

Work-related health advice in primary care

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Background	The dangers of long-term sickness absence and worklessness are well recognized. In the UK, the occupational health (OH) community was challenged to seek new partners to support health in working age people. A National Health Service OH service and Leicestershire general practice set up a pilot clinic to provide work-related health advice in primary care.
Aims	To recruit 100 patients to an OH clinic in general practice and record their demographic characteristics, diagnoses and occupational outcomes.
Methods	Pre-booked 30 min appointments for work-related health consultations in general practice were offered over 12 months. Consultations were recorded electronically and questionnaire feedback invited 3–6 months later. The main outcome was subjective reporting of benefit and workplace adjustments.
Results	Ninety-six patients attended OH appointments in general practice, 86 were in employment: 49 on sick leave at the time of their consultation and 10 were workless. Mental health and musculoskeletal problems accounted for the most common diagnoses. Following their consultation, 29% of patients reported workplace adjustments which were beneficial to them. None of the workless reported a return to employment.
Conclusions	Patients will access work-related health advice in primary care. Extended OH consultations by general practitioners can achieve positive self-reported outcomes for patients in employment.
Key words	Occupational health; primary care; sick leave; work.

Introduction

The importance of primary care involvement in workplace health issues and assessment of fitness for work have been recognized by both general practitioners (GPs) and occupational health physicians (OHPs) [1]. The difficulties in providing work-related advice within the time constraints of a standard GP consultation have been highlighted [2].

In the UK, GPs have a long-established role in sickness certification. Their concerns about potential conflicts between their dual role as patient advocates and gatekeepers to the UK benefit system have been recognized [3]. The role of OHPs in the UK has been largely confined to individuals and organizations where an occupational health (OH) service is provided and funded by the employer [4].

Dame Carol Black's review of the health of Britain's working age population challenged OHPs to seek new partners in the delivery of work-related health advice [4]. Her review suggested that GPs should issue fit notes

rather than sick notes, concentrating on what their patients can do, rather than what they cannot. The government response also recommended that new models of 'Fit for Work' services should be tested and the benefits of work-related interventions evaluated [5].

There are no reports of a formal OH clinic within a UK general practice setting. The Sheffield Occupational Health project, from 1980, focussed on the detection of occupational disease. Structured interviews and limited screening tests were administered by non-clinical staff working in GP surgeries in an industrial city [6].

In Scandinavia, there has been a greater focus on the assessment of functional ability by GPs [7]. However, their experience has shown that it remains difficult to increase the uptake of partial return to work, probably because of inflexible work arrangements and poor collaboration between stakeholders [8]. In the UK, there has been increasing recognition by GPs and other doctors that work is good for health. The Royal College of General Practitioners is running an educational programme of

workshops for GPs on managing health and work issues in their practice population [9].

Our study was designed to investigate the potential impact of an OH clinic in primary care. A National Health Service (NHS) OH service and general practice set up the clinic, as a limited pilot study, to discover whether patients will access specific OH appointments provided in their own primary care practice. The aim was to recruit 100 patients and look at the demography, diagnostic profile, work situation and outcomes of those who attended.

Methods

Pre-booked 30 min appointments for work-related health consultations were offered over a 12 month period to patients of a semi-rural general practice (list size 11 700). Posters and leaflets in the practice waiting room titled 'Is your health affecting your work?' advertised the clinic. Subheadings suggested that patients 'on sick leave, undergoing treatment or awaiting planned surgery, coping with a health problem, living with a disability or currently claiming incapacity benefit', might like to make an appointment for the practice OH clinic. Reception staff and clinical members of the practice team were briefed about the clinic's role to enable them to answer questions appropriately and facilitate appointment making.

The OH service and practice collaborated to set up the protocol for the OH consultations delivered by two GP principals in the practice. Each had an interest in occupational medicine, the Diploma in Occupational Medicine qualification and had worked on a sessional basis in the NHS OH service. Advice and support, including referral if required, was available throughout the project from a specialist OHP and specialist OH nurse.

Patients attending the clinic were advised that this was a new venture and given an explanatory leaflet. This included a request to provide feedback and to allow their consultation data to be analysed on an anonymous basis to evaluate the success of the project. Advice was sought from the NHS National Research Ethics Service, East Midlands, who confirmed that formal ethical approval was not required.

The consultation, which followed the format of consultations in the NHS OH service, explored the patient's work and health situation and any relationship between them. Clinical notes were made on a purpose-designed proforma. A summary record on the practice computerized database, Egton Medical Information Systems (EMIS) noted the patient's current job, sick leave, principal diagnosis and any clinical or occupational interventions. These included referrals for treatment, communication with the patient's workplace and referral to Department for Work and Pensions services, including

Access to Work and Disability Employment Advisors. All communications were made with the patient's understanding and consent.

Feedback, including information about the patient's current work situation and any changes following their OH appointment, was invited 3–6 months later via a simple questionnaire posted to the patient's home address.

The proportion of patients in whom there was some evidence of workplace adjustments following their clinic consultation was compared with figures relating to NHS staff seen in the in-house OH clinics of the sponsoring service. Data related to all OH service consultations were logged on a Microsoft database maintained in the OH department and audited annually.

Results

The demography, employment profile and principal diagnosis of patients attending OH appointments in general practice between October 2008 and October 2009 are shown in Table 1.

The occupational interventions and clinical referrals that followed are summarized in Table 2. A letter to the patient's employer or line manager followed 30% of consultations with employed patients. Letters included recommendations about gradual returns to work and other modifications of workplace duties or provision of equipment which might assist the patient to return to, or remain at, work. Adjustments were discussed with another 7% of patients for whom a letter was not necessary or was declined. Thirteen per cent of patients, including three NHS staff, were referred by letter to their workplace OH service.

Clinical referrals were made when treatment might assist a patient to continue in work. None were referred for specialist occupational medical advice or assessment. Changes in medication were recommended to 7%.

Feedback questionnaires were returned by 75% of patients. The majority of replies were positive, and self-reported outcomes are summarized in Table 2. Many patients gave specific examples of ways in which their work situation had improved following communication with their employer. These included phased returns to work, alterations in work site, work duties, reduction in travelling, provision of IT equipment and overall recognition by their employer of workplace stresses coupled with measures to reduce these for the patient and other staff. In the NHS OH Service, where the authors also work, workplace adjustments and modified work programmes were recommended for 30% of staff assessed in OH clinics (unpublished data, A. de Bono, Annual Report for University Hospitals of Leicester NHS Trust OH Service, 2008–2009).

Five per cent of patients seen in the GP clinic did not feel that they had received any benefit. Reasons given

Table 1. Demographics of patients attending OH clinic in primary care setting

	<i>n</i> (%)
Appointments	
Number of appointments booked	106
Number of appointments attended	96
Reason for attendance	
Off sick and seeking assistance to return to work	49 (51)
At work, struggling because of health issues	37 (39)
Workless because of ill-health or chronic disability	10 (10)
Age distribution	
Under 35	26 (27)
36–50	38 (40)
Over 50	32 (33)
Sex distribution	
Men	36 (38)
Women	60 (62)
Employment profile ^a	
White-collar admin and professional	21 (22)
Manufacturing industry	16 (17)
Health care (including 6 NHS staff)	14 (15)
Transport including driving	12 (12)
Public service including fire/police/teaching	12 (12)
Retail	10 (10)
Cleaning/maintenance/catering	8 (9)
Other	3 (3)
Principal health problem/diagnosis ^b	
Mental health	31 (33)
Musculoskeletal	28 (29)
Other medical including neurological, cardiovascular and respiratory ^c	36 (38)
Other—non-medical	1

^aIncludes last job for 10 workless patients, if known.

^bIncludes eight recovering from recent surgery.

^cNeurological diagnoses (11) were the largest single category.

were that workplace adjustments had not been implemented (2%), employment had been terminated before the outcome of surgery was known (1%) or there had been no success in finding employment (2%). None of the 10 workless patients had secured employment 6 months later although 9 were seen by the employment advisory services and 4 were offered some training.

Discussion

Patients responded to the offer of OH advice in their practice. High proportions of those seeking OH advice in primary care had mental health problems (33%) and were on sick leave at the time of their consultation (51%). Almost half the consultations for those in work resulted in communication with the patient's employer. Identifiable workplace adjustments followed for almost a third. Help for the workless was limited despite referral to appropriate agencies.

Ninety-six patients represent only a small proportion of the expected working population of the practice. The

Table 2. Recommendations, interventions and self-reported outcomes for patients attending the OH clinic

	<i>n</i> (%)
Number of patients seen	96
Employment interventions	
Letters to patient's employer recommending adjustments at work	26 (27)
Adjustments suggested—no letter	7 (7)
Referrals to workplace OH service ^{a,b}	12 (13)
Health interventions	
Referral to medical specialists	6 (6)
Orthopaedics	4 (4)
Rheumatology	1 (1)
Coloproctology	1 (1)
Referrals for community treatment	
Physiotherapy	3 (3)
Chiropody	1 (1)
Psychological therapies	4 (4)
Changes in medication	7 (7)
Self-reported outcomes	
Questionnaires returned	72 (75)
Questionnaires undelivered ^c	9 (9)
No reply	15 (16)
Consultation was beneficial	62 (65)
Workplace adjustments followed consultation	28 (29)
Phased return to work	10 (10)
Long-term alteration in hours of work	5 (5)
Altered duties	9 (9)
Transfer to alternative job, same employer	1 (1)
Provision of equipment to assist work, e.g. seating IT equipment	3 (3)
Seen by Employment Advisory Service	9 (9)
Offered training by Department for Work and Pension agencies	4 (4)
No benefit from consultation	5 (5)

^aIncludes two letters to OH physician where a referral had already been made by the employer.

^bIncludes three NHS staff.

^cHad changed address since consultation and could not be traced.

higher proportion of female patients (65% of attendees) reflects the known pattern of consultations in general practice where women are more likely to attend than men except at the extremes of age [10]. Women are also more likely to attend the surgery with children or other family members and may have seen the posters advertising the new clinic.

We recognize that patients may self-refer for OH consultations because they do not feel they are getting good advice from their current GP. Interventions in this clinic were limited to those related to ability to work. Two patients with chronic health conditions already under the care of a specific GP within the practice were referred back to that doctor for further advice.

Outcomes were self-reported and we had no access to workplaces to verify the adjustments recorded by patients. The high response rate to the questionnaire was encouraging. Rates were highest in those on sick

leave at the time of their consultation (42/49) and in the workless (10/10).

Our study supports the premise that targeted work-related health advice in the primary care setting may be effective in assisting patients with mental health problems and on sick leave. Recent guidance from the National Institute for Health and Clinical Excellence on managing long-term sickness absence and incapacity for work has emphasized that effective interventions at an early stage can help patients to remain in employment [11]. Long-term sickness absence and worklessness are associated with recognized multiple health and social disadvantages [12].

The GPs who saw the patients in our clinic had specific experience in OH. Doctors without their background might not have achieved comparable results. Fit notes were introduced in April 2010 and their availability may limit some of the utility of referrals to a primary care OH clinic. However, they are not necessarily a substitute for the extended 30 min consultations that allowed time for exploration of work-related health issues.

It is perhaps surprising that there were no referrals for specialist occupational medical advice. Review of the records identified nine patients with possible work-related health problems. Five gave a history indicative of work-related stress, a carpenter with a 7 year history of daily use of vibrating tools presented with Raynaud's phenomenon, a cleaner reported episodes of chest tightness at work following the introduction of a new cleaning product and a concrete worker at a quarry presented with a history of bilateral upper limb disorder that had prevented him working for several months. The carpenter was referred to his employer's in-house OH service and to a rheumatologist but there is no record of any further specialist assessment for the other eight patients.

Study size and timeframe were limited by funding. OH advice in primary care does not attract any quality framework payments. This study was sponsored by the NHS OH service that funded sessional commitments by the two GPs, allowing locums to cover their routine surgery while they provided the OH clinic.

This is the first report of outcomes following Dame Carol Black's challenge to the NHS to be involved in provision of work-related health interventions for those who do not have access to OH [5]. Preliminary results in 2009 demonstrated patients' willingness to attend a primary care OH clinic [13]. Further investigation has confirmed self-reported workplace interventions for 29% of those who attended.

The 2010 White paper calls for patient centred services commissioned by health care professionals closest to patients' needs [14]. We suggest that this model, of collaboration between NHS OH services and primary care, could bring cost-effective benefits to patients.

Key points

- Patients responded positively to provision of an occupational health clinic in their general practice.
- Mental health problems and current sickness absence were the most common reasons for seeking work-related health advice.
- Workplace adjustments, following recommendations by the occupational health clinic, were reported by a third of patients in employment.

Funding

This work was supported by the UHL NHS Trust OH Service and limited to reimbursement for clinical and administrative costs.

Acknowledgements

The authors would like to thank the staff of the Orchard Practice, Broughton Astley, and the UHL NHS Trust Occupational Health Service who facilitated this study.

Conflicts of interest

None declared.

References

1. Gunnyeon B, Parker G, Sharp C *et al.* The health and work handbook: patient care and occupational health: a partnership guide for primary care and occupational health teams. *Faculty Occup Med* 2005; 1–3.
2. Morrison J. The role of the GP in keeping people in work. *Occup Med (Lond)* 2011; **61**:74–75.
3. Verbeek J, Madan I. From sick notes to fit notes. *Br Med J* 2009; **339**:587–588.
4. Department for Work and Pensions, Department of Health, Black C. *Working for a Healthier Tomorrow: Dame Carol Black's Review of the Health of Britain's Working Age Population*. London: The Stationery Office, 2008.
5. Department for Work and Pensions, Department of Health. *Improving Health and Work: Changing Lives: The Government's Response to Dame Carol Black's Review of the Health of Britain's Working-Age Population*. London: The Stationery Office, 2008; 57–65.
6. Pickvance P. An occupational health service in primary care. *Occup Med (Lond)* 1992; **42**:61–63.
7. Krohne K, Brage S. How GPs in Norway conceptualise functional ability. *Br J Gen Pract* 2008; **58**:850–855.
8. Kausto J, Miranda H, Martimo KP, Viikari-Juntura E. Partial sick leave—review of its use, effects and feasibility in the Nordic countries. *Scand J Work Environ Health* 2008; **34**:239–249.

9. Royal College of General Practitioners, National Education Programme for General Practitioners. Health and Work in General Practice 2009. http://www.rcgp.org.uk/courses_events/health_and_work_training.aspx (12 March 2011, date last accessed).
10. The Health and Social Care Information Centre. Trends in Consultation Rates in General Practice 1995 to 2008. <http://www.ic.nhs.uk> (12 March 2011, date last accessed).
11. National Institute for Health and Clinical Excellence. *Managing Long-Term Sickness Absence and Incapacity for Work*. 2009. <http://www.nice.org.uk/PH19> (10 March 2011, date last accessed).
12. Waddell G, Burton AK. *Is Work Good for Your Health and Wellbeing?* London: The Stationery Office, 2006.
13. de Bono A, Collington C, Beckley A, Lees B. A Fit for Employment Service in Primary Care: A Pilot Study. Annual National Primary Care Conference 2009, 2009 November 5–7, Glasgow Scotland.
14. Department of Health. *Equity and Excellence: Liberating the NHS*. The Stationery Office, 2010; P27–P37.