

BACKGROUND

Work loss due to ill-health is a leading global concern, costing the UK economy alone around £100bn per year (Joint Work & Health Unit 2017). It is a major cause of socioeconomic disadvantage and inequality, placing a considerable burden on health, employment and welfare systems. Policy-directed research conducted over more than a decade suggests that much of this burden is avoidable (Waddell & Burton 2006) (Waddell et al 2008). The evidence showed that most work loss actually stems from common health problems (mild to moderate conditions which typically fluctuate over the working life), rather than from severe injury, serious disease or profound disabilities. Therefore, in principle, with timely support, most people can be helped to remain in work or return to work as soon as possible. It logically follows that healthcare professionals (HCPs) have a crucial role in helping to prevent work loss as they are often the first point of contact for workers presenting with common health problems.

Informed by these principles, since 2008 relevant policy and clinical guidance has argued that healthcare must be ‘work-focused’ (Black 2008) (Department for Work & Pensions 2008) (National Institute of Clinical Excellence 2009). Figure 1 documents the relevant UK policy initiatives launched over the decade since 2008 to promote this agenda.

[Figure 1 here]

Policy has not articulated a formal definition of ‘work-focused healthcare’, but a recent definition put forward in the latest research proposes it is:

“Where the healthcare professional acknowledges the importance of work by identifying and addressing obstacles to work participation in the clinical encounter and collaborates with other stakeholders” (Xie et al 2021).

In 2017, the current UK government commissioned Public Health England (PHE) to further implement this agenda:

“When working-age individuals consult with healthcare professionals, we want to see them receive work-related advice and supportive engagement as part of making work a health outcome. This is based on the understanding that good work is good for health” (Joint Work & Health Unit 2017).

The remit of PHE’s programme of work is primarily to promote HCPs understanding of the health benefits of good work, and to enable them to have appropriate, supportive conversations about work with their patients at every opportunity. By doing this, it is proposed the programme will lay the foundations, amongst HCPs and the National Health Service (NHS) as a whole, to support patients to remain in or return to work. Based on this rationale, PHE proposed the Making Every Contact

Count (MECC) model as a vehicle for improving work conversations in routine healthcare (Public Health England 2016).

MECC seeks to use everyday interactions that organisations and people have with members of the public to support them in making positive changes to their health and wellbeing. MECC interactions are intended to be brief, take a matter of minutes, not add materially to the burden on staff, and be structured to fit into existing professional engagement approaches. However, the existing clinical guidelines and evidence for the recommendations on health behaviour change that underpin the MECC approach relate only to established individual health behaviour risks (e.g. diet, weight, alcohol consumption, exercise, smoking, wellbeing and mental health) (National Institute of Clinical Excellence 2014). It is unclear whether or to what extent the MECC framework is transferable to the 'work-focused healthcare' context.

Because of this uncertainty, in 2019 PHE commissioned the authors of this paper to conduct a review of the literature on work conversations in healthcare, augmented with qualitative data collected from key HCPs (Bartys et al 2019). The main objective for the commission was to establish the feasibility of conducting a behavioural analysis of data in the existing literature. Behavioural analysis informs the MECC approach by establishing which interactions - with whom, where, and when - are the most effective for the desired behavioural outcome. In line with the premise of MECC as using everyday interactions, the focus of the commission was on routine (non-occupational) healthcare consultations where work conversations were not the main focus, and the initiation and delivery of supportive discussions aimed at facilitating work retention or return to work.

The purpose of this paper is not to simply reproduce the published report, but to show how the commission provided a unique opportunity for the authors to participate in a continuous informal and timely exchange of information with the funders (as policymakers) to address some key misunderstandings in the above objectives. As experts in the field, it was apparent to the authors that these knowledge gaps were acting as obstacles to policy progress:

- (a) there was a presumption that the launch of numerous, evidence-informed initiatives with supportive clinical guidance over the last decade had meant that work conversations in healthcare were routinely taking place, and that there would be a resultant evidence-base comprising the required behavioural data (i.e. on 'supportive' discussions) which could be examined for their association with work outcomes. The authors knew this was not the case, and these data did not exist;
- (b) the MECC model is a clinical intervention aimed at preventing and treating illness in a standardized manner by changing behaviour of both patients and HCPs (Dagenais et al 2020). However, the latest evidence points to the need for a 'whole-systems' approach to reduce work-loss due to ill-health, with

integration of healthcare and employment systems (Bartys et al 2017). Isolating the healthcare system in respect of a targeted clinical intervention without making the necessary changes to the other inter-linking social systems (the workplace, welfare) contradicts the evidence and is unlikely to be effective;

- (c) there was a presumption that stakeholders were needed to inform the literature search and general information gathering. This would be unnecessary because of the authors' expert knowledge of the (limited and disparate) relevant evidence base.

Building on their position as 'trusted allies' (Nichols et al 2020), the authors engaged with the funder throughout the research process to ensure findings would address these knowledge gaps and meaningfully inform decision-making. It was not feasible to make this process explicit in the published report; hence the present paper. In outlining that process here, qualitative data collected from a wide range of HCPs as part of the commission are presented for the first time. These data heavily influenced findings and subsequent policy recommendations, but were not required in the published report. In presenting them here, we are able to further illuminate and expand on the report findings and recommendations. As a result, this paper reveals novel insights about the ongoing knowledge exchange, advocacy, and alliances needed between academic, policy, and HCPs to mobilise policy into practice.

METHODS

A steering group was established between the authors, PHE, and their funder - The Joint Work & Health Unit (WHU) (a cross-government unit, jointly sponsored by the Department for Work and Pensions and the Department of Health and Social Care). The aims of the steering group were to foster a collaborative approach for the research, to monitor and discuss the work at regular intervals, and for the funder(s) to provide input where appropriate. The authors used this opportunity to engage the funders as outlined above. Acknowledging the authors' concerns, the funders agreed to revise the original research protocol and widen the remit of the literature review and qualitative data collection.

However, due to the governance around the commissioning process, the original study rationale (e.g. MECC) and the related research questions could not be altered. Thus, they are outlined below to provide the necessary context for illuminating the production of report findings and policy recommendations presented in this paper:

- What are the current national, or widely implemented local interventions (including policies, programmes and services) that encourage conversations about work in a health setting?

- When, where and between whom are supportive (i.e. evidence-informed) conversations about work and health already taking place?
- What are the key behaviours of healthcare professionals and key players in the healthcare system (structural and managerial) that support or hinder the initiation and delivery of supportive conversations about work and health? What are the influences (barriers and facilitators) on those behaviours?
- What is the most desirable outcome from a supportive conversation about work and health and how can this be measured?
- What are the most promising opportunities for supportive conversations about work and health?

In this vein, the literature review had to remain the required focus of the commission. Therefore, it is also necessary to include a summary of the review methodology and findings here (see authors' own, 2019 for full details) to be able to explain and discuss the linked qualitative element of the research as the focus of this paper.

Literature review

A best-evidence synthesis (BES) of the published literature was undertaken. The purpose of a BES is to systematically identify, evaluate and synthesise the best evidence in a given context (Slavin 1986). The authors had employed this methodology successfully in previous policy-relevant evidence reviews (Waddell & Burton 2006) (Waddell et al 2008) (Burton et al 2013). This approach was agreed by the funders as the most appropriate taking into account the revised remit.

A BES incorporates a wide range of peer-reviewed and grey literature on the selected topic, and draws conclusions about the balance of evidence based on its quality, quantity and consistency. This sets the results in context, so that decision-makers can reach a deeper understanding that is likely to be of use to them when planning and implementing effective programmes (Goldsmith et al 2007, Silverstein et al 2005). Synthesizing the variety of different forms of relevant evidence is seen as critical to supporting policy decisions and producing guidance for health systems (Langlois et al 2018).

As part of the revised remit, it was agreed that a wide range of information from a variety of HCP consultations and interventions in a variety of healthcare settings would be included. A search strategy was devised using medical subject headings (MeSH) terms, database specific subject headings, and free text keywords drawn from existing reviews and the authors' knowledge of the field. A list of synonyms for each of the identified keywords was created and a strategy developed and tested to search the MEDLINE and CINAHL databases. The search strategy was then approved by the funder and also used to search policy documents, guidelines and other grey literature. An additional grey literature search of government documents was also undertaken by the funder. The search applied the following limits:

- from Jan 2008 to Dec 2018 to reflect the 'work-focused healthcare' policy agenda timeline
- documents published in English language only

Articles were included if they identified any conversations about work between HCPs and patients, where conversations about work were not part of routine practice, or a clinical pathway. Articles were excluded if they reported conversations relating to cancer and work, where it was routine practice for the HCP to discuss work (i.e., occupational healthcare) and where the focus of the article was in the workplace. All retrieved titles were screened by one author (AE). A second author (SB) independently screened 20% of the retrieved titles for agreement. The abstracts were then screened by authors (AE, SB and KB) and any differences were resolved by majority vote. Using a data extraction table, AE, SB and KB extracted key features as they related to the research questions. A consensus on final inclusion/exclusion was then reached, and evidence tables were developed.

Qualitative data

The methodology and findings from the qualitative element of the commission are presented in full here for the first time. Aligning to the research questions as a-priori themes, an online survey and a telephone interview schedule were developed, informed by a Qualitative Description design (Kim et al 2017). This methodology is widely used in health care studies where the phenomena requires comprehensive description and the researcher is interested in answering questions about who is doing what, and where. It involves 'low-inference' interpretation, which makes it easier for researchers to reach consensus and more accurately present the data collected (Sandelowski 2000). This was agreed as the most appropriate approach in recognition of the flexibility and variability of HCPs conversations about work with their patients, and to provide contextually relevant evidence to support decision-making around the implementation of an intervention (Petticrew et al 2019) (Noyes et al 2019). This approach could also be informed and supported by the authors' professional practice knowledge (Parker et al 2015), further enabling the research to be conducted within the time limits.

The online surveys comprised a mixture of multi-choice questions and narrative responses, and the telephone interview schedules used open questioning. To ensure emerging ideas were explored within the time constraints of the project, an iterative approach was applied to the interview schedule (Busetto et al 2020). This technique is often used with time sensitive projects whereby data collected in one interview are used to inform a subsequent interview, and so on. Based on the authors' knowledge and contacts, respondents were recruited using a purposive sampling strategy via an electronic project brief. Using the authors' and funders' existing professional networks, and links from previous educational and research projects in this area, the project brief was disseminated by email and social media to

relevant professional bodies, networks, special interest groups, social media groups, working groups, private sector organisations, and individual professional contacts (as 'topic experts'). This pragmatic recruitment strategy was the most appropriate and efficient in attempting to gather rich descriptive data from as wide a range of HCPs (and their representatives) as possible, with the resource and time available (Etikan et al 2016). Respondents were offered a choice of completing the survey and/or being contacted for a telephone interview. Key topic experts were asked to take part in a telephone interview only, to allow a more in-depth exploration of the research objectives.

Data from both the surveys and interviews were analysed by one author (RM) using thematic analysis techniques (Braun and Clarke 2006) - a flexible approach that can be applied across a wide range of qualitative methodologies. The recommended 6-step approach was followed: (1) familiarisation (reading the qualitative comments in the questionnaires and interview transcripts multiple times); (2) coding (highlighting portions of the text in different colours where they reflected the research questions/a priori themes, and/or emerging ideas and labelling these); (3) generating themes (bringing coded material together into broader themes); (4) reviewing themes (comparing the themes with the original data); (5) defining and naming themes (refinement of the themes) and; (6) writing up (descriptive summaries of each theme, with supporting quotations). The coding was both deductive (in order to meet the research objectives) and inductive (to adhere to the principles of Qualitative Description) in ensuring data and emergent themes were not discounted. Coding was verified by a second author (CP) as a measure of trustworthiness.

Where survey and interview responses align, illustrating coherence on a specific theme, anonymous sample quotes are presented and attributed to 'participants' collectively. The interviewees, as topic experts, often provided more detailed and/or nuanced responses. To highlight this, anonymised quotes are presented and assigned a 'topic expert' number - their voice is representative of the views of several topic experts or it provides a unique perspective within the identified theme (Lingard 2019).

FINDINGS

Literature review

The search of peer-reviewed and grey literature sources yielded 79 articles and documents that were deemed eligible for inclusion. The peer-reviewed articles originated in various countries including the UK, France, Netherlands, Scandinavia, Israel, Canada, Australia, and New Zealand, but extracted findings were transferable to the UK based on the authors' expert contextual knowledge of the field. Most of the grey literature originated in the UK, providing information that was

directly contextually relevant. Peer-reviewed studies used a range of quantitative and qualitative methods (e.g. randomised controlled trials (RCT), surveys, cross sectional studies, prospective cohort studies, interviews and evaluations). Other (non-primary) peer-reviewed studies variously used narrative and systematic review methods and meta syntheses. Grey literature comprised discussion pieces, guidelines, book chapters, policy documents, evaluations, and electronic documents.

The BES revealed there was no research or evaluation aimed at establishing the outcome or efficacy of any particular components, content, or strategies for work conversations in healthcare, nor how these may be measured. This meant it was not possible to grade the quality of the evidence as is usual practice in a BES. However, the literature did provide important information about why this policy agenda had stalled. Therefore, rather than simply responding to the specified research questions with very little meaningful data, a revised rationale for the overarching narrative of the published report was discussed and agreed with the funders. Findings for the report were produced to highlight the obstacles to policy progress outlined in the literature.

The qualitative data were particularly pertinent sources of additional information in this respect. Therefore, they were synthesised with the findings of the literature review using the data extraction table applied to the selected literature (to align with the specified research questions). This enabled the authors to supplement the limited literature with further narrative detail in order to answer the research questions more meaningfully and articulate policy recommendations.

Qualitative data

Seventy online surveys were returned, and of those, 59 were fully completed and included in the final analysis. Within the timeframe available, sixteen telephone interviews were conducted. The data reflected the interactions of a wide range of HCPs for a variety of health conditions across primary and secondary care, as well as private and non-clinical settings.

The survey respondents represented a range of healthcare professions. Whilst the majority were physiotherapists (n=22), there were also nurses (n=15), occupational therapists (n=5), medics in general practice (n=6) and others (n=11). Occupational health was the most commonly identified area of practice/specialism (n=11), followed by musculoskeletal (n=9), general practice (n=7) and mental health (n=4). The majority of respondents were based in primary care/community practice, but other settings were identified, including secondary care/hospital, private practice, and education. Six respondents had non-clinical roles (research, education or management).

The interviewees were experts in health and work; half had strategic, commissioning or management responsibilities in clinical or rehabilitation companies (the National Health Service (NHS), or in a local government organisation). The majority of these 'topic experts' had occupational health/medicine backgrounds, and had more than one role working across two or more settings (primary care, private practice, academia and local government). The health professions of physiotherapy, occupational therapy, doctors in general practice and psychiatry were also represented. Several respondents had a role in promoting/championing health and work, or in work-focused health professional organisations.

Obstacles to policy progress

As a first step, Figure 1 was produced to provide a contextual basis for decision-makers, and offer a backdrop on which to pin the findings and policy recommendations. It was beyond the remit of the study to evaluate the policy initiatives outlined in Figure 1, but in essence, the available data show that robust implementation of these initiatives had been limited, and that HCP awareness, engagement, and adoption remained low. It was important to highlight this to the funders in the first instance, because it helped set the narrative for the report, with our findings revealing the consequences of this lack of implementation – limited empirical data with slow policy progress.

The presentation of findings in the published report was constrained by the requirement to align to the commissioned research questions. Free from those constraints here, findings have been presented to more accurately reflect the salient issues revealed, a more nuanced understanding of which came from the qualitative data. The use of more accurate headings here allows for a fuller explanation and discussion of the report findings and policy recommendations.

What is a work conversation in healthcare?

A consistent, agreed description of what work conversations in healthcare should comprise was not found in the literature. Instead, the literature revealed that although most HCPs agree that work is an important health outcome, most do not have conversations about work with their patients. Nevertheless, the study participants were able to provide some important insights into what a 'good-quality' conversation should comprise. The topic experts explicitly suggested empathy was key, as part of an informal and gentle approach. All participants indicated that the conversation should involve simple, open-ended questioning, adjusted to match the person's work status/health condition, seeking to establish patients' thoughts/feelings/experiences about work, such as:

'How's work going?'
'What does your job entail?'

'What have you enjoyed doing/disliked?'
'How are you coping with work at the moment?'
'What is it about the job that is making it difficult to go back at the moment?'

One topic expert suggested this should also be supported by the provision of evidence-informed information about work and health, conducted in a way that fits with usual clinical practice, i.e. 'prescribing', but prescribing something other than time off work:

'Does the person need signposting to a career change?' (Topic Expert 15)

It was also stated that this gentle unpicking of patients' uncertainties about work should involve 'myth busting', including challenging the view that a person needs to be fully fit to continue working or return to work – this aligns with the evidence base which suggests that work can be health-supportive and part of recovery:

'...reframe the perception along the lines that it wasn't work that made you ill, ... a gentle reintroduction to activities is a much better way of getting there.'
(Topic Expert 5)

Perhaps reflecting a more nuanced understanding of the evidence base, this latter point was particularly emphasised by six of the topic experts. They highlighted that a conversation needed to bring together all relevant HCPs involved with a patient (and their employer if applicable):

'...doing a clear and detailed return-to-work plan and encouraging them to share it with other HCPs' (Topic Expert 1)

The approaches most commonly suggested that may facilitate work conversations included focusing on ability rather than disability, supporting problem solving, establishing a relationship/rapport with patients, and helping the patient to accept the things they cannot change about their job. Several participants thought MECC could be a way of helping them to embed conversations in routine practice:

'Why not? HCPs used to be scared about smoking & alcohol.'

'We just need to be not afraid to have the discussions. MECC is all about raising that conversation about health and wellbeing – you may be the first person to have that discussion and may be the instigator of support and improving well-being.'

Guideline recommendations conflict with professional judgement

To date, 'work-focused healthcare' policy has largely been translated into simplistic guideline recommendations that all healthcare professionals ask their patients about

work during routine clinical encounters. However, the literature clearly demonstrated that these simplistic recommendations are not sufficient; rather it is *what* HCPs say during such conversations, and not simply raising or initiating the conversation, that likely has an important influence on patients' work outcomes. Relevant policy and guidance also suggests that HCPs should advise patients to remain in work, or return to work as soon as possible, perhaps with temporary job modifications. However, there was substantial evidence in the literature showing that HCPs largely view recommendations to discuss work as conflicting with their own clinical judgement. Thus, it cannot be assumed that work conversations will take place as recommended.

Aligning with the literature, scepticism about simplistic recommendations was also voiced by study participants. The majority agreed the issue of work should be raised early, but reported that sometimes the nature of the patient's condition led to the conversation being held at a later stage. Whilst professional judgement was considered to be important, several of the topic experts placed greater emphasis on talking about work to all patients, regardless of their employment status or health problem:

'... every conversation should include something about work' (Topic Expert 4)

'...acquired or massive brain injury. Still might have the conversation but later in recovery...' (Topic Expert 10)

It was suggested that a stepped approach was needed, allowing conversations to be adapted to patient circumstances. One topic expert said that this was because a stricter, set approach can lead to certain patients being excluded from these conversations:

'Mandation is generally a bad way of doing things for individuals - telling them what they have to do often makes them more creative in ways in which they can avoid doing it' (Topic Expert 5)

'Working/not working' is an inhibiting outcome

'Work-focused healthcare' policy articulates a successful outcome as helping people to remain in, or return to, work. However, as demonstrated by the findings above, the policy does not define the mechanisms between work conversations and work outcomes. Thus, there was no evidence demonstrating the efficacy of work conversations in respect to any work outcome in the literature. In line with these findings, all study participants highlighted the difficulties in measuring a successful outcome in relation to conversations about work and work-related interventions.

One key query highlighted by 4 topic experts was whether the HCP role is to get people back into paid work, or in supporting engagement in occupation in a more holistic sense as an aid to recovery. Two topic experts strongly advocated that the role of the HCP was not to facilitate economic activity or to get patients off benefits. It was also recognised that re-engagement in employment can take time, particularly if the person has been out of work with health issues for a long time. There was a real concern that HCPs would be set up to fail if the metric was 'working/not working', and several respondents were concerned that relevant commissioning needed to be thought through very carefully to be meaningful:

'We're in nudge territory – don't think we will have a single metric ... we will nudge the population towards the labour market more than they are now' (Topic Expert 5)

It was also recognised that there are many variables that affect whether a patient returns to, or stays in, work. Therefore, it is difficult to demonstrate that the conversation or associated interventions, such as referral to a work-related service, have an impact. The majority of participants recommended measurement of the process rather than definitive working/not working outcomes, identifying three aspects: 1) HCPs taking up training; 2) HCPs having the conversation; and 3) HCPs providing work-related support. However, one topic expert felt that these could only be measured if included in routine documentation and audited:

'Yeah, 'if it's not documented, it didn't happen' approach: we audit [a sample] of notes per annum, we look at the conversations about work' (Topic Expert 10)

As a result, there were suggestions for capturing interim, patient-focused outcomes, including whether the person has made a plan for return to work, made a self-referral to a service that encourages social integration, or is volunteering. Whether the patient feels confident about returning to work and whether they felt the conversation was helpful in this respect were also said to be important outcome measures.

Systemic obstacles to work conversations in healthcare

Many wider, systemic factors were implicated as major hindrances to work conversations (and work participation outcomes) in the literature. The most commonly reported barriers in the literature were HCPs believing the health-work agenda was not within their professional remit, which was related to: lack of training, financial incentives, time, role clarity, and local services; increasing job demands; unrealistic patient expectations; role conflict (treatment vs work); believing a strong patient influence on decision making was necessary to preserve doctor-patient relationship; a perceived lack of patient motivation; lack of communication/loss of contact; lack of confidence; poor communication, poor coordination, and difficult cooperation between stakeholders involving complex and challenging discussions.

Aligning with the literature, a broad range of healthcare system barriers were commented upon by all participants, including resource and time limitations, a lack of buy-in from their own line managers, and the problems of integrating work into healthcare practice when it is not a commissioned part of the service. Some of the survey respondents referred to practical issues, such as healthcare settings being unsuitable environments for work conversations, lacking privacy for confidentiality. One key factor reflected by all participants was the tension between the patient advocate versus the welfare gatekeeper role. It was felt this resulted in HCPs waiting for patients to lead the conversation, and patients distrusting the motives of HCPs raising the work question. Patient concerns about with whom the HCP will share information were reported, along with HCP fears that the advice they give may result in the patient having financial difficulties/benefit issues:

'The benefits system is a real barrier to support people into meaningful work'

In relation to this issue, there were concerns expressed by the topic experts about patients not expecting HCPs to discuss work, in some cases referring to patient hostility/risk of violence and defensiveness. As such, they expressed a need for patient education in addition to staff training to address these risks, suggesting it should:

'...cover both confidence and competence – neither enough on their own.'
(Topic Expert 5)

All participants were in agreement that HCPs generally lack suitable knowledge and skills to have the conversation, and that the resulting discussion will tend to be superficial in nature, and any information gleaned will not be acted on. However, in contrast to the survey respondents, all the topic experts offered more self-critical reflections rather than just focusing on system barriers. They suggested that HCPs tend to be over-protective and make assumptions about capability and/or patient's own beliefs and motivation, which then obstructs the conversation. It was also suggested HCPs are reluctant to have the conversation if they feel they cannot change the situation for a range of reasons, such as high unemployment in the area. However, some felt this reluctance was reinforcing the message that work was detrimental:

'Need to stop saying work is bad for you or colluding with the sentiment'
(Topic Expert 12)

It was suggested there are a wide range of services to which HCPs can signpost or refer patients. Yet it was acknowledged that because of this variety, it was very difficult to judge whether they are helpful or even to know many exist:

'It's like the Wild West out there in terms of employment programmes. Some are virtually in competition with each other and won't share good practice'

(Topic Expert 8)

'We do have [various services including] patient advisory services. Various third sector organisations [but] ... how do GPs know about it?' (Topic Expert 14)

A further reflection was HCP's use of a medical model or a condition management approach, thus hampering a more holistic exploration/view of work being an integral part of recovery and participation:

'The NHS has become increasingly clinical and scientific ... that meant they very rarely looked at the wider social determinants' (Topic Expert 8)

DISCUSSION

Since Dame Carol Black published her 2008 report *Working for a Healthier Tomorrow* (Black 2008), the potential for healthcare to reduce sickness absence and work disability has been reflected in numerous policy initiatives and clinical guidance, right up to the present day. As a result, there was an assumption by policymakers that current healthcare is 'work-focused'. The findings from this commission showed this is not the case. A lack of robust implementation of the policy means that HCPs are faced with a plethora of obstacles and uncertainty, and as such, most do not engage their patients in conversations about work. Therefore, the overarching focus of the commission in attempting to identify which interactions, with whom, where, and when were most effective in initiating 'supportive' work conversations was misguided. It was based on incorrect assumptions that work conversations in healthcare were routine practice, that HCPs had the knowledge and skills to initiate such conversations, and that the evidence base would reflect this practice and allow a detailed appraisal of interactions. There is an overwhelming lack of empirical evidence to support this policy agenda.

However, the research did provide clear indications about what was needed to implement this policy. Therefore, some clear, short- and long-term policy solutions were articulated. These were succinct reflections of the key findings, based on the authors' knowledge of the policy agenda, their professional understanding of healthcare practice, and the format required for decision-making:

- ***Cultural awareness***

A high impact solution, which would overcome many of the reported barriers to work conversations in healthcare, is to promote a wider understanding of the positive link between work and health at a societal level, delivered in a public health campaign. There is good evidence to support this approach, showing effectiveness and cost-effectiveness (Buchbinder et al 2001). The findings indicate that simple, myth-busting messages are likely to be effective: e.g. work is important for health and wellbeing, working can mean faster recovery, and it is 'good to talk about work'.

- ***Conversation starters***

The findings indicate that simple, inexpensive approaches, comprising a few questions about the patient's work can be helpful, if supported with patient-facing educational material and/or shared-decision making tools. It is generally recommended in the literature that if HCPs are to address work issues, they need to have sufficient knowledge, along with tools, guidance, and checklists, to respond to questions and initiate actions (Tran 2018). Moreover, the use of conversation starters aligns readily to usual clinical practice: the provision of advice and/or patient education material as part of treatment or recovery.

- ***Integrated practice***

The importance of training was also acknowledged, suggesting work conversations must form part of generic competencies in the undergraduate curriculum, and should be managed by local champions to help take learning into everyday practice. A key aspect of training should focus on addressing HCPs beliefs and attitudes about the importance of work-health conversations, and their confidence in managing them, including signposting to relevant evidence-informed material (Cohen et al 2010) (Parker et al 2015). It is important for HCPs to develop their skills experientially, and for those newly acquired skills to be measured objectively (Morgan and Cleave-Hogg 2002) (Mullan and Kothe 2010).

Therefore, widening the successful Health and Work Champions model has merit: initial evaluations indicate this can be scaled up (Martin et al 2018) (Public Health England 2020). This is particularly relevant because it has been shown to improve HCPs confidence to raise questions about work in routine practice. Many clinical teams will benefit by having access to a Champion for assistance with more challenging/complex work conversations, with identifying and signposting high quality occupational health services, and with involving employers. Champions could also help facilitate routine clinical audits and process measurements to evaluate HCPs engagement in work conversations and the outcomes.

The original commission for the research described in this paper reflected a lack of understanding of these implementation issues. Such knowledge gaps raise a wider concern about how scientific evidence is understood and used by decision-makers.

There is a common misperception that policymaking should be informed by the same kind of research used to inform clinical guidelines (Oliver and Dickson 2016) (Kneale et al 2019). But this approach requires the evidence base to be comprised largely of clinical research, whereas 'work-focused healthcare' is actually a more complex biopsychosocial intervention – an understanding of the relevant evidence-base was not apparent with the proposed policy development.

The 'top down', didactic approach of guidelines is perhaps appealing to policymakers - the advantages being the potential of a relatively rapid up-take of evidence across a whole sector (Martin and Williams 2019). However, there is significant evidence reporting the limited use and efficacy of clinical guidelines as a way to implement work-focused healthcare (Baker 2017) (Bartys & Stockkendahl 2018) (Croft et al 2020). Indeed, scepticism about simplistic guidelines was voiced by participants in the commissioned research, in that they leave no space for adjustment of the evidence to professional practice. This gives rise to implementing a set of treatment principles rather than building up an evidence-base which can accurately inform decision-making (Nutley and Davis 2000).

Rather, this commission has shown that HCPs have an important (but largely unsupported) role in mobilising the relevant evidence and advancing this policy agenda. The qualitative data collected from HCP participants were particularly illuminating and significantly augmented the limited empirical data. By drawing heavily on these data in the articulation of findings and policy recommendations, the authors were able to put forward practical solutions incorporating both policymaker and HCP requirements. The aim of this was to facilitate more of a 'bottom-up', co-design approach to implementing the policy which is called for in the public sector (Donetto et al 2015). Using the best available evidence, along with practical expertise may result in more effective translation of 'work focused healthcare' policy into practice.

This commission also demonstrated there may be further opportunities for academics to build alliances with decision-makers who are concerned with the research topic, enabling the exchange and collaborative production of knowledge. This has been shown to be integral to evidence-based policy change by facilitating a 'what works' perspective (Oliver and Faul 2018) (Aiello et al 2020) (Nichols et al 2020). This shared understanding of professional boundaries has been reported to motivate engagement between decision-makers and academics because it allows more open-ended opportunities for critical discussion and reflection (Wilkinson et al 2012). These factors are reported to foster and facilitate relationships that are founded upon trust - a critical precondition underpinning evidence-informed decision-making processes (Cvitanovic et al 2021). This kind of collaboration is currently believed to be one of the best ways to support the rapid application of

research which has greater impact on health systems and societal outcomes (Gagliardi et al 2015) (Jull et al 2017).

However, such activity is time-consuming, rarely funded, and often compounded by government workforce models (particularly those in the UK) which encourage regular movement across a wide range of roles in several different departments. This process makes it difficult to retain and build a legacy of knowledge, whereby the necessary nuance of a particular field and its evidence base (including its gaps) is understood, giving a better chance for policymakers to ask the right questions of it. It has recently been argued that a system is required which also values specialists, rewarding those who stay in post in order to advance evidence-informed policy agendas (Sasse and Norris 2019). More specifically, this has been called for as a means to facilitate the effective transfer of knowledge needed to reduce work loss due to ill-health (Van Eerd et al 2017). This study provides some valuable new insights in this respect, with implications for evidence-based policymaking more broadly.

Limitations

It was not feasible to formally study the researcher-policy engagement process outlined in this paper because it was not anticipated. This presents a limitation in terms of advancing theoretical knowledge in those fields aimed at maintaining the usefulness of academia in solving real-world problems (Moser & Fazey 2021). However, the paper does provide novel insights into the oft-hidden, tacit relational elements that are effective at influencing decision-making. Time and resource constraints meant that pragmatic methodological approaches were necessary. However, the relevant systematic processes for collecting and reporting data were adhered to and are explicitly detailed as far as possible. Despite wide dissemination of the study invitation, the majority of participants had an interest and/or expertise in the study topic area, leading to the possibility of response bias. A more targeted recruitment of participants who did not have this knowledge may have provided a more accurate reflection of how this policy agenda has been interpreted more widely. However, the relevant expertise of participants resulted in novel insights which provided a fuller and more nuanced understanding of the study objectives. The benefits of including these data in terms of helpfully informing policy were deemed to outweigh any potential bias.

CONCLUSION

At the time of writing, work restrictions due to the COVID-19 pandemic are steadily being lifted. Many workers will have existing health problems, some will have post-COVID-19 symptoms, and most will have concerns about their work situation. With a gradual opening up of workplaces, clear and consistent advice from HCPs across many settings will continue to be expected. However, it will not be possible to provide occupational health services to all. 'Work-focused healthcare' is now even

more of a priority, but accepting that does not diminish the challenge it presents; after more than a decade, it remains an evidence-informed policy aspiration rather than an evidence-based practice. Our recommendations can usefully support the coordinated action needed to advance this policy and ameliorate even greater societal impacts resulting from work loss due to ill-health.

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