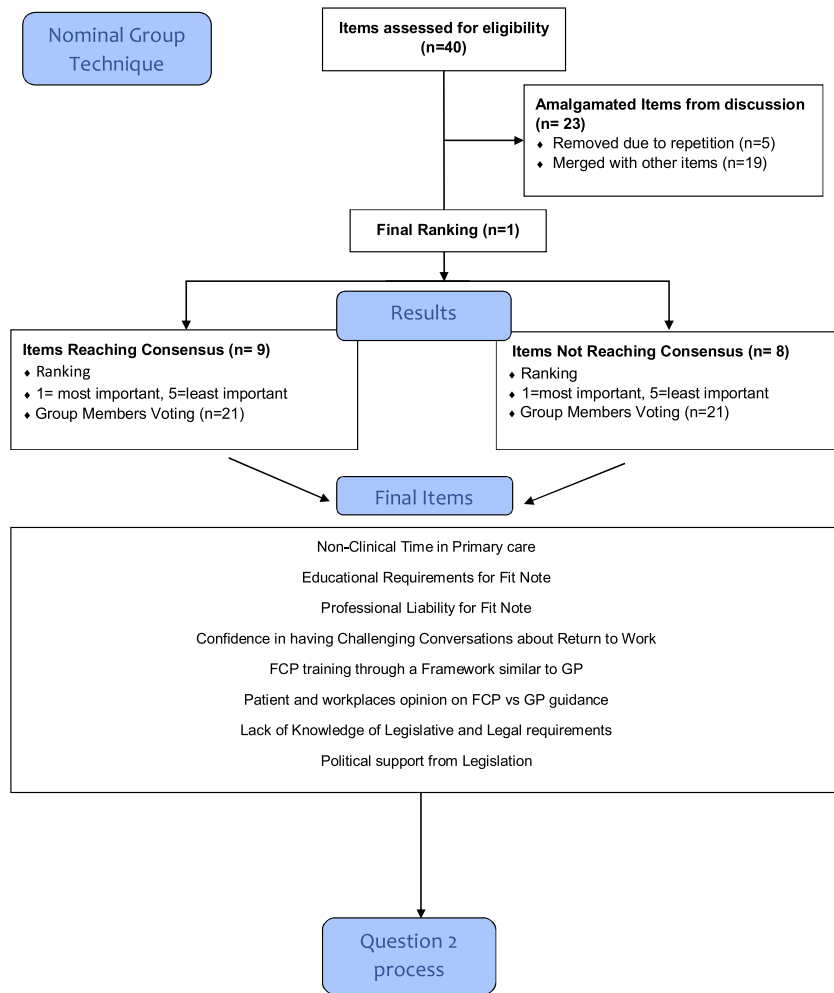


Fig. 3. Nominal Group Technique Question 1.

Table 2
Expert-defined items that reached consensus for Question 1.

Items for question 1	Consensus level (% of participants)	Importance score (mean reciprocal rank [MRR])	Median rank
Non-clinical time in primary care to allow for administrative tasks, fit note paperwork and to provide OH advice	100 ⁺	0.6 ^a	2.5
Educational requirements of Fit Note requirements	100 ⁺	0.6 ^a	2
Professional Liability aspects of Fit Note requirements	100 ⁺	0.5	2
FCP training through a framework similar to GP training	100 ⁺	0.4	4
Patient and workplace’s opinion on FCP vs GP guidance in relation to professional standing	100 ⁺	0.2	5
Confidence in having challenging conversations about return to work	78	0.6 ^a	4
Political support from Legislation allowing AHPs to sign Fit Notes	78	0.4	3
Lack of overall governance, clinical supervision and competencies on a national scale	78	0.4	3.5
Lack of knowledge of legislative and legal requirements	67	0.5	3

^a Most important item(s) + Full consensus on item(s).

GP Guidance in relation to professional standing’, ‘Political support from Legislation allowing AHPs to sign Fit Notes’ and ‘Non-clinical time in primary care to allow for administrative tasks, Fit Note paperwork and OH advice’.

For the second question, 43 items were generated (Fig. 4) for the key learning and development needs with nine reach-

ing the threshold consensus level: ‘Educational standard for Fit Note competency and training’, ‘Shared decision making and guiding patients to independently manage their conditions’, ‘Training on legal and legislative aspects of the Fit Note’, ‘Communicating complex topics such as pain in the absence of pathology to employers’, ‘Understanding

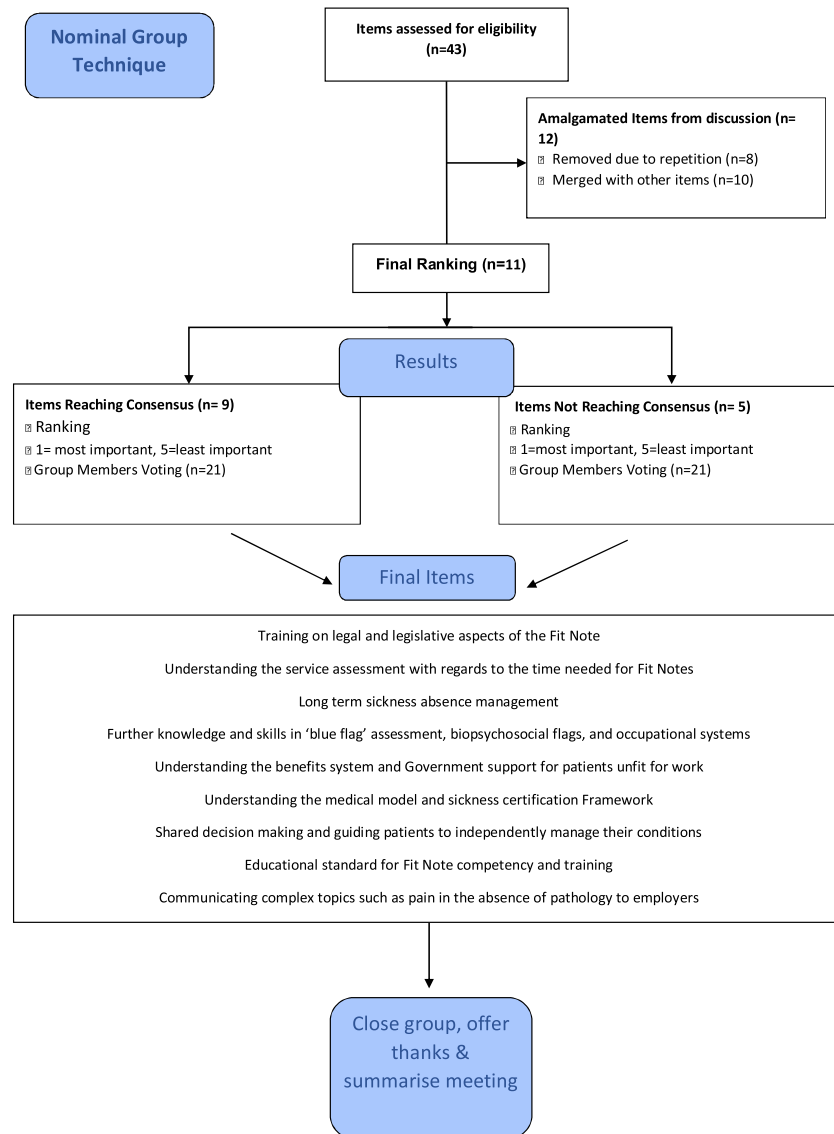


Fig. 4. Nominal Group Technique Question 2.

the medical model and sickness certification framework’, ‘Understanding the service assessment in consideration of regards to the time needed for Fit Notes’, ‘Long term sickness absence management’, ‘Further knowledge and skills in ‘Blue Flag’ assessment, biopsychosocial flags and occupational systems’ and ‘Understanding the ‘benefits system’ and Government support for patients unfit for work’ (Table 3).

Discussion

The UK’s NHS is committed to implementing FCP practice across all primary care settings [1]. This will involve support for skill development, training, and an increase in knowledge of topics not previously considered within the traditional therapeutic approach of managing MSK condi-

tions, such as managing sickness absence and fitness for work advice in those with complex MSK and medical needs. The proportion of the working age population aged between 50 and the state pension age will increase from 26% in 2012 to 34% in 2050 – an increase of over 5.5 million people [24]. With this ageing population, the prevalence of those with MSK conditions is expected to rise further, potentially impacting on the UK’s productivity and economic success [25]. In 2017, MSK conditions were the second largest cause of National sickness absence with around 28.2 million days lost in work (nearly 25% of total sickness absence) [25] with considerable risk for a premature exit out of the workforce because of incapacity and disability [15,26,27]. This burden is estimated at costing the UK taxpayer £8.6 billion in personal independence payments annually because of MSK disability [15] and the cost of sickness absence amounts to around £9 billion each year [25].

Table 3
Expert-defined items that reached consensus for Question 2.

Items for question 2	Consensus level (% of participants)	Importance score (mean reciprocal rank [MRR])	Median rank
Training on legal and legislative aspects of the Fit Note	100 ^a	0.8 ^a	1
Understanding the service assessment with regards to the time needed for Fit Notes	100 ^a	0.5	2
Long term sickness absence management	100 ^a	0.4	3
Further knowledge and skills in ‘blue flag’ assessment, biopsychosocial flags and occupational systems	100 ^a	0.4	4
Understanding the benefits system and Government support for patients unfit for work	100 ^a	0.3	4
Understanding the medical model and sickness certification Framework	89	0.5	2
Shared decision making and guiding patients to independently manage their conditions	89	0.5	2.5
Educational standard for Fit Note competency and training	89	0.5	3
Communicating complex topics such as pain in the absence of pathology to employers	67	0.6	2

^a Most important item(s) + Full consensus on item(s).

Therefore, primary care may be an ideal target to encourage older people to remain in work to help society to support growing numbers of dependents, with FCPs being the right professional first time. FCPs ideally will provide better, faster, and convenient access for longer-term health conditions such as MSK conditions that can place a substantial burden on the NHS and other care services [8] but also personalised care plans that support people to manage these conditions in work, with reasonable adjustments to work where needed. Central to this proposition is to ensure that patients maintain stable employment for good MSK health and seeing work as an outcome when recovering from a MSK-related problem. There is robust evidence to suggest that a lack of work-focused healthcare to address work issues within a clinical encounter is an obstacle to work participation [28].

This study provides the first known published evidence regarding the challenges faced in delivering sickness absence certification and fitness for work advice within primary care practice with FCP expert consensus. Sickness certification processes have wide-ranging implications for FCP practice and societal benefit including patient welfare, health economics and the socioeconomic impact of reduced sick leave.

Importantly, this study considers the key learning and development needs (solutions) in response to the ambition of having focussed occupational health specific discussions in a fully homogenous group of FCPs that work primarily in primary care. It is anticipated that FCPs will be able to provide sickness absence using the traditional Statement of Fitness for Work/Med 3 also known as the ‘Fit Note’, providing the UK Government widens the legislation for its use.

The NGT was an effective and time efficient method for generating items for the main topic discussions and allowing FCP experts to share their perspectives. Of these items, FCPs rated ‘Confidence in having challenging conversations about return to work’, ‘Educational requirements and professional liability of Fit Note requirements’ and ‘Non-clinical

time requirements for Fit Note paperwork and to provide OH specific advice’ as the most important challenges in meeting stakeholder work focussed healthcare, with item ‘Patient and workplaces opinion on FCP vs GP guidance in relation to professional standing’ gaining full consensus but not deemed as important.

In relation to knowledge, skills, and training, it is recommended that FCPs cohere to the recently published *Primary Care Educational Roadmap* [7]. The results indicate that FCPs report deficiencies in the aforementioned advanced knowledge items. This may limit their ability to assist individuals in preventing MSK-related work loss by utilising an AHP Health and Work Report, have challenging conversations about work and in considering the time needed to effectively promote work participation. For question 2, ‘Training on legal and legislative aspects of the Fit Note’ was ranked as the most important item, with four other items gaining full consensus. The GP Fit Note has been in use in the UK since 2010, when it was implemented following the UK Government commissioned *Working for a Healthier Tomorrow* Report [29] and the results suggest that FCPs feel the need for extended training in its use and the use of the AHP Health and Work Report [30]. The consensus levels within the expert group suggest their learning needs encompass the whole UK sickness absence arena, including legislation and how to effectively manage those at risk of, or experiencing long term absence.

The lack of training and awareness within this sphere is not unique to Physiotherapists, as despite approximately 2.3 million Fit Notes certificates being issued in quarter 1 in 2019/20 by GPs, data indicates that only 75% of GPs are confident in dealing with issues around return to work and 29% feel comfortable in dealing with Fit Note requests for individuals already in the welfare system [2]. In addition, research suggests that 2 in 3 feel obliged to give Fit Notes for non-medical reasons and only 7% received training related to this topic

in the past 12 months [31]. Despite this, the AHP health and work report and GP Fit Note can be powerful tools in supporting employees in work and in returning to work [30,4]. There is convincing evidence to suggest that appropriately conducted work focussed conversations result in positive effects on patients' mental and physical health and overall wellbeing [28]. Conversely, worklessness and the resultant risk of unemployment is associated with poorer physical and mental wellbeing, with increased GP consultations and higher mortality rates [4,33].

FCPs have assumed the role of MSK gatekeeper in primary care. Multi-stakeholder agenda suggests that work advice is needed for employed people at risk of avoidable sickness absence, this is especially true if fit-note certification is extended to other allied healthcare professionals [1]. Despite this, a national evaluation of the FCP model in primary care suggests that only 29% of employed patients surveyed reported receiving specific work advice from an FCP (with a predefined service success criterion target of $\geq 75\%$) [32]. In fact, this specific criterion was the only criterion out of twelve not met in the evaluation, with less than half of patients receiving advice about work, even when they solely reported MSK-related days-off-work. The authors concluded that supporting FCPs to deliver work advice is an unmet need and that training in the use of work-related advice is inconsistent. They also acknowledged that further work was needed to explore barriers to FCPs providing work advice. This is important as studies suggest that up to 35% of MSK consultations in primary care necessitate the use of GP Fit Notes and therefore may need work focussed conversations [33]. Without adequately understanding the individual training and system barriers to delivery of this health and work agenda topic, the specific FCP contextual and system factors will continue to limit work conversations, the use of the 'Fit Note' and work participation outcomes.

Most people's health needs are addressed within UK primary care. Early 'light touch' work-related support for most MSK conditions can be addressed for the vast majority, and complex cases can be referred to other specialist services. This fits with the UK's initiatives on 'work as a health outcome programme', 'Make Every Contact Count' and 'prevention is better than cure' by Public Health England and Department of Health and Social Care.

Evidence suggests a small cultural shift has occurred in the understanding of health-related aspects of work, in which the 'Fit Note' has facilitated 'light touch' work-related discussions, but the detail and quality of these varies within GPs [31]. Indeed, some physiotherapists may already provide this in practice, as one study found that physiotherapists used a structured approach (proforma/protocol-driven) to routinely consider work and job difficulties whereas GPs rarely used such structured measures to enquire about work unless it was raised by the patient themselves [36]. In the Netherlands, one study found that physiotherapists acknowledged the importance of work for their patients, but a limited knowledge about laws and regulations were a common barrier to offering work

conversations [37]. Positive impacts are more likely to be reported by healthcare professionals with higher levels of confidence in dealing with patient issues around return to work, and those with more training in health-work in the past year are more confident in dealing with such issues, influencing the quality of consultations and outcomes for patients [31].

Several studies have suggested how competency in this area can be reached and evaluated [38,39]. They suggested that training, with special interest group support summing speciality competencies on the topic. This may be further managed by health and work champions to implement theory into primary care practice. A key aspect of training should focus on addressing FCPs beliefs and attitudes about the importance of the topic, for example, having confidence in discussing the work issues and signposting to evidence-informed information (ibid). If FCPs are to address work issues and provide Fit Notes, they need to have sufficient knowledge, along with the support of guidance, checklists and tools to respond to patient related questions and initiate actions [40]. FCPs need clear information on the purpose of such work conversations, including universal information initially and increased detail depending on the time available in primary care. Our challenges and learning and development needs listed need to be embedded within undergraduate physiotherapy practice and postgraduate education (including FCP modules) as part of normal practice rather than a standalone occupational health topic. This can influence practice and support data collection.

Evidence from Public Health England (PHE) [41] on work conversations in the form of 59 surveys across a variety of healthcare professionals in primary, secondary and private and non-clinical settings suggested that measurement should be of the process rather than outcomes per se. They identified 'taking up training', 'having the conversation' and 'providing work-related support' as important aspects that can be measured, as long as it is included in routine documentation and audited. However, other respondents did consider measuring direct work outcomes such as work status at the first presentation and end of management, or through surrogate outcomes of return to work planning, self-referral to work-related advice and patient-focused outcomes such as confidence about returning to work and their rating of a work conversation. At this time, there is no best evidence to establish how content, supportive conversations about work and health or the outcomes from any other work-related components can be measured. This may, in part, be an indication of the significant barriers reported in conducting sickness absence certification and fitness for work advice in primary healthcare.

It is evident that work outcomes are not currently seen as a goal within FCP consultations, with many professionals seeing these as a conflict, as they tend to frame conversations based on clinical considerations only. This is despite evidence-based guidance suggesting it should occur. Indeed, one systematic review and meta analysis found that health-

care professionals report a lack of knowledge and confidence in such clinical guidance, as well as not necessarily agreeing with guidance recommendations for work or activity for patients [42]. This PHE evidence also suggests that brief interventions, consistent evidence-based positive messaging and advice on work may be concepts that can enhance MSK recovery. It is also argued that the vast majority of patients with MSK conditions may be suitable for some form of work with short-term adjustments. Indeed, it seems clinicians currently are not implementing clinical practice guidelines which results in a lack of work-focused healthcare, a likelihood to advise on work avoidance and overall these result in obstacles to work participation [41]. In sum, people with MSK conditions are less likely to be in work, are more likely to retire early, yet many want to work with the right support. FCPs may be ideally suited to overcome the current barriers that patients face in their recovery journey and work absence domains.

Conclusion

To our knowledge, this is new evidence regarding the challenges and learning and development needs identified by a group of FCP clinicians working within primary care in consideration of the occupational health specific topic. Thus far, the only other study to consider a summary of skills, knowledge and attributes needed to work as a FCP in MSK healthcare did not identify any qualitative work-related themes [34]. This is despite the CSP's FCP project team and FCP evaluation steering group reporting that supporting patients to remain in and return to work is a key success criterion. Occupational health specific topics are also supported within the core capabilities document [35], roadmap to practice capabilities [7] and in the wider UK Government and employer context of empowering sick patients to be supported in work. The asynchronous nature of the study is a key limitation of the current study. The study was conducted early in the COVID-19 pandemic response and experts had to be flexible to meet service demands, this resulted in some needing to contribute at an alternative meeting, thus the whole group did not contribute at the same time. In addition, the format was fully online which can influence group dynamics when compared to an 'in-person' meeting. However, this approach allowed the NGT meeting to be accessed and completed quickly by busy, hard-to-reach professionals during one of the most challenging times in healthcare practice. NGT's optimally run with between 8 and 12 participants, which is below our studies 21 participants. This may have made the NGT meetings more challenging to run, especially during the digital pivot because of the COVID-19 pandemic. Despite this, the depth and richness of the data and number of items that reached consensus did not seem to be influenced by the above dynamics.

Contribution of the paper

- Physiotherapist FCPs are becoming the MSK gatekeepers in primary care settings; however, challenges and solutions exist in FCP practice when considering work and health specific advice for patients presenting with MSK conditions in primary care.
- This role has been traditionally conducted by the General Practitioner and FCPs in this study have developed and reached consensus on items related to the challenges involved and their learning and development needs.
- The main challenges FCPs faced in delivering fitness for work advice and sickness absence certification centred on the non-clinical time in primary care to carry out tasks related to administration, documenting a Fit Note and in providing evidence informed fitness for work advice. In addition, FCPs identified that they require further educational training on the use of the Fit Note from stakeholders. Both items reached full consensus from the group (% of participants ranking the items) and were deemed the two most important items for question 1.
- The key learning and development needs centre on further training on the legal and legislative aspects of the Fit Note. This item reached full consensus from the group (% of participants ranking the item) and was deemed the most important item for question 2.
- Important items that reached a priori defined consensus (% of participants ranking the item) during the NGT meetings are presented above for both questions.
- FCPs may be ideally suited to provide and prompt supportive conversations about work, at an early stage (as most of the population's health needs are addressed by primary care as the first point of contact and 'cornerstone' in the NHS system) as long as identified challenges and learning and development needs are considered
- This study provides evidence to suggest that the Fit Note can become an enabler for conversations about health and work, if FCPs have the challenges/barriers for its use in practice considered and comprehensive training and development needs supported. This will improve the competency of healthcare professionals dealing with MSK health and will empower them to provide work-related advice.
- FCPs training and development should integrate the above items into future undergraduate and postgraduate education and competency frameworks so that FCPs can become occupational health champions in primary care.
- If FCPs can become competent in this area, it will ensure light coverage for now (not comprehensive Occupational Health services) of work-related advice for the vast majority of MSK conditions in the UK, to potentially reduce the burden of work-related ill health. More focused interventions could be considered with more specialised training.

Challenges and solutions exist

Challenges and solutions exist in FCP practice when considering occupational health specific advice for patients presenting with MSK conditions in primary care. FCP experts reached consensus on nine items with regards to the challenges faced in delivering occupational health specific advice, with ‘Non-clinical time in primary care to allow for administrative tasks, fit note paperwork and to provide OH advice’ and ‘Educational requirements for Fit Note’ deemed the most important items. FCP experts reached consensus on nine items with regards to the learning and development needs when considering OH specific information, with ‘Training on legal and legislative aspects of the Fit Note’ deemed the most important item. This study provides evidence to supplement and support UK competency frameworks on a topic not currently considered in the scientific literature.

Acknowledgement

The authors would like to express their appreciation to the anonymous reviewers whose insightful comments facilitated the quality of this article.

Data Availability

Data will be made available on request.

Funding: The authors did not receive financial support for the research, authorship, and/or publication of this article.

Ethical approval: Ethical approval was granted by Glasgow Caledonian University’s Health and Life Sciences Research Ethics Committee (Ref: HLS/PSWAHS/19/144).

Conflict of Interest: The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

References

- [1] UK Government. Improving Lives: The Future of Work, Health and Disability. Available from: <https://www.gov.uk/government/publications/improving-lives-the-future-of-work-health-and-disability>. [Accessed 15th January 2021].
- [2] Coole C, Nouri F, Potgieter I, Watson PJ, Thomson L, Hampton R, et al. Recommendations to facilitate the ideal fit note: are they achievable in practice? *BMC Fam Pract* 2015;16(1):138.
- [3] NHS Digital. Fit Notes Issued by GP Practices, England; 2017. Available from: <https://digital.N.H.S.uk/data-and-information/publications/statistical/fit-notes-issued-by-gp-practices/fit-notes-issued-by-gp-practices-england-june-2017>. [Accessed 15th February 2021]. June.
- [4] Dorrington S, Roberts E, Mykletun A, Hatch S, Madan I, Hotopf M. Systematic review of fit note use for workers in the UK. *Occup Environ Med* 2018;75(7):530–9.
- [5] Nordhagen HP, Harvey SB, Rosvold EO, Bruusgaard D, Blonk R, Mykletun A. Case-specific colleague guidance for general practitioners’ management of sickness absence. *Occup Med (Lond)* 2017;67(8):644–7.
- [6] The Chartered Society of Physiotherapy. The Allied Health Professions Health and Work Report; 2019. Available from: <https://www.csp.org.uk/professional-clinical/professional-guidance/fitness-work/ahp-health-work-report>. [Accessed 10 February 2021].
- [7] Health Education England. First Contact Practitioners and Advanced Practitioners in Primary care : (Musculoskeletal) A Roadmap to Practice. Available from: <https://www.hee.nhs.uk/our-work/primary-care/first-contact-practitioners-advanced-practitioners-musculoskeletal>. [Accessed 15th January 2021].
- [8] National Health Service. NHS Long Term Plan. Available from: <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf>. [Accessed 15th January 2021].
- [9] National Health Service England and British Medical Association. Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan. Available from: <https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>. [Accessed 15th January 2021].
- [10] Office for National Statistics. Sickness absence in the Labour Market. Available from: <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/sicknessabsencefallstothelowestratemin24years/2018-07-30>. [Accessed 15th January 2021].
- [11] Public Health England. Musculoskeletal Health: A 5-year strategic framework for prevention across the lifecourse. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/810348/Musculoskeletal_Health_5_year_strategy.pdf. [Accessed 10th November 2020].
- [12] ARTHRITIS U.K. The State of Musculoskeletal Health; 2019. Available from: <https://www.versusarthritis.org/media/14594/state-of-musculoskeletal-health-2019.pdf>. [Accessed 10th December 2020].
- [13] Hartvigsen J, Hancock MJ, Kongsted A, Louw Q, Ferreira ML, Genevay S, et al. What low back pain is and why we need to pay attention. *Lancet* 2018;391(10137):2356–67.
- [14] Greenhalgh S, Selfe J, Yeowell G. A qualitative study to explore the experiences of first contact physiotherapy practitioners in the NHS and their experiences of their first contact role. *Musculoskeletal science & practice* 2020;50:102267.
- [15] Cieza A, Causey K, Kamenov K, Hanson SW, Chatterji S, Vos T. Global estimates of the need for rehabilitation based on the Global Burden of Disease study 2019: a systematic analysis for the Global Burden of Disease Study 2019. *Lancet* 2020;396(10267):2006–17.
- [16] Van de Ven AH, Delbecq AL. The nominal group as a research instrument for exploratory health studies. *American Journal of Public Health* 1972;62(3):337–42.
- [17] Manera KE, Johnson DW, Craig JC, Shen JI, Ruiz L, Wang AY, et al. Patient and Caregiver Priorities for Outcomes in Peritoneal Dialysis: Multinational Nominal Group Technique Study. *Clin J Am Soc Nephrol* 2019;14(1):74–83.
- [18] McMillan SS, King M, Tully MP. How to use the nominal group and Delphi techniques. *Int J Clin Pharm* 2016;38(3):655–62.
- [19] Vander Laenen F. Not just another focus group: making the case for the nominal group technique in criminology. *Crime science* 2015;4(1):1–5.
- [20] Heckathorn DD. Comment: Snowball versus respondent-driven sampling. *Sociological Methodology* 2011;41(1):355–66.
- [21] Manera K, Hanson CS, Gutman T, Tong A. Consensus Methods: Nominal Group Technique; 2019. p. 737–50.
- [22] Cho Y, Sautenet B, Rangan G, Craig JC, Ong ACM, Chapman A, et al. Standardised Outcomes in Nephrology-Polycystic Kidney Disease (SONG-PKD): Study protocol for establishing a core outcome set in polycystic kidney disease. *Trials* 2017;18(1):560.
- [23] Chapelle O, Metzler D, Zhang Y, Grinspan P. Expected reciprocal rank for graded relevance. *Conference on Information and Knowledge Management* 2009:621–30.

- [24] Government Office for Science. Future of an ageing population. Available from: <https://www.gov.uk/government/publications/future-of-an-ageing-population>. [Accessed 01st February 2021].
- [25] Office for National Statistics. Sickness absence in the UK labour market; 2018. Available from: <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/articles/sicknessabsenceinthelabourmarket/2018>. [Accessed 10 January 2021].
- [26] Health and Safety Executive. Working days lost in Great Britain, 2019/20. Available from: <https://www.hse.gov.uk/statistics/dayslost.htm>. [Accessed 01st February 2021].
- [27] World Health Organization. Musculoskeletal conditions. Available from: <https://www.who.int/news-room/fact-sheets/detail/musculoskeletal-conditions>. [Accessed 01st November 2020].
- [28] Steenstra IA, Steenstra IA, Munhall C, Munhall C, Irvin E, Irvin E, et al. Systematic Review of Prognostic Factors for Return to Work in Workers with Sub Acute and Chronic Low Back Pain. *J Occup Rehabil* 2017;27(3):369–81.
- [29] Black CM. Working for a healthier tomorrow Dame Carol Black's review of the health of Britain's working age population: presented to the Secretary of State for Health and the Secretary of State for Work and Pensions. London: TSO; 2008.
- [30] Chartered Society of Physiotherapy. The Allied Health Professions Health and Work Report. Available from: <https://www.csp.org.uk/professional-clinical/professional-guidance/fitness-work/ahp-health-work-report>. [Accessed 22nd October 2020].
- [31] Department for Work and Pensions Research Report No 733. General Practitioners' attitudes towards patients' health and work Dr Mark Hann and Professor Bonnie Sibbald. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/214507/rrep733.pdf. [Accessed 06th October 2020].
- [32] Stynes, S, Goodwin R., Bishop A. National Evaluation of First Contact Practitioner (FCP) model of primary care. Available from: https://www.csp.org.uk/system/files/documents/2020-11/final_fcp_phase_3_national_evaluation_report.pdf. [Accessed 20th January 2021].
- [33] Wynne-Jones G, Mallen CD, Mottram S, Main CJ, Dunn KM. Identification of UK sickness certification rates, standardised for age and sex. *British Journal of General Practice* 2009;59(564):510–6. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2702016/pdf/bjgp59-510.pdf>. [Accessed 20th January 2021].
- [34] Langridge N. The skills, knowledge and attributes needed as a first-contact physiotherapist in musculoskeletal healthcare. *Musculoskeletal Care* 2019;17(2):253–60.
- [35] Health Education England. Musculoskeletal core capabilities framework for first point of contact practitioners. Available from: https://www.csp.org.uk/system/files/musculoskeletal_framework2.pdf. [Accessed 11th January 2021].
- [36] Wynne-Jones G, Artus M, Bishop A, Lawton SA, Lewis M, Jowett S, et al. Effectiveness and costs of a vocational advice service to improve work outcomes in patients with musculoskeletal pain in primary care: a cluster randomised trial (SWAP trial ISRCTN 52269669). *Pain* 2018;159(1):128–38.
- [37] Oswald W, Hutting N, Engels JA, Staal JB, Nijhuis-van der Sanden MWG, Heerkens YF. Work participation of patients with musculoskeletal disorders: is this addressed in physical therapy practice? *Journal of Occupational Medicine and Toxicology* 2017;12:1–11.
- [38] Martin R, Parker C, Prior Y, Arafin N, Smyth G. Health and work champions: a pilot training programme. Project Evaluation Report. Public Health England, Royal College of Occupational Therapy; 2018.
- [39] Parker C, Martin R, Ceolta-Smith J, Brown T, Weinberg A, Hopkins J. Work for Health Programme: Healthy Work Conversations. Project Evaluation Report. University of Salford Greater Manchester Public Health; 2015.
- [40] Tran A. Does remaining in work benefit those with MSK conditions? Evidence Briefing. London: Public Health England; 2018.
- [41] Public Health England. Work conversations in healthcare: How, where, when and by whom? Available from: <https://www.gov.uk/government/publications/work-conversations-in-healthcare-literature-review>. [Accessed 22nd February 2021].
- [42] Slade SC, Kent P, Bucknall T, Molloy E, Patel S, Buchbinder R. Barriers to primary care clinician adherence to clinical guidelines for the management of low back pain: protocol of a systematic review and meta-synthesis of qualitative studies. *BMJ Open* 2015;5(4):e007265.

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