Public Health England

Protecting and improving the nation's health

Work conversations in healthcare:

How, where, when and by whom?

A review to understand conversations about work in healthcare and identify opportunities to make work conversations a part of everyday health interactions

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, research, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

Public Health England
Wellington House
133-155 Waterloo Road
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

Prepared by: Dr Serena Bartys, Dr Amanda Edmondson, Professor Kim Burton (University of Huddersfield), Christine Parker and Rachel Martin (University of Salford)
For queries relating to this document, please contact: s.bartys@hud.ac.uk

Published August 2019
PHE publications
gateway number: GW-648

PHE supports the UN
Sustainable Development Goals

Contents

Glossary of terms

DH: Department of Health

DHSC: Department for Health and Social Care

DWP: Department for Work and Pensions

GMCA: Greater Manchester Combined Authority

GMPHN: Greater Manchester Public Health Network

GP: General Practitioner

HCP: Health Care Professional

HSE: Health Services Executive

IT: Information Technology

MECC: Making Every Contact Count

NICE: National Institute of Clinical Care and Excellence

OT: Occupational Therapist

PHE: Public Health England

RCGP: Royal College of General Practitioners

RCOT: Royal College of Occupational Therapists

SDM: Shared Decision Making

WHU: Work and Health Unit - Joint Department for Work and Pensions and Department for Health and Social Care

Executive summary

As part of a 10-year strategy to improve employment outcomes for working-age people with health conditions and/or disabilities, the Joint Work and Health Unit (WHU) has funded Public Health England (PHE) to implement a ‘work as a health outcome’ programme. The programme seeks primarily to promote healthcare professionals’ (HCPs) understanding of the health benefits of good work and encourage HCPs to have supportive conversations about work and health. The programme has been informed by the evidence base for Making Every Contact Count (MECC) (1). To further understand whether and/or to what extent the MECC framework is transferable to this context, a comprehensive literature review with stakeholder engagement was conducted.

Following a search of peer-reviewed and grey literature sources, 79 articles and documents were included in a realist best evidence synthesis. In addition, 59 online stakeholder surveys were completed, and 16 telephone interviews were conducted. Data were synthesised and presented as key findings, aligned to specified research questions. An in-depth examination of interactions with a wide range of HCPs for a variety of health conditions was produced, providing a more detailed understanding of conversations about work in healthcare: how, when, where and by whom.

Despite the launch of numerous, potentially relevant initiatives over the last decade, few have been directed specifically at stimulating conversations about work during routine clinical encounters. Promotion and implementation of these initiatives has been limited and, as a result, healthcare awareness, engagement, and adoption has remained low. The evidence reveals many barriers.

Most of these barriers are underpinned by the lack of a consistent, agreed description or measure of ‘supportive’ conversations, and because the purpose of such conversations has not been clearly articulated or formally embedded within clinical practice. There was no evidence from research or evaluation to establish the outcome or efficacy of any particular components, content, or strategies of conversations about work in healthcare, nor how these may be measured. It was found that most HCPs accept that work is generally good for health and wellbeing, but these fundamental limitations mean that most do not engage their patients in conversations about work.

However, there are reasons for optimism: the evidence points to some short- and long-term policy solutions that will better equip HCPs to have supportive conversations about work, and to further advance the ‘work as a health outcome’ agenda within routine healthcare. These are conceptualised as ‘cultural awareness’, ‘conversation starters’ and ‘practice integration’.

Background

“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” (2).

As part of a 10-year strategy to improve employment outcomes for working-age people with health conditions and/or disabilities, The joint Work and Health Unit (WHU) has funded Public Health England (PHE) to implement its ‘work as a health outcome’ programme. The programme seeks primarily to promote healthcare professionals’ (HCPs) understanding of the health benefits of good work, and encourage them to have appropriate, supportive conversations about work and health with their patients during routine clinical encounters.

That programme has been informed by the evidence base for Making Every Contact Count (MECC) (1). 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 NICE guidelines and evidence for the recommendations on health behaviour change (PH49) that underpin the MECC approach relate specifically to established behavioural risks (diet, weight, alcohol, exercise, smoking, wellbeing and mental health) (3). It is uncertain how these findings – which ultimately aim to change health behaviours – may be suitable for encouraging HCPs to initiate health and work conversations.

It has been reported that HCPs have reservations about the acceptability of discussing work issues when they are not part of the patient’s agenda. Similar barriers are known to exist amongst HCPs implementing MECC. It is also acknowledged that work conversations may not always be appropriate at every healthcare interaction and are likely to be counterproductive if they are not evidence-informed and consistent.

It is unclear whether or to what extent, the MECC framework is transferable to this context, or whether a different approach is better suited. Therefore, what is required is a more detailed understanding of conversations about work in healthcare: the how, when, where and by whom.

Method

A literature review and stakeholder engagement activities were conducted to gather data, which were synthesised to answer the following primary research questions.

1. What are the current national, or widely implemented local interventions (including policies, programmes and services) that encourage conversations about work in a health setting?
2. When, where and between whom are supportive (evidence-informed) conversations about work and health already taking place?
3. 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?
4. What is the most desirable outcome from a supportive conversation about work and health and how can this be measured?
5. What are the most promising opportunities for supportive conversations about work and health?

Literature review

Based on our expert understanding of the literature in this field, a realist best evidence synthesis was conducted. This method uses 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 − it 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 (4-6). This methodology has been successfully applied in our previous reviews which currently underpin government policy in work and health (7-9). It is acknowledged that this method involves a degree of subjective judgement, particularly as many studies are included due to relevance (because of the disparate nature of the evidence in this field), as well as those measuring causal relationships and/or efficacy. Therefore, the potential for bias is accepted. In order to minimise the risk of bias, the researchers adhered to processes similarly applied in a systematic review and detailed their processes as explicitly as possible in the Appendices.

The literature search used medical subject headings (MeSH) terms, database-specific subject headings, and free text keywords drawn from existing reviews and our knowledge of the field. A list of synonyms for each of the identified keywords was

created and a strategy developed and tested, and this was used to search the MEDLINE and CINAHL databases (see Appendix 1a).

Policy documents, guidelines and other grey literature from PHE and other related sources (such as DWP, WHU, NICE, DHSC, HSE, professional groups etc.) were sought through the internet, professional contacts, and personal databases. A grey literature search was also undertaken by Public Health England (see Appendix 1b). This approach was augmented through a stakeholder engagement (including the research team's expert contacts) for unpublished material/grey literature. Reference lists and forward citations of included articles were also searched: additional studies that become available during the project were included if they added substantially to the evidence-base. The search applied the limits:

- from January 2008 to December 2018 to reflect contemporary data and current policy
- documents published in the English language only

The titles of all retrieved articles were screened by one reviewer against the agreed criteria (from research questions/definitions), and a second reviewer independently screened 20% of the retrieved titles to check for agreement. The abstracts of the selected titles were then screened by 3 reviewers to decide whether to obtain the full document – any differences were resolved by majority vote. The full document selection was divided among the 3 reviewers, who each extracted relevant data into evidence tables, and final inclusion/exclusion decisions were made following a discussion amongst all 3 reviewers. Final evidence tables were developed which held key information from included articles and documents (see Appendix 2).

Stakeholder engagement

Documentary evidence was expanded through a stakeholder engagement activity, to fill gaps in the evidence and directly reflect the views of a wide range of HCPs. The activity comprised 2 parts: an online questionnaire-based survey, followed by individual interviews with HCPs and topic experts. These were informed by a qualitative description design in recognition of the flexibility and variability of methods likely to be used by HCPs in their conversations about work (10). Ethical approval for the stakeholder engagement was obtained from the University of Salford (HSR1819-062).

A project brief was developed and published on the website Good Work, Good Health: working knowledge in work and health (https://www.goodworkgoodhealth.com/), which provided background to the project and information to enable an informed decision about taking part. To seek respondents, the link to the project brief was disseminated via relevant professional bodies, networks; special interest groups; social media groups, working groups, private sector organisations, and individual professional contacts. This

approach aimed to gather data from as wide a range of HCPs (and their representatives) as possible. We acknowledge that those who ‘opt in’ are more likely to already have an interest and/or expertise in work and health, but this pragmatic recruitment strategy was the most appropriate and efficient with the resource and time available.

In an iterative approach, interviewee responses were used to inform subsequent interview schedules, a particularly useful method for time-sensitive projects (11). Notes were taken during the interviews and data were analysed from both the surveys and interviews using thematic analysis techniques (12) – based on a-priori themes (aligned to the research questions) – and checked by 2 members of the research team.

Findings from the literature review were integrated with data from the stakeholder engagement to provide narrative detail on the complexities of the topic – the how, where, when, and by whom. This also answers wider questions of interest, resulting in the articulation of evidence-informed recommendations for policy and practice.

Results

Literature characteristics

The search of peer-reviewed and grey literature sources yielded 79 articles and documents that were deemed eligible for inclusion (see Appendix 3). 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 researchers' expert contextual knowledge of the field. More contextually relevant information was provided in the grey literature, most of which originated in the UK.

Peer-reviewed studies used a range of quantitative and qualitative methods (such as 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.

Stakeholder characteristics

Out of 70 survey responses received, 59 were fully completed and therefore deemed eligible for inclusion in the final analysis. Sixteen telephone interviews were conducted with those stakeholders who indicated this preference in their response to the project brief (see below) within the timeframe available.

The stakeholder engagement data allowed an examination of interactions with a wide range of HCPs (as defined in the agreed inclusion criteria – See Appendix 1a) for a variety of health conditions. These included GPs, practice nurses, physiotherapists, occupational therapists, chiropractors, exercise therapists, physicians, rheumatologists, oncologists, social workers, mental health professionals (nurses, counsellors), orthopaedic surgeons, vocational rehabilitation staff, case managers, return to work coordinators and medical students. The evidence was available across primary and secondary care, as well as private and non-clinical settings. Full details of stakeholder characteristics can be found in Appendix 4.

Key findings

By way of order and convenience, key findings are initially presented as they align to the specified research questions above and linked to the supporting references.

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

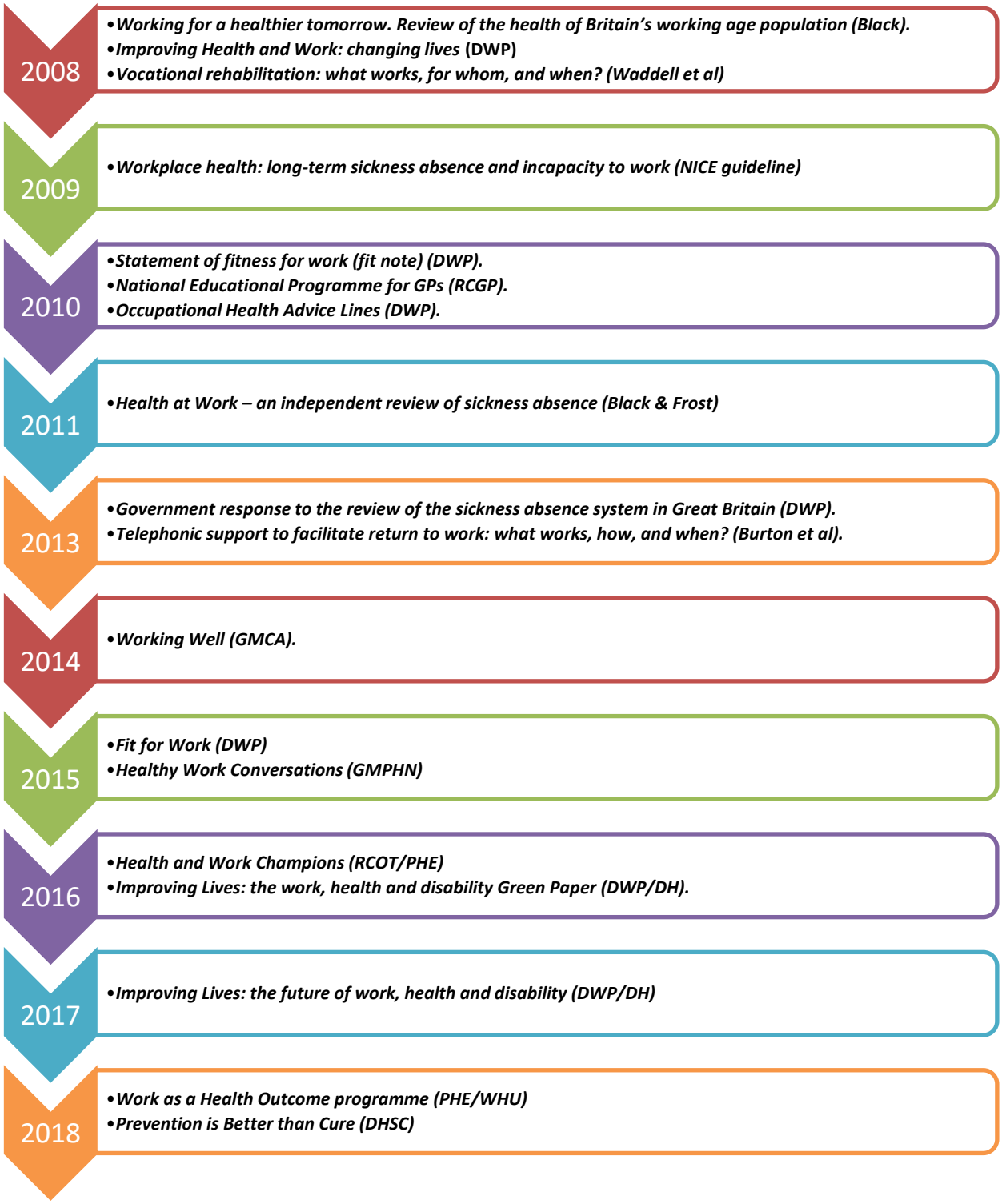

Figure 1: Timeline of relevant initiatives (2008 to 2018)

Figure 1 above documents relevant events, publications, and initiatives launched within the timeframe of our search limits (2008 to 2018). While this timeline deliberately goes

beyond the current picture, it is offered to demonstrate previous attempts at embedding the work-health relationship within healthcare as a means of stimulating a cultural shift.

It is beyond the remit of this study to evaluate these initiatives as a whole, but some relevant narrative evaluation is given where it exists (see Appendix 5). While the nature and scope varied, they shared a common theme of linking the potential benefit of work to health (as distinct from seeing work as necessarily a risk to health).

Figure 1, then, offers a contextual basis for the findings of this study. It demonstrates that numerous potentially relevant events and initiatives have been launched at various times, both at national and local level. However, they were not specifically coordinated, relatively few are ongoing, and fewer still have been directed specifically at stimulating conversations about work during routine clinical encounters. In essence, the available evaluation data show that widespread promotion of these initiatives has been limited, and that healthcare awareness, engagement, and adoption/implementation has remained limited (see Appendix 5). Further information as to why this has been the case is revealed in answering the remaining research questions.

When, where and between whom are supportive (evidence-informed) conversations about work and health already taking place?

A consistent, agreed description of ‘supportive’ in terms of work conversations in routine healthcare settings has not been established. The most well-developed evidence base in this respect comes from the oncology literature. While there are some general principles that are transferable (such as adopting a positive approach), there are qualitative differences relating to the non-routine aspect of oncology consultations that mean many of the findings seem not applicable to the present topic.

Where the wider evidence does exist, it has been proposed that ‘good-quality’ conversations are ‘work-focused’: defined as the inclusion of work as one of the goals of treatment – this variously can involve posing simple questions about the job, identifying psychosocial obstacles to work participation, talking to the patient and the employer about job accommodations, and agreeing a date for returning to work (9, 13). In a narrative review, it was proposed that promotion of the core self-management skills of problem-solving, decision making, resource utilisation, developing a cooperative partnership between clinician and patient, and making an action plan with active follow-up are also necessary components (14).

A focus group study with GPs identified ‘a give-and-take’ stepwise process of alliance-building and mutual understanding, then actively focusing on early return to work, involving other stakeholders/HCPs as necessary (15). An observational study of work disability assessment training reported that communicative competencies were narrowed down to empathy and the clarity of the information provided (16). An editorial

affirmed that communication styles and language are important, and that common HCP terminology (jargon) can have negative connotations for patients. It concluded that the health-work conversation needs to be conducted in a careful, positive, empathetic manner to avoid lowering self-efficacy and positively influence outcomes (17).

A recent qualitative study found that physiotherapists used a structured approach (proforma/protocol-driven), which enabled them to routinely ask patients about their job and work difficulties, while GPs rarely used such structured measures and were less likely to enquire about patients' work situation unless it was raised (18).

An international discussion piece has recommended several communication strategies for evaluating and addressing occupational factors within a physiotherapist role, including:

- primary recommendations include administration of self-report questionnaires to assess a patient's perspective of physical job demands
- patient-centred interviewing to highlight individual return to-work concerns
- early discussions with patients about possible job modifications
- incorporation of patients' workplace concerns in progress reports and summaries (19)

It has been highlighted that just raising or initiating the discussion about work in the clinical encounter is not sufficient – rather it is what HCPs say during such conversations that has an important influence on patients' work outcomes (20).

The stakeholder views were aligned with the literature, demonstrating how conversations might be initiated and providing insight into their perceptions of what a supportive conversation involves (see Appendix 6 for abridged data example). Empathy was said to be key, as part of an informal and gentle approach: the conversation should involve open-ended questioning, adjusted to match the person's work status/health condition, supported by the provision of evidence-informed information about work and health, and how good work fits with treatment. Also, the gentle unpicking of patients' uncertainties about work should involve myth busting, including challenging the view that a person needs to be fully fit to work or return to work – this aligns with the notion that work can be therapeutic and part of the recovery process (21).

Some respondents suggested the conversation should seek to establish patients' thoughts /feelings/experiences about work, and advised that questions should be simple, 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?

It was also said that clinical judgement determines when to have the conversation: 'the majority of respondents felt work should be raised early in the treatment process, but sometimes the nature of the patient's condition led to the conversation being held at a later stage in recovery'. It was suggested that a stepped approach was needed, because this allows conversations to be adapted to patient circumstances. Some respondents said that a stricter, set approach can lead to certain patients being excluded from these conversations.

Beyond making initial enquiries about work, some of the interviewees confirmed that they were comfortable progressing to further analysis of what makes work difficult, offering work modification suggestions, and providing signposting. Limited data was provided on referral to other services, although it was suggested HCPs need knowledge of what is available and have confidence in those services. One suggestion was made that patients could be responsible for producing and updating a record of their employment status to take to GP appointments. It was also suggested that HCPs should be communicating with the employer/manager and encouraging the dialogue between the employer and employee:

> "Empowering [patients] to discuss and negotiate with their employer, perhaps through use of the AHP Fitness for Work advisory report for example."

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?

Both individual and system barriers to the delivery of conversations about work in healthcare were widely reported factors in the literature. In the main, they emerged from studies attempting to implement work interventions, rather than from studies setting out to explore barriers and facilitators directly.

Although the majority of HCPs believed that work was generally beneficial to health, contextual and system factors were implicated as major hindrances to work conversations and work participation outcomes. The most commonly reported barriers were HCPs believing the health-work agenda was not within their professional remit, this being related to:

- lack of training
- lack of financial incentives
- lack of time
- lack of role clarity
- lack of 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
- difficult cooperation between stakeholders involving complex and challenging discussions (22-33)

These findings have been echoed and expanded on in several evaluation studies of relevant national and local initiatives (see Appendix 5).

A UK qualitative study conducted before the fit note was routinely implemented found that many GPs perceived their role was limited to providing support and management only for health-related issues (34). There was a perceived risk of physical assault in addressing these issues with some patients, reflecting the tension between the patient advocate versus the welfare gatekeeper role highlighted in the literature. This issue was articulated in the stakeholder engagement as patients distrusting the motives of HCPs raising the work question. A range of examples of this were provided, including patient concerns about who the HCP will share information with, and 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 undertaking meaningful work.”

This same study reported that HCPs felt strongly that discussing return to work once a patient was on long-term benefits should happen within the welfare system. Almost a decade later, another UK study found that some GPs deliberately did not initiate work discussions to avoid raising patient expectations for a fit note, with some preferring to avoid the issue altogether. GPs did not feel they were adequately informed to offer extensive occupational advice to patients, and that that is why they often did not initiate such discussions (18).

Most GPs accept they have a proactive role to play in helping patients return to work, and that the fit note had had a positive impact on the quality of their consultations and outcomes for patients. Even so, positive perceptions of the topic are most likely among GPs and other HCPs, with higher levels of confidence in dealing with work issues, and this confidence was strongly linked with prior training and education (23, 25, 35-37). Unfortunately, the provision of training has been found to be limited, with an assumption that only HCPs whose role directly involves occupational health would get any training in clinical conversations on health and work (32).

In recent research commissioned by PHE (38) HCPs reportedly saw themselves largely as facilitators, focusing on support, opening conversations, and signposting rather than giving practical advice about work. HCPs identified a wide range of potential solutions and wider strategies that they believed could help to support better conversations and outcomes around work and health. These are clustered into 3 broad categories, summarised below.

1. Cultural awareness. To address issues around mind set (beliefs and attitudes); this included ideas for the public and guidance/education for HCPs as well as patient information.
2. Fundamental solutions. To address problems around time, resources, knowledge, and capacity; this included ideas around funding support, a tiered service, and community services
3. System solutions. To address problems around process issues; this included ideas around changes to the fit note, including patient input into the fit note.

The stakeholder engagement responses also focused mainly on barriers to the conversation (rather than facilitators), which were similar to those documented in the literature. Some commented on a negative impact if HCPs did not view work as important or part of their role, while others suggested HCPs lack the knowledge and skills to have the conversation: the discussion will tend to be superficial in nature, or any data gathered will not be acted on. There was also a view that HCPs tend to be over protective and make assumptions about capability and/or patient's own beliefs, which then obstructs the conversation. HCPs are also 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, yet 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'

A broad range of healthcare system barriers were commented upon, including resource and time limitations, a lack of management buy-in, and the problems of integrating work into healthcare practice when it is not a commissioned part of the service. Some respondents referred to healthcare settings being unsuitable environments, lacking privacy for confidentiality. It was suggested there are a wide range of services to which HCPs can signpost or refer patients, but because of this variety, it is very difficult for them to judge whether they are helpful. There were also concerns about patients not expecting HCPs to discuss work, referring to patient hostility and defensiveness. A further concern was HCP's use of a medical model or a condition management approach, rather than embracing the biopsychosocial model, thus hampering their exploration of social determinants of health, including work and the associated issues of debt and housing, for example.

A few comments were made about how HCP behaviours may facilitate health and work conversations – these 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. Some respondents thought MECC could be a way of embedding conversations in routine practice:

> "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."

What is the most desirable outcome from a supportive conversation about work and health and how can this be measured?

There was no evidence of research or evaluation to establish the desired outcome or efficacy of any particular components, content, or strategies for supportive conversations about work and health, nor how these may be measured.

This lack of evidence may be, in part, a reflection of the many reported barriers to conducting work conversations in healthcare. Despite an appreciation of the benefits of work, it is clear that work outcomes are not currently a key target within healthcare consultations. There is substantial evidence showing that HCPs largely frame conversations based on clinical considerations, and often see these conflicting with recommendations to discuss work.

For example, a systematic review found strong evidence that HCPs with a biomedical orientation or elevated fear-avoidance beliefs are more likely to advise patients to limit work, and are less likely to adhere to guidelines (39). Several studies, conducted with a wide variety of HCPs, found that the biomedical approach is routinely adopted, that many HCPs advise patients to take time off work, and many do not adhere to the latest evidence-based guidance (29-31, 40-44). Another systematic review and meta synthesis found that HCPs reported a lack of knowledge of, and confidence in, clinical guidelines, as well as not necessarily agreeing with recommendations to return to work or activity (45).

This suggests that even though HCPs are basing their judgements on clinical indicators/outcomes, they do not necessarily align with, or use, clinical guidelines. This means it cannot be assumed that work conversations will take place just because relevant recommendations are included in clinical guidance (46). Scepticism about guidelines was often voiced in the stakeholder engagement.

To address non-adherence to guidelines, an international evidence synthesis examining system obstacles to work participation (including the healthcare system, the workplace, and the family) recommended introducing:

- multidimensional initiatives and implementation strategies
- decision support systems
- multi-level educational strategies
- reminder systems
- clinical practice audits
- regulatory change (such as incentives to communication, mandatory engagement)
- actions to ease administrative burden on HCPs
- improve time pressures
- provide access to assessment tools and communication platforms (13)

The stakeholder engagement also highlighted the difficulties in measuring a successful outcome in relation to good quality conversations about work and work-related interventions. One key issue was the lack of consensus about the desired outcome: an important concern was whether the HCP role is to get people back into paid work, or in supporting engagement in occupation in a more general sense, as an aid to recovery and health.

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 a positive impact. 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."

The respondents recommended measurement of the process rather than the outcomes, identifying 3 aspects that could be measurable, such as HCPs:

- taking up training
- having the conversation
- providing work-related support

It was felt that these could 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 on a regular basis, including conversations about work."

Some suggestions were made by respondents for measuring direct work outcomes, one example being recording work status at the beginning and end of treatment. There were also suggestions for capturing interim outcomes, including whether the person has planned for returning to work, or made a self-referral to a service that encourages social integration. Plus, a need to take a patient-focused approach to measurement was suggested, including whether the patient feels more confident about returning to work (a measure of work ability), and whether they felt the conservation was helpful.

What are the most promising opportunities for supportive conversations about work and health?

Several studies have suggested that training, with interest-group support, must form part of speciality competencies around work and health, and that this 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 (34, 36, 37). It was generally recommended 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 (47).

In concert with this, a series of evidence-informed leaflets: ‘Advising Patients About Work', ‘Work and Health', and ‘Health and Work' were commissioned by DWP with industry support (21, 48, 49). These were written and designed specifically to provide information and practical advice to healthcare professionals, employers/workplaces, and workers about the work-health relationship, with a view to encouraging health-work conversations among stakeholders to influence sickness absence behaviours.

Each of the 3 leaflets is written in a language appropriate to its audience, and they were published following peer-review and end-user content evaluation. The leaflets have been successfully assessed for feasibility within physiotherapy practice, with implications for more widespread implementation (50). It has been reported that patient-facing literature is welcomed by HCPs, to be used as part of a conversation or given out to patients so they have something practical to take away. Work-supportive literature is thought to be helpful for those HCPs who feel uncomfortable raising the work issue or who are short on time or knowledge, and that up to date information and advice is useful for the HCP to read as well as the patient (38).

A guidance tool to facilitate discussions with HCPs initiated by workers/the workplace has been developed to minimise the impact cancer may have on patients’ work outcomes. This tool facilitates discussions through a set of questions individuals can use to find solutions to problems: the process and design of this particular tool probably can lend itself to other health conditions (51). Additionally, a guide for HCPs to start the conversation

about work with people with multiple sclerosis has recently been produced (52). More recently, the Talking Work resource has been launched as an online desktop aide, based around a checklist, to guide doctors in discussing work and work modifications (also see Appendix 5) (53). Further research is needed to establish the efficacy of these tools for facilitating supportive work conversations and influencing work outcomes.

Several online learning initiatives for GPs have been developed including:

- Electronic
- Experiential
- Learning
- Audit and Benchmarking (EELAB)
- The Health and Occupation Reporting (THOR) network
- Health e-Working
- Health and Work Training Resource (28)

A very recent study has investigated (through interviews with HCPs, workers, and employers) the potential of IT (such as an app), as an alternative to paper-based forms and checklists, for use in work conversations, with a transition to an IT-mediated tool being supported in principle; however, major caveats exist in relation to perceived value and fit with stakeholder practice (54) (similar to those mentioned above in relation to adherence to clinical guidelines). System support and stakeholder cooperation are likely necessary to adopt the change, yet IT-mediated communication is at its early stages so has yet to demonstrate value, both for GPs or other HCPs.

Stakeholder respondents also commented on the need for increased training, embedded within undergraduate and postgraduate education as part of normal practice rather than a specialist topic. Some also referred to the provision of a list/guidance on support agencies/resources available (both online and face-to-face), and on the availability of tools to make conversation practices easier and support data collection. Their suggestions for achieving this reflect the literature, including improved IT systems, and information leaflets for self-management and self-referral to services. It was also suggested the patient could be asked to complete a work-focused questionnaire before an appointment. Stakeholders referred to the need for a simple, shared decision-making tool which would guide the conversation, facilitate problem solving, support the identification of the obstacles to work, and indicate strategies to assist return to, or staying in, work.

In addition to guidance and tools, there is a need to consider a wider view of health-work conversations. The international literature demonstrates that clinically located HCPs are not the only group of professionals to recognise as having health-work conversations. Indeed, they may not be best placed to take forward any actions from the conversation. There is robust evidence that caseworker, case manager, and

coordinator roles providing a link to the workplace are highly successful (7). A qualitative study conducted in Australia highlighted the role of nurses who also had the role of return-to-work coordinators besides their usual work tasks. It was found that interpersonal coordination skills may be more important to facilitate return-to-work than having a healthcare background, with a collaborative case management style being found important (55).

In Denmark, a ‘work-focused’ intervention offered patients individual appointments with a caseworker during the first days of treatment in secondary care where work histories, family lives, and obstacles to return-to-work were discussed. The caseworkers contacted participants’ employers to inform them of the program and inquire about possible temporary modifications at work. The patients then created a return-to-work schedule together with the caseworker and the multidisciplinary team (56). A similar intervention was tested in Sweden as part of a randomised controlled trial examining the effect on work ability when a workplace convergence dialogue meeting (CDM) is added to physiotherapy practice (57).

It is acknowledged that the differing systems and legislation in other countries may better facilitate interventions with a workplace component, but a successful UK example of this approach was found in a randomised controlled trial of embedding vocational advisors in primary care. Patients in the experimental practices could be referred (by GP or nurse practitioner) to the specially trained vocational advisors if they were sick listed or struggling with work: they received a biopsychosocial (mostly telephonic) stepped approach to return to work. The content and the delivery model (with various members of the practice team included, not just GPs) offers a template for future attempts to instil a positive health-work culture in healthcare settings (58).

Discussion and evidence-informed recommendations

In the UK, for over a decade, the potential for healthcare to reduce work loss has been recognised and is underpinned by the notion of considering ‘work as a health outcome’. Translated to the healthcare system, this means that HCPs should be encouraged to have work-focused conversations with their patients. Numerous major policy changes have taken place to support this activity, and several national and widespread local initiatives have been launched, along with relevant recommendations in clinical guidelines (see Figure 1). Thus, it is natural to assume that conversations about work are now routinely taking place in healthcare. The findings from this study indicate this is not the case. Accepting that work-focused healthcare is desirable does not diminish the challenge it presents.

The findings demonstrate that HCPs largely do accept the concept that (good) work is generally good for health and wellbeing, yet perceptions of clinical roles can be an impediment to engaging in health and work conversations. Some HCPs, particularly those with a special interest and training can and do get involved in conversations about work. Most, however, do not.

While the findings reveal many barriers to the initiation of these conversations, the evidence also indicates ways that they can be overcome. Some clear, short- and long-term policy solutions that can help to embed the ‘work as a health outcome’ agenda within routine healthcare have been revealed in the evidence. Building on recent research commissioned by PHE to inform this agenda (38), the proposed recommendations are conceptualised as ‘cultural awareness’, ‘conversation starters’, and ‘integrated practice’.

Cultural awareness

From the existing evidence, it is clear that individual attitudes, beliefs and behaviours of HCPs are substantial barriers to initiating conversations about work, yet these are heavily influenced by wider cultural and systemic issues. Healthcare acts as a crucial stakeholder among other equally important systems that have an influence on health and work interactions. Thus, it would be difficult to isolate the healthcare system in respect of targeted behaviour change without making the necessary changes to the other inter-linking systems (employment, welfare). The lack of directly relevant evidence reflects the low uptake of this agenda, which in turn reflects the lack of a ‘whole-systems’ culture: this is a long-term objective requiring legislation.

The overwhelming majority of the evidence included in this study did not directly examine the initiation or implementation of conversations about work in healthcare, so does not provide enough robust data for a behavioural analysis. While there is insufficient evidence for firm recommendations on 'what works' in this respect, there is good evidence on what might help promote the agenda across systems.

A short-term high impact policy solution is to further promote a widespread understanding of the positive link between work and health at a societal level, delivered in a public health campaign – this aligns with the 2019 Healthcare Professionals' Consensus Statement on Health and Work (https://www.aomrc.org.uk/news-and-views/healthcare-professionals-consensus-statement-on-health-and-work/). There is good evidence to support this approach, showing effectiveness and cost-effectiveness (59, 60). There is now sufficient knowledge to enable a small expert team to draw up a set of relevant messages ready for early piloting, prior to a national campaign. The findings indicate that myth busting, practical messages are likely to be effective: work is important for health and wellbeing, working can mean faster recovery, and it is 'good to talk about work'.

This aligns with the evidence principles underpinning the MECC philosophy – all key stakeholders (individuals, healthcare, employment and welfare) need to have a shared understanding as a necessary precursor to health behaviour change.

Conversation starters

It is clear that further resources are required to assist HCPs to engage in work discussions with patients and clients. Clinical guidelines are necessary, but they are clearly not sufficient. Consistent, practical guidance on how to initiate and conduct a 'good-quality' (evidence-informed) conversation about work has not been made widely available, implemented, or evaluated. Nor has it been clearly articulated as to what the purpose and outcome of such conversations ideally should be. There is a logical sequence of steps, each requiring a skill set and time to deliver: raising awareness, aligning beliefs, or managing the return to work process. Faced with such uncertainty, the evidence shows that HCPs are likely to avoid work discussions, and thus fail to provide helpful advice. This is further compounded by the evidence showing that HCPs allow a high degree of patient influence on their decision-making to preserve the patient-practitioner relationship.

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. Some practice-ready examples include a series of free evidence-informed information/advice leaflets for clinicians, employers, and workers (21, 48, 49) and the Shared Decision-Making (SDM) tool – see http://www.fitforworkuk.com/projects/). Such 'conversation starters' answer many of the

concerns of HCPs highlighted in this study and can ensure delivery of consistent evidence-informed messages. In addition, download data can provide a simple metric for estimating the likely penetration as a surrogate for actual conversations. Moreover, conversation starters align readily to usual clinical practice: the provision of advice and/or patient education material as part of treatment or recovery.

Integrated practice

Addressing the healthcare system barriers identified here and removing procedures that increase conflict with other important systems appears to be of key importance to facilitate conversations about work: relevant incentives, mandatory engagement, and cooperation with other stakeholders seem to be ultimately required. Embedding work and health training across the undergraduate and postgraduate (including CPD) curriculum as standard, rather than a specialist topic, is also called for. To be effective, though, that all necessitates development of curricula that teach an evidence-informed approach that is acceptable, consistent, and integrated across the various disciplines.

It is vital the curricula are clear on the purpose(s) of the conversations, which will likely vary across disciplines. Currently, this purpose is not well developed, and thus poorly articulated: unless the purpose is made clear in training, this will necessarily be suboptimal. A tiered approach seems essential – a baseline understanding for all (supported by a public health campaign as suggested above) with increasing levels of detail as the practical expectations on HCP groups increases. These are necessarily long-term solutions requiring substantial coordination, as well as significant policy change, resource, and legislation. The longer there is no action, or the longer the action is uncoordinated, the more entrenched the problem will be.

There are shorter-term, less costly policy solutions. Widening the successful Health and Work Champions model to recruit and train a much larger number of HCPs has merit: initial evaluations indicate this can be scaled up (36). Many clinical teams will benefit by having access to a Champion for assistance with more challenging/complex conversations, with identifying and signposting high quality occupational health/social services, and with involving employers – all shown to be important factors in the evidence. Champions could also help facilitate routine clinical audits and process measurements to evaluate the link between conversations in healthcare and work participation.

Appendix 1a: search terms

AB (interaction or communication) OR AB assessment OR AB (interventions or strategies or best practices) OR AB support OR AB (protocol or guideline or policy) OR AB patient care planning OR AB consultation OR AB (conversation or communication) OR AB (involvement or participation or engagement) OR AB holistic care OR AB holistic approach OR AB professional boundaries in healthcare

AND
AB healthcare professionals OR AB (nurs or nurse or nursing or nurses role) OR AB (doctors or physicians) OR AB doctor patient relationship OR AB (physicians or doctors) OR AB (clinic or outpatient or ambulatory) OR AB (surgery or operation or surgical procedure or surgical treatment) OR AB (primary health care or primary care) OR AB secondary health care OR AB secondary health prevention OR AB tertiary healthcare OR AB (pharmacy or pharmacies or pharmacist or pharmacists)
AND

MH "Return to Work") OR (MH "Work Engagement") OR (MH "Work") OR (MH "Work Performance") OR "work OR workplace OR (employment or jobs or work or career) OR (job satisfaction and performance) OR sickness absence OR (return to work or rtw or employment or vocational rehabilitation or work resumption or work re-entry) OR work ability OR work ability assessment OR sick pay"

Appendix 1b: grey literature search strategy, conducted by PHE

Google search terms in various combinations:
"return to work" health conversations engagement doctors nurses discussion discourse talk conversations about +"return to work" "back to work" job satisfaction
"return to work" health conversations engagement medical care
“Work engagement” employment career
Operation surgery medical practitioner nurse doctor GP
+site:nhs.uk

OPEN GREY
((talk OR conversation AND (nurs* OR Doctor* OR “healthcare professional” OR GP) AND work))
((“return to work” AND (conversation OR talk OR dialogue OR verbal OR discuss) AND health))
“return to work AND health
“good work” AND health
((discuss* AND (nurs* OR doctor* OR dr* OR GP*) AND (work OR employ*))
Limit work AND discuss* in #health sevices / #health administration / #community care services
LG = EN
>2008

TRIP: All = work / health / conversation / discourse / doctor / healthcare practitioner / nurse

Appendix 2: evidence tables

Peer-reviewed literature

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
Bartys et al (2017) (22) Bartys and Stochkendahl (2018) (13)	**System influences on work disability due to low back pain: An international evidence synthesis** **Work-focused Healthcare for Low Back Pain (International Society for the Study of the Lumbar Spine Online Textbook)** Healthcare professionals (HCPs) are in a prime position to administer the latest evidence-based guidance. To date, however, there is only sparse and conflicting evidence demonstrating the successful implementation of guidelines and the resultant effects on improving rates of LBP disability. Work-focused healthcare involves HCPs taking an interest in, and accepting responsibility for, addressing obstacles to work participation in the clinical encounter. This shift reflects the emerging evidence which suggests that, rather than focus solely on individual factors, the wider systems involved can contribute directly or indirectly to work disability due to LBP. There is robust evidence to suggest that a lack of work-focused healthcare (a failure by healthcare professionals (HCPs) to address work issues within the clinical encounter) is an obstacle to work participation. Addressing work issues in the clinical encounter was defined as talking to the patient and the employer; posing questions and giving advice to the patient about work accommodation/date for return-to-work and prevention of re-injury; and referral to other relevant HCPs. Reasons for not addressing work issues were reported as HCPs don't generally regard engagement in work issues within their professional remit and some of the reasons for this are proposed to include a lack of financial incentive, a lack of time and standard procedures/role clarity, and increasing job demands. Some of the evidence indicated that HCPs do not adhere to guidelines and give advice to (over)rest and take an unnecessarily long time off work. One study suggested that this was because HCPs do not believe guidelines to be valid and true and, therefore, are unlikely to apply them. In this vein, it was also reported that HCPs' distress about complexity in work disability management and their own misconceptions about working	Musculoskeletal	Various

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
	with LBP could be an indirect determinant for advising sickness absence and not engaging in work discussions. A seemingly important aspect was the difficulty HCPs reported with finding a balance between being a patient advocate and also gate-keeper of sickness absence certification. Many of the studies conducted in the countries where this kind of system is in place indicate that HCPs allow a high degree of patient influence on their decision making about sickness certification in order to preserve the patient-practitioner relationship. There is robust evidence to suggest that a lack of communication and timely cooperation between HCPs and relevant stakeholders (Such as., employer, occupational therapist, compensatory system) is an obstacle to work participation. In several different types of studies, a lack of communication or loss of contact between stakeholders, poor communication skills, or poorly communicated (and coordinated) activities in a return-to-work program among stakeholders, and unidirectional communication between stakeholders were specifically cited as negative influences on work participation. According to some of the evidence, a lack of common goals, structural barriers between stakeholder practice, societal norms and HCPs desire to maintain the professional status quo, and HCPs being unaccustomed with involving others in their practice were proposed to act as barriers to communication. Time delays from incorrect or slow procedures affecting other stakeholders were seemingly reduced, as well as addressing additional issues, such as conflicting demands from relevant stakeholders and lack of trust. Despite a consensus among the studies that HCP communication with relevant stakeholders is important, a question about the independent effects of HCP communication have been raised in an observational study. The authors found that giving a patient a work-resumption date and providing guidance on how to prevent recurrence and re-injury were positively associated with an early return-to-work in this study, but this association became weaker upon adjusting for other variables (such as socio-demographic and job characteristics, pain duration and co-morbidity), highlighting the importance of other systemic factors. From the evidence, it is clear that further resources are needed to assist HCPs to engage in work discussions with LBP patients, which can often be complex and challenging. Unrealistic expectations and misconceptions are a difficult issue for HCPs to manage, and often result in the use of practices that are not recommended or evidence-based, such as referral for imagery. It has also been shown that HCPs themselves have misconceptions about the work-health relationship.		

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
	This has been put forward as one of the factors explaining non-adherence to current evidence-based clinical guidelines for LBP, a phenomenon that is found across several different countries.[8] However, this study also supports the more nuanced and complex picture reported in other studies focusing on barriers to implementation of guidelines. It would seem that in order to address non-adherence to guidelines, multidimensional initiatives and implementation strategies such as decision support systems; multilevel educational strategies; reminder systems; clinical practice audits; and regulatory change such as incentives to increased communication would be beneficial. Actions to ease the administrative burden on HCPs and to improve certain issues like time pressure, and access to proper assessment tools and communication platforms would also be helpful. Findings also highlight how the healthcare system acts as a crucial stakeholder among various other important systems (such as the workplace and compensation/insurance systems). Thus, removing procedures that increase stakeholder conflict also appears to be of key importance. Healthcare practices that are unhelpful for the return-to-work process are often further reinforced by compensation and welfare systems requiring a medical diagnosis for a condition that often does not have a specific underlying pathology. In the evidence reviewed, HCPs described their cooperation with other stakeholders as unclear, scarce, and often initiated late in the process. It was reported that HCPs are generally not accustomed to initiating contact with other relevant stakeholders, and, therefore, it appears important to further promote a widespread understanding of the positive link between work and health amongst these stakeholders. Altering working procedures to include relevant incentives, mandatory engagement and cooperation with other stakeholders, as well as improving the transparency and consistency of the return-to-work process, is also required.		
Cohen et al (2010) (34) UK Primary care Qualitative study	**Managing long-term worklessness in primary care: a focus group study** Explores HCPs (mainly GPs) perceptions of the management of individuals in receipt of long-term incapacity benefits and their attitudes to UK government funded return to work programmes. A key finding was that many of the participants felt that their role in managing long-term worklessness was limited to providing support and management of health-related issues only. The perceived risk to their own personal safety in addressing these issues with some patients also impacted on decision making. There was strong feeling among some participants that discussing return to work once a patient was on long-term benefits lay outside of contractual responsibilities. Once patients were in receipt of long-term state benefits, they saw the responsibility for instigating a discussion about return to work lay with the benefit department.	Not specified	GPs, practice nurses, medical students

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
Cohen et al (2016) (61) UK Secondary care Evaluation	**Fit for work? Evaluation of a workshop for rheumatology teams** A study reporting on the efficacy of pilot workshops using material devised for National Education Programme rolled out by RCGP in 2009 to increase the knowledge, skills and confidence of rheumatology team members to support work-related issues in outpatient clinics (n=99). The workshops focused on how important participants thought health and work conversations were and their confidence in managing them. The workshops had high face and content validity and changed both participants' attitudes to the importance of health and work conversations and their confidence in having such conversations. Previous research has explored general practitioners' attitudes to sickness certification and health and work conversations, but to develop sustained and effective change, secondary care specialities must also use such learning in their practice. Effective use of the 'fit note' can support such change and requires widespread use throughout health care. If work is to become a health outcome, training must form part of speciality competencies and be supported by the appropriate interest groups. Workshops for rheumatology teams will now be extended throughout the UK, managed by the BSR with local champions to help incorporate resulting learning into everyday practice.	Musculoskeletal	Rheumatologists
Coole C et al (2010) (62) UK Qualitative study Ind. Interviews	**Staying at work with back pain: patients' experiences of work-related help received from GPs and other clinicians. A qualitative study** Participants experienced that GPs and other clinicians had provided little or no work-focused guidance and support and rarely communicated with employers. Sickness certification was mainly used to manage participants' work problems and only a few had received assistance with temporary modifications. Not uncommonly, participants had remained in work despite the advice they had received and they generally did not expect that GPs and other clinicians could offer much to address work issues. Participants were workers doing all kinds of work, had various levels of education, and were employed in both public and private sector. [Indicates that a combination of lack of practice for engaging in the RTW process, lack of habit to communicate with other stakeholders, and lack of trust from patients of the GPs capability could serve as an obstacle for RTW].	Musculoskeletal	Patient perspective – talking about GP and other clinicians
Darlow (2012) (20) International Primary and secondary care	**The association between health care professional attitudes and beliefs and the attitudes and beliefs, clinical management, and outcomes of patients with low back pain: A systematic review**	Musculoskeletal	GPs, physiotherapists, chiropractors, rheumatologists, orthopaedic surgeons and

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
Systematic review	This review aimed to investigate the association between HCP attitudes and beliefs and the attitudes and beliefs, clinical management, and outcomes of this patient population (including sickness absence and certification). There is strong evidence that HCP beliefs about back pain are associated with the beliefs of their patients. There is moderate evidence that HCPs with a biomedical orientation or elevated fear avoidance beliefs are more likely to advise patients to limit work and physical activities and are less likely to adhere to treatment guidelines. There is moderate evidence that HCP attitudes and beliefs are associated with patient education and bed rest recommendations. There is moderate evidence that HCP fear-avoidance beliefs are linked with reported sick leave prescription and that a biomedical orientation is not associated with the number of sickness certificates issued for LBP This is proposed to be influenced by case-specific factors, such as patient preferences, relationship maintenance, time pressure, and funding issues, or the GP's general propensity to issue sickness certificates, thus masking any association with HCP attitudes and beliefs. However, a causal link cannot be implied due to the observational nature of the majority of studies included.		other paramedical therapists
Darlow et al (2013) (39) New Zealand; UK Qualitative interviews	**The enduring impact of what clinicians say to people with low back pain** People with back pain expressed the view that clinicians influenced their patients' understanding of the source and meaning of symptoms, as well as their prognostic expectations. Such information and advice could continue to influence the beliefs of patients for many years. Many messages from clinicians were interpreted as meaning the back needed to be protected. These messages could result in increased vigilance, worry, guilt when adherence was inadequate, or frustration when protection strategies failed. Clinicians could also provide reassurance, which increased confidence, and advice, which positively influenced the approach to movement and activity. It was concluded that HCPs have a considerable and enduring influence upon the attitudes and beliefs of people with low back pain. It is important that this opportunity is used to positively influence attitudes and beliefs. [While work per se was not a focus of the study, it follows that what HCPs say during a health-work conversation can have a considerable and enduring influence on the person's attitudes and beliefs in respect of work and their work ability, for good or ill. This article emphasises the notion of 'words that do harm' – a recognition that HCPs can give negative messages in brief conversations, and that these messages can have an enduring (negative) effect. In the context of the present report, it is a reminder that the idea of	Musculoskeletal	Patient perspective

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
	promoting health-work conversations needs to take account they be unhelpful as well as helpful: the content of the conversation is a crucial element].		
Demou et al (2014) (63) Scotland Primary care Survey	**Case management training needs to support vocational rehabilitation for case managers and general practitioners: a survey study** This survey confirms a need for further training of CCMPs, which was unexpected given that this professional group works in VR, routinely uses the principles of the biopsychosocial model and receives training in these areas. The low response rate from the GPs prevents from generalising the results to the entire GP population. However, the findings from the respondent GPs in the health board assessed, show that they are not fully equipped to deal with patients' employability and vocational needs. GPs also reported a lack of understanding about the role of Case and Condition managers. Training for these professional groups and others involved in multidisciplinary VR could improve competencies and mutual understanding among those advising patients on return-to-work.	Not specified	Condition/case managers/GPs/VR
Dorrington et al (2018) (64) UK Systematic review	**Systematic review of fit note use for workers in the UK** The intention of the fit note, introduced in UK in 2010, was to facilitate a conversation between the GP and the patient around health and work, to focus on ability not disability, and allow discussion (with advice) of what the person could do if the work was adapted. Fit notes represent a major shift in public policy. The authors review suggest that they have been incompletely researched and not implemented as intended: specifically, the use of 'may be fit' was found to be low. On the basis of available evidence, it is unclear whether fit notes would, if properly implemented, give a desired change for patients. The authors suggest that evidence suggests that fit note implementation could be improved by legislation which encourages employers to adapt to the needs of patients. [The fit note has the potential to facilitate health-work conversations, but the evidence from GPs suggests that it may not. Rolling out the fit note to other HCPs may or may not result in the same low effect size. Integrating the fit note with other systems (employers), perhaps with some mandating, is an interesting policy suggestion. The possible message for initiating the health-work conversation is that simple facilitation through expectation or statutory instrument may be necessary, but is likely to be insufficient].	Not specified	GPs
Hughes (2009) (65) UK Primary care Postal survey	**Chronic Fatigue Syndrome and Occupational Disruption in Primary Care: is there a Role for Occupational Therapy?** This survey supports the findings of other studies suggesting that the most helpful intervention that GPs can offer is recognition of the illness and its implications by means of diagnosis and access to sickness benefits. In addition, the patients wanted reassurance	CFS/ME	GPs

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
	from their GP that it was not a 'life-threatening illness'; they wanted permission to rest, to take time off work and to gain access to symptom relief and support.		
Ikezawa et al (2010) (40) Canada Survey Questionnaire	**Do clinicians working within the same context make consistent return-to-work recommendations?** Participants were physiotherapists, occupational therapists, exercise therapists and physicians. Subjects showed a high percentage agreement regarding RTW readiness on fracture and dislocation scenarios (97.2 and 94.4%, respectively), while agreement on a back pain scenario was modest (55.6%). In all cases, more than 50% of clinicians relied on biomedical information, such as physical examination. [*HCPs are clearer about handling straightforward conditions such as fractures compared to back pain. The biomedical approach is widely used to address all conditions, which is not in line with guidelines for back pain conditions.*]	Musculoskeletal	physiotherapists, occupational therapists, exercise therapists and physicians
James, C., et al. (2011) (55) Australia Qualitative study Focus groups	**The Return-To-Work Coordinator Role: Qualitative Insights for Nursing** Participants were health care personnel such as nurses that had the role as RTW coordinator besides their usual work tasks. Study findings: The interpersonal skills of RTW Coordinators may be more important to facilitate RTW than a healthcare background. A collaborative case management style was also highlighted and the difficulties associated with juggling conflicts of interest, multiple organisational roles and the emotional impact of the work. [RTW coordinators' interpersonal skills are important as well as being able to create a teamwork in the workplace collaborating and not so much their educational background. In this study, the coordinators were almost a kind of workplace peer support – and thus, the results are more/just as relevant for the employer theme].	Not specified	Nurses
Johnston et al (2012) (24) Australia Qualitative study	**Experiences and Perspectives of Physical Therapists Managing Patients Covered by Workers' Compensation in Queensland, Australia** Key findings: -Physical therapists believe they are important in RTW -Physical therapists use a variety of methods to determine work capacity -Physical therapists experience a lack of role clarity -Novice therapists were less confident in making RTW decisions	Musculoskeletal	Physical therapists

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
	Therapists made recommendations for RTW using clinical judgment informed by subjective and objective information gathered from the injured worker. [Lack of: role clarity, consistency in assessment of workability, and of work experience complicate RTW for physiotherapists and therefore serve as potential obstacles for RTW].		
Johnston et al (2013) (14) Australia Primary care Narrative review	**Applying principles of self-management to facilitate workers to return to or remain at work with a chronic musculoskeletal condition** Authors conclude that the clinician is ideally placed to assist individuals with chronic musculoskeletal conditions manage to remain at work or return to work. This can be achieved through such activities as the promotion of the core self-management skills of problem-solving, decision making, resource utilisation, developing a cooperative partnership between clinician and patient and making an action plan. Provides detailed description of elements of what can be a work conversation (albeit, here, focused on self-management): establish rapport; active listening communication; [provide information]; [develop action plan]; use non-judgemental language; facilitate problem solving; promote self-efficacy; [link person with resources]; [encourage maintenance of personal health records]; active follow up. [Essentially, these are ideas on how people can be helped in self-management of the RTW process. Initiating the 'supportive' conversation seems to be a given: "It is incumbent on health care professionals to support patients…to manage the impact of their condition on their life". That is an aspirational goal that (we know) may not be realised. But if it is, the reported framework may be useful].	Musculoskeletal	Physiotherapists
Meunier et al (2016) (66) France Rheumatology Observational-telephone survey	**Work-related discussions between French rheumatologists and their rheumatoid arthritis patients** Questionnaire study of rheumatologists' and patients' (not matched) details of recent consultation. To document the occurrence of patient/rheumatologist work-related discussion from rheumatologists'' and patients' perspectives. Pre-existing expert opinion suggested no work-related discussion in more than two-thirds of consultations. A discussion was considered work-related if discussion of one or more of the following occurred: psychological work-related problems, physical work-related problems, adaptation of working conditions, impact of long-term sick leave, return to work, difficulties in going to work and difficulties in disclosing the disease to the employer. Study found higher than expected discussions about work: ~50% reported by French rheumatologists and patients, suggesting work is very important to rheumatoid arthritis patients. Rheumatologists' most frequent discussion topics: physical problems related to work	Musculoskeletal	Rheumatologists (+ patients)

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
	(88%); disclosing the disease to the employer (55%). Patient's most frequent discussion topics: physical problems related to work (88%); adaptation of working conditions (43%). [It seems that rheumatoid arthritis patients want to discuss work ability, and that rheumatologists should not be afraid to doing so. Other than the topics, no information on the actual conversations].		
Morrison et al (2015) (67) Canada Primary care Interview with vignettes	**Physicians' perspectives on cancer survivors' work integration issues** Owing to a lack of training and time, as well as the belief that work integration issues are not part of their mandate of care, physicians perceive themselves as ill-equipped to address cancer survivors' work integration issues. Although the participants felt other professionals were better equipped, they made few referrals - possibly due to the perception among physicians that patients viewed work as a burden (and physicians see it as trivial compared with the gravity of the illness. Insurance gatekeeping seen as burden to physicians. Some quotes: "If this was something that was important to the patient, they would bring it up." "The physician is faced with this constant conflict of the bad guy go back to work, versus the good guy cure the cancer. It's a constant conflict with these forms." "I don't think they see that as the task of their primary care physician … as far as returning to work, I think they see that as coming from their oncologist". "This isn't something that we get taught in medical school or fellowship". "Have I assessed how many pounds she can lift, for how many minutes, of course I'm not going to do that.… I don't know and I don't really care. In fact, if I see that, I'm probably even more likely [to say] that she can't go back to work". [Although focus is cancer, there are some nuggets about barriers (for physicians), some of which may transpire to be generic].	Cancer	Physicians + oncologists
Munir et al (2013) (51) UK People with cancer Tool development + pilot	**Using intervention mapping to develop a work-related guidance tool for those affected by cancer** Healthcare professionals do not consider the work-related needs of patients and employers do not understand the full impact cancer can have upon the employee and their work. Authors therefore developed a work-related guidance tool to facilitate discussions with healthcare professionals (and others). Tool comprises a set of questions to find solutions to problems and minimise the impact cancer may have on their employment, sick leave and return to work. Article focuses on tool development using intervention	Cancer	All + workplace + person

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
	mapping, followed by pilot study with people at various stages of cancer. The self-led tool can be used by any person with a cancer diagnosis working for most types of employers. The pilot study indicated that the tool was relevant and much needed.		
Myhre et al (2014) (56) Norway RCT	**The effect of work-focused rehabilitation among patients with neck and back pain** RCT with patients listed as sick for 1 to 12 months due to neck or back pain and referred to secondary care. Comparing work focused rehab with MDT rehab. Work focused intervention offers the patient individual appointments with a caseworker during the first days of treatment. Work histories, family lives, and obstacles to RTW were discussed. The caseworkers contacted participants' employers by phone in most cases (unless the patient refused) to inform them of the program and inquire about possible temporary modifications at work. The patients created a RTW schedule together with the caseworker and the multidisciplinary team. The patients and the caseworkers also discussed relevant issues for a meeting with the employer.	Musculoskeletal	Not specified
Nilsen et al (2015) (15) Scandinavia Primary care Focus-group study	**GPs' negotiation strategies regarding sick leave for subjective health complaints** Exploration of GPs' negotiation strategies regarding sick-leave issues with patients with subjective health complaints. Specific strategies apparently applied when dealing with the question of sick leave for patients with subjective health complaints. These (trained) GPs adopted a give-and-take stepwise process of alliance-building and mutual understanding, then actively focusing on early return to work (by pointing out the positive effects of staying at work, making legal and moral arguments, and warning against long-term sick leave) supported by involvement from other stakeholders. While seen to be a helpful way of handling sick leave negotiations, it is unknown whether such strategies occur in real life. [Interesting in that it sheds light on a negotiating process to limit long-term sick leave, yet there is no information on how these conversations might be initiated].	Not specified	GPs
Nilsing et al (2013) (26) Sweden Qualitative study Nilsing et al (2013) University Medical Dissertation	**Primary Healthcare Professionals' Experiences of the Sick Leave Process: A Focus Group Study in Sweden** **The Sick Leave Process: Sick Leave Guidelines, Sickness Certificates, and Experiences of Professionals** Participants have different backgrounds (Physicians, Occupational Therapists, Physiotherapists and Counsellors (such as a specialist nurse in psychiatrics)). - They find prioritising the sick leave process difficult due to challenges with balancing increasing job demands (increasing numbers of older patients and more frequent visits by severely disabled patients requiring investigations and complicated referrals) with still taking on usual generalist tasks. Access to health care was also mentioned.	Not specified	Primary Healthcare Professionals' (Physicians, Occupational Therapists, Physiotherapists and Counsellors (such as a specialist nurse in psychiatrics)

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
	- Sick certification was issued as a means of rehabilitation more than as an intervention with a specific goal. - Physical findings were considered essential to make evaluation about need for sick leave, without findings HCPs became mistrustful towards patients and felt insecure. - Lack of patient motivation, conflicts at work or with authorities, lack social support, and family problems were considered of greatest importance in terms of being obstacles for rehabilitation or RTW. - Collaboration with other stakeholders (employer, employment office, insurance office) was considered important however; it is lacking: low trust, no structure for handling sick certification and sick certification handled inconsistently. - Work ability assessment was inconsistent due to different perceptions of work ability, somewhat dependant on patients (if no clear findings), lack of assessment tools and lack of using team competencies. Quotes: '..that patient functioning and needs might not be adequately communicated in the sick leave process. Despite the implementation of sick leave guidelines, this information is limited in sickness certificates and the collaboration is poor among the involved stakeholders, such as health care, the social insurance office, the employers, and the OHS' [HCPs themselves consider contextual factors to be of greatest importance for hindering RTW. They recognise that their efforts in terms of cooperation with other stakeholders, prioritising sick leave process and work ability assessment however, contribute these shortcomings of their practice to poor working conditions and the unhelpful features of the 'RTW system'].		
Olsson et al (2016) (68) Sweden Questionnaire	**What positive encounters with healthcare and social insurance staff promotes ability to return to work of long-term sickness absentees?** Previous studies suggest that positive encounters with healthcare and social insurance staff may be important in promoting return to work among long-term sickness absentees. This study aimed to identify more specifically what positive encounters are important for promoting ability to return to work The positive encounters with both healthcare and social insurance staff significantly associated with promoting ability to return to work after adjusting for the other positive encounters were: "Believed in my work capacity"	Not specified	HCPs and social insurance staff

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
	"Supported my suggestions for solutions": Was supportive and encouraging": Additionally, the encounter with healthcare staff most strongly associated with promoting return to work was "Let me take responsibility" Healthcare and social security staff being supportive, encouraging, and believing in the sickness absentee's work capacity may be very important for increasing the probability for long-term sickness absentees' ability to return to work		
Oswald et al (2017) (27) Netherlands Primary care-physiotherapists Survey	**Work participation of patients with musculoskeletal disorders: is this addressed in physical therapy practice?** The aim of this study is to quantitatively investigate how generalist PTs in the Netherlands, who treat patients with musculoskeletal disorders, currently integrate occupational factors within their practice, and to identify their opinions and needs with regard to enhancing the integration of the patient's work within physical therapy practice. Survey of 142 PTs. Most of the respondents had a positive attitude towards paying (more) attention to occupational factors. While respondents indicated that they regularly or always address occupational factors within their patient interview, fulfilling the I-Change model does not necessarily lead to adequate behavior with regard to addressing work: most think that the patient's work should be more extensively addressed. Barriers included lack of payment for a workplace assessment and limited knowledge about laws and regulations. (50%) were identified as needs of the respondents Although generalist (Netherlands) PTs address occupational factors within their practice, there is room for improvement. [Culture among Netherlands PTs seems to acknowledge importance of work conversations but they are not universal, and there are barriers]	Musculoskeletal	Physiotherapists
Petersen et al (2017) (69) Denmark Hospital/job centre Qualitative - interviews	**Return-to-work intervention during cancer treatment – The providers' experiences** Interviews revealed 3 themes: (1) treatment first; (2) work as an integrated component; (3) challenges in bringing up work issues. Differences in providers' experiences of the RTW intervention offered to cancer patients were found: in the hospital setting RTW was a second priority, whereas in the municipality job centers it was an integrated component. The challenges split between setting: hospital cautious and veer away from discussing work, and pleased that the municipal support is there. (In Denmark people sick listed must attend municipal job centres for case managed RTW). [Although focused on cancer and the intervention was RTW focused, there is interesting info on the influence of setting affecting the providers' expectations of what their involvement should be].	Cancer	Physicians, nurses, social workers (job centre)

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
Pincus et al (2011) (29) UK Cross-sectional study (n=337)	**Advising people with back pain to take time off work: a survey examining the role of private musculoskeletal practitioners in the UK** Participants were physiotherapists, chiropractors and osteopaths. Main findings were: -*Many practitioners do not endorse direct work-related activity as part of their remit.* -*Many practitioners do not regard establishing contact with work as part of their role, and view at least* *some aspects of work as detrimental to patients' recovery.* -The majority of practitioners recommend work absence to at least some patients with LBP. [*HCPs do not regard RTW as a part of their work tasks and thus do not engage in RTW discussions with either patient or workplace. They tend to give recommendations not in line with existing guidelines.*]	Musculoskeletal	Private physiotherapists, chiropractors and osteopaths
Poitras et al (2011) (30) Canada Qualitative	**Use of low-back pain guidelines by occupational therapists: a qualitative study of barriers and facilitators** OTs asked to use LBP guidelines with at least 2 clients. All of the therapists found the guidelines generally clear and easy to understand. However, most therapists noted that some interventions lacked explicit details for their application. Some therapists mentioned that, although comprehensive in the evaluation of the client's physical and psychological dimensions, the guidelines did not sufficiently emphasise or provide adequate tools to explicitly evaluate the client's environment, a dimension that could explain part of the client's disability. [might this include work environment]. The guidelines did not explicitly detail interventions to manage identified barriers, reflecting the current need for further research in this area. Therapists reported that client expectations, often biomedical/ pathophysiological/ pain related in nature, were not congruent with the biopsychosocial/ functional/ reactivation elements found in the guidelines. Social norms: resistance in clients, peers and stakeholders in applying a biopsychosocial model in the management of LBP, as is proposed in the current guidelines. Almost all therapists believed that the majority of peers focused their clinical management too much on a biomedical/pain alleviation model of care, a clinical approach perceived as not always compatible with the approach of managing factors related to persistent disability. The differing clinical approaches were reported by these therapists as a source of confusion for the client. The biomedical focus was perceived by some therapists as a contributor to client expectations, expectations that were difficult to change afterwards. Because of the guidelines' biopsychosocial	Musculoskeletal	Occupational Therapists

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
	perspective, they anticipated problems regarding client expectations and collaboration with other health professionals. Quote: "If I push to say that we go in a direction. . . we want to return to work as soon as possible. . . it seems I push and. . . it doesn't go through because there will be other messages. . . no, it doesn't work. They have more weight. The other message has more weight. If it comes from physical therapy, from the doctor, the person's entourage, if it comes from what the persons think is needed as care, but if there is only me that says. . .well, we should be thinking about return to work, well, it won't work" The introduction by the OT of an approach focusing on the management of factors related to persistent disability was seen by almost all therapists as possibly disturbing to the relationship with peers. Reactivation, putting less emphasis on pain and more on function, and return to work issues were seen by therapists as potential sources of conflict between peers and them. Lack of motivation by the patient to become less disabled was seen as a limiting factor. They cited financial incentives related to disability and job dissatisfaction as key demotivating factors for the patient. Some questioned if their work organisation, based on group therapy, would limit their use of the guidelines (did not allow for sufficient individual therapy). Though introducing more one on one therapy would reduce productivity, which could be not well perceived by their employer. Bio med is useful for acute presentation but chronic speaks to biopsychosocial. Also recommends knowledge of workplace rehab and accessibility be incorporated in to OT curriculum.		
Poitras et al (2012) (31) Canada Qualitative	**Guidelines on low back pain disability: interprofessional comparison of use between general practitioners, occupational therapists, and physiotherapists** Studies have demonstrated inadequacies of practices of clinicians with regard to LBP management and prevention of persistent disability. Barriers to use of evidence by clinicians should be evaluated to understand these inadequacies and develop implementation strategies. To evaluate barriers to use of management recommendations, aimed at preventing low back pain (LBP) disability, with general practitioners (GPs), occupational therapists (OTs), and physiotherapists (PTs Asked to use guidelines with 2 patients.	Musculoskeletal	GPs, Occupational Therapists and Physiotherapists

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
	Barriers to use were lesser for OTs and greater for GPs, with divergences among PTs. OTs agreed with the guidelines, found them compatible with their current practice, and thought that using them would prevent persistent disability. GPs and PTs thought that the guidelines did not provide enough information on the pathophysiological management of LBP. GPs thought that it would be difficult to implement the guidelines in everyday practice. All 3 groups thought that management recommendations could conflict with patient expectations. They thought that most patients expected to be managed using a biomedical and not a biopsychosocial approach, as the one found in the guidelines. Most PTs stated that the guidelines were more appropriate for patients with multiple yellow flags, at risk of or with long-term disability. They thought that the guidelines were less appropriate, with patients financing the treatment privately. For GPs, all but 1 said that their role in management of LBP was the identification of the pathophysiological cause and red flags and pain management. Most GPs not only stated that absence from work and return to work authorisation was their role but also mentioned that this was often difficult to determine. Most GPs systematically referred to other professionals for disability management, mostly PTs but sometimes OTs. However, most PTs thought that they were not adequately trained to manage psychosocial factors. Conclude by saying: "To address identified barriers, a process of care is proposed by fitting tasks to the most compatible providers. The task of GPs could focus on pain management through medication, red flag screening, encouragement to stay active, and reassurance. The tasks of PTs could centre on pain management, general exercise, and encouragement to stay active. The tasks of OTs could focus on disability prognosis, yellow flags management, and return to activity parameters. The efficacy of this process of care to prevent persistent LBP disability should be assessed in a trial." [Study expands on Poitras 2011 to include other HCPs (GP and PTs)].		
Schrooten and de Jong (2016) (16) Netherlands Work disability assessment Training and observation	**If You Could Read My Mind: The Role of Healthcare Providers' Empathic and Communicative Competencies in Clients' Satisfaction with Consultations** This study investigated the role of empathy and clarity of information in the context of work disability examinations, and the relationship with clients' overall satisfaction with consultations. Two aspects of empathy were included: empathic attitude (sensitivity to the clients' perspective) and empathic skills (ability to estimate clients' evaluations). Communicative competencies were narrowed down to the clarity of the information provided. Both aspects of empathy and clarity of information significantly contribute to clients' overall satisfaction and as such confirm the importance of empathy and communication in medical consultations. Basic conclusion is that clinicians should be trained in empathic and communicative competences.	Not specified	Various

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
	[This study shows that empathy and communicative competences are important for client satisfaction in the work disability assessment scenario where the relevance of empathy may not be self-evident. It seems logical that empathy and communication competences will also be important in typical clinical encounters when work may be discussed].		
Sennehed et al (2018) (57) Sweden RCT	**Early workplace dialogue in physiotherapy practice improved work ability at one-year follow-up—WorkUp, a randomised controlled trial in primary care.** RCT of the effect on work ability when a workplace convergence dialogue meeting (CDM) is added to physiotherapy practice. CDM is a model aimed at helping the patient, the care giver, and the employer to support work ability and return-to-work. The physiotherapist started CDM by inviting the patient to an individual interview where the patient gave her/his informed consent of contacting the employer. In the second step, the employer was invited to talk to the physiotherapist, either in person or by phone. The conversations with the patient and the employer focused on the neck/back pain in relation to work and on possible or already conducted workplace adjustments to support return-to-work or to stay at work. Finally, the patient and the employer were invited to a meeting together with the physiotherapist. This meeting aimed at a plan of action with a written record of suggested workplace changes/improvements as well as changes to the patient's daily life with the aim of strengthening the patient's work ability and/or supporting return-to-work. The findings led to the conclusion that an early workplace dialogue in addition to structured physiotherapy improved work ability significantly. [Since it is a clinical trial, the 'conversation' and its initiation is embedded in the protocol. However, the findings strengthen the notion that effective conversations likely need to have a clear purpose, in this case improving work ability. [See also Wynne-Jones et al 2018].	Musculoskeletal	Physiotherapists
Shaw et al (2011) (19) International Discussion piece	**Addressing occupational factors in the management of low back pain: implications for physical therapist practice** There is mounting evidence that occupational factors influence the extent of sickness absence following an episode of low back pain, but there have been limited efforts to integrate the identification and management of occupational factors into the routine practice of physical therapists. Recommended strategies for evaluating and addressing occupational factors are explored with respect to the physical therapist's role in client assessment, development of activity and lifestyle recommendations, therapeutic exercise, communication with other providers, and summary reports.	Musculoskeletal	Physical therapists

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
	[Provides a useful strategy for incorporating workplace concerns into PT treatment sessions, including sample questions and worksheets].		
Simmonds et al (2012) (42) Canada Survey	**Physiotherapists' knowledge, attitudes, and intolerance of uncertainty influence decision making in low back pain** Participants were Physiotherapists. Only 12% were able to identify clinical practice guidelines for LBP. HCPs did not generally agree with recommendations to return to work or activity. Quote: 'A biomedical orientation was a significant predictor of clinical judgments of spinal pathology and was associated with an increased sense of IU. In contrast, a behavioural approach better predicted treatment recommendations for return-to-work or activity.' [Seemingly, PTs did not agree with recommendations to return to work or activity and thus, they become an obstacle for RTW by not following recommendations].	Musculoskeletal	Physiotherapists
Singh and O'Hagan (2019) (54) Canada Qualitative	**"Apping Up": Prospects for Information Technology Innovation in Return to Work Communication** During return to work (RTW), communication between health care providers and employers largely takes place through standardise paper-based forms. This study investigates, through interviews with HCPs, workers, and employers, the use of IT as alternative. A transition to an IT-mediated tool for RTW communication is supported in principle; however, major caveats exist in relation to perceived value and fit with stakeholder practice. System support and stakeholder cooperation are likely necessary to adopt the change, yet IT-mediated communication has yet to demonstrate value. [While not addressing the HCP-patient conversation, the study offers some cautious support for using IT approaches for RTW communication].	Not specified	Various
Slade et al (2015) (45) International Systematic review and meta synthesis	**Barriers to primary care clinician adherence to clinical guidelines for the management of low back pain: a systematic review and metasynthesis of qualitative studies** The clinical guidelines include "maintenance or early return to usual activities" also "enhanced guideline adherence by clinicians has also been demonstrated to improve outcomes for primary care patients' return to work self-efficacy. The review reports on a number of barriers to adherence – time constraints to do everything required, we might infer similar barriers to talking about return to work/usual activities. Also use the guidance when they have conflict with a patient (could be about work).	Musculoskeletal	Primary care clinicians

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
	"current recommendations were not practical or realistic to implement in their existing format" "Beliefs that the guidelines were not supported by research evidence and that this evidence was not sufficient to inform the guideline. Most clinicians reported minimal knowledge of guideline content and how they were derived and some were unaware of their existence" [Provides indicators about barriers in relation to guidelines / looking at references, although no data on conversations]		
Stockhendahl et al (2018) (43) Norway, Sweden and Denmark Private and NHS practice Qualitative	**Can chiropractors contribute to work disability prevention through sickness absence management for musculoskeletal disorders? - a comparative qualitative case study in the Scandinavian context** Currently, Norwegian chiropractors have legislated sickness certification rights, whereas their Danish and Swedish counterparts do not. Against the backdrop of legislative variation, they describe, compare and contrast the views and experiences of Scandinavian chiropractors engaging in work disability prevention and sickness absence management. In a comparative qualitative case study design, they explored the experience of chiropractors regarding sickness absence management. Interview topics covered include: Current role in sickness absence management, collaboration with GP/workplace etc. barriers and facilitators and future role. Chiropractors' capacity to support patients in sickness absence management revolved around 4 key issues: • issues of legislation and politics; • the rationale for being a sickness absence management partner; • whether an integrated sickness absence management pathway existed/could be created; • The barriers to service provision for sickness absence management. Conclusion: Allied health providers, in this instance chiropractors, with patient management expertise can fulfil a key role in sickness absence management and by extension work disability prevention when these practices are legislatively supported. In cases where these practices occur informally, however, practitioners face system-related issues and professional self-image challenges that tend to hamper them in fulfilling a more integrated role as providers of work disability prevention practices [Much of the information is about sickness certification rights, but illustrates influence of systems].	Musculoskeletal	Chiropractors

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
Stratil and Swincer (2012) (44) Australia Prospective cohort study	**Work-related back pain study: measuring biopsychosocial risk factors** The objective of this study was to improve the early identification of specific psychosocial risk factors that could be targeted by evidence-based medical and vocational management. The medical, physiotherapy treatment pattern have not changed over time to address risk issues as recommended in evidence guides. Given the evidence obtained in this study that psychosocial assessment can identify risk issues, which do not appear to be noted by the clinicians involved, highlights the need to develop strategies that help inform these practitioners and provide a better model of care as outlined in the recommendations [HCPs tend to take on a solely clinical approach leaving out important psychosocial issues, which emphasise the need for improving information to practitioners and models of care].	Musculoskeletal	Various
Sturesson (2014) (70) Sweden Qualitative Primary care health centre	**Healthcare encounters and return to work: a qualitative study on sick-listed patients' experiences** Explored how sick-listed patients in Sweden perceive their contact with healthcare professionals in primary healthcare and to analyse what they view as crucial components for returning to work. Participants had met different professionals at the healthcare centre. Some of the participants had only met physicians. Some patients had met a physician and other professionals such as a rehabilitation coordinator, an occupational therapist, a physiotherapist, or a social worker, and some patients, during their appointments, had contact with a team consisting of a physician and rehabilitation staff. Different diagnoses had caused the participants to take sick leave. 'Trust in the relationship' contains categories describing the patients' feelings of participation, and of being believed, confirmed, and listened to, and also dedication on the part of healthcare providers. Healthcare encounters that were characterised by professionalism, knowledge, continuity, and a holistic approach seemed to create trust. The theme 'Structure and balance' contains the participants' views on important factors that could support the return-to-work process. All participants stated the importance of follow-up and a plan for rehabilitation. Sick leave itself can make a person passive, and participants in this study asked for support to balance activity, exercise, and work demands, which could facilitate their return to work." [Info is from patient perspective, but relevant to discussion].	Various	Various

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
Wells et al (2013) (71) International Systematic review and metasynthesis	**Supporting 'work-related goals' rather than 'return to work' after cancer? A systematic review and metasynthesis of 25 qualitative studies** Macmillan Cancer Support, has recently drawn attention to the importance of vocational rehabilitation, producing a toolkit and funding a series of vocational rehabilitation initiatives. Systematic reviews of vocational rehabilitation interventions have, however, highlighted the paucity of methodologically sound interventions on the basis of existing evidence. The development of such interventions depends on a thorough understanding of the range of factors influencing return to work and work-related experiences. Synthesising the findings of multiple qualitative studies can provide such an understanding. The following questions guided the review: (1) What are cancer survivors' (a) Attitudes to work during and after cancer treatment? (b) Experiences (both positive and negative) of gaining employment, working through treatment or returning to work? (c) Strategies to overcome any challenges experienced? (2) What are the roles, attitudes and experiences of family/ carers' and/or employers' in relation to facilitating or obstructing cancer survivors' work experiences? One of the themes mentions "Positive experiences of working through or after cancer were dependent upon the provision of good organisational and/or interpersonal support. Organisational support included work-related support provided by health care professionals (HCPs), social workers and occupational health, and employers' willingness and ability to make adjustments to the workplace and job role (such as flexible working hours and shared workloads)." Authors conclude by saying "On the basis of the existing scientific literature, we have produced a conceptual model that may guide future studies in this field. In addition, our model provides a basis from which meaningful assessment tools and support materials can be developed to support return to work; it illustrates the need for clinicians to consider and ask about issues of identity, family and finance, meaning of work and work environment factors, in order to ensure a more person-centred approach to supporting the achievement of survivors' work-related goals rather than return to work per se. Finally, it underpins the need for multi-level and multi-faceted interventions, which address individual and organisational factors influencing return to work".	Cancer	Various
Werner et al (2009) (33)	**Low back pain and determinants of sickness absence** HCP competencies can form obstacles to RTW, and may be related to:	Musculoskeletal	Various

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
International Narrative review Various types of studies included	- poor communication skills - unhelpful back beliefs - healthcare system (For example lacking practice for cooperation between HCPs regarding sick listing) - gatekeeper role threatens patient-HCP relationship - conflicting demands from other stakeholders and feeling blamed for failing to make impossible reconciliations [HCP competencies, role towards patients, personal beliefs, cooperation with others (HCPs/stakeholders), and the 'ways' of the system may serve as obstacles for RTW].		
Wrapson and Mewse (2011) (72) New Zealand Qualitative study	**Does the doctor or the patient control sick leave certification? A qualitative study interpreting patients' interview dialogue** Mainly, patients experienced that they had some influence as to whether they got a sick certification. HCP response was divided into 4 types: Process (HCP decision), Cued (++Patient influence), Consultative (HCP/Patient) and Laissez-faire (++Patient influence). Thus, in most response-types patients had some/much influence on whether to issue a sick certification and for the length of time for which one is issued. [Findings suggest that HCPs tend not to take overall responsibility for the decision about sick listing].	Musculoskeletal	GPs
Wynne Jones et al (2014) (58) UK Qualitative Local physio depts. GP practices	**Perceptions of health professionals towards the management of back pain in the context of work: a qualitative study** Authors recognise that GPs and physiotherapists adopt different methods. Authors state that "the physiotherapists routinely asked patients about their job and work difficulties using a structured (protocol-driven) approach, while GPs rarely used such structured measures and were less likely to enquire about patients' work situation". [Focus how the conversation about work is started – whether it's part of a routine psychosocial assessment or first question on a proforma].	Musculoskeletal	GPs + Physiotherapists
Wynne-Jones et al (2018) (18) UK RCT	**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)** RCT of an intervention that placed a vocational advisor (VA) in the primary care team. Experimental and control practice teams were asked to provide best current (work-focused) care. The provision of best current care was supported by providing GPs and NPs with an education session lasting 1 hour. This emphasised 4 key messages: (1) work is usually good for people with musculoskeletal pain, (2) long periods of absence are generally harmful, (3) musculoskeletal pain can generally be accommodated at work, and	Musculoskeletal	Primary care HCPs

Authors (date) (ref) country setting/type	Key features [reviewers' comments in square brackets]	Condition	HCP
	(4) planning and supporting return to work are important aspects of clinical management. Patients in the experimental practices could be referred (by GP or nurse practitioner) to the specially trained vocational advisors if they were sick listed or struggling with work: they received a biopsychosocial (mostly telephonic) stepped approach to RTW. The VA intervention improved measures of work performance, presenteeism, and self-efficacy to return to work, with economic benefits. [The best-practice support sessions were intended to provide education on the health-work relationship, and encourage supportive conversations (and stimulate referrals to the VAs). It is not possible with the study design or data to know whether the best practice support sessions at the control practices encouraged supportive health-work conversations. However, the content and the delivery model (with various members of the practice team included, not just GPs) offers a template for future attempts to instill a positive health-work culture in practices. And that begs the question about the purpose of the health-work conversation and the supportive systems (in this case VAs) needed for the HCPs to engage and act. See also Sennehed et al 2018].		
Yagil et al (2018) (73) Israel Qualitative	**Health care professionals' perspective on return to work in cancer survivors** Health care professionals play a significant role in cancer survivors' decisions regarding return to work (RTW). While there is ample research about cancer survivors' views on RTW, little is known about the views of the professionals who accompany them from diagnosis to recovery. The results indicate that some health professionals adapt communication to their perception of the cancer survivors' understanding of illness implications; yet, more structured training in this regard might further facilitate the interaction with cancer survivors who tend to exaggerate or downplay illness implications. Additionally, awareness of role perceptions might elaborate professionals' views of their role. For example, physicians and nurses might be trained to engage in an open discussion with cancer survivors, acknowledging various options and engaging in a shared decision-making process. [Although focus is cancer, one of the themes is professionals' perception of their role, and discussing options and implications].	Cancer	Various

Grey literature

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
Ahuja et al (2019) (53) Council for Work and Health UK Checklist Tool	**Talking Work** The Talking Work Checklist is offered as an online desktop aid. The information in the checklist is supplemented by information about talking work with patients in the main guide. The guidance can also be downloaded as a PDF to use offline. It is anticipated that doctors will read the complete guidance first but utilise the Talking Work Checklist within their routine practice to conduct regular work-related conversations with their patient, referring back to the main guide only as a reference. Doctors are encouraged to add the recommended fit note phrases within their templates which can then be added to the fit notes as per requirement. "'Talking work' with patients doesn't have to be time consuming. It needn't take away the focus of your routine consultation which is about supporting and managing patient to manage their health condition. However, work is a key aspect of most people's lives. This guide helps you provide tools to start work related conversations. We provide suggested questions, responses to queries and recommended resources to which employers and patients can be referred for further detailed information or assistance". https://www.councilforworkandhealth.org.uk/work-modifications/ [Also refers to PHE online training programme for a wide range of HCPs, to support patients return or remain in work through work discussions during clinical interactions. It can be accessed through] [The guide contains much useful evidence-informed information and advice for doctors and other HCPs. However, its format/presentation is text-dense. There is no one-page aid or checklist as such: rather the checklist comprises 10 rather wordy items defining a (clinical consultation) process, each being linked to online guidance. A key aspect of the guide seems to be on 'considering adjustments', just what these adjustments might be and how they might be implemented is buried in the guidance text (and are not obviously linked to the 4-fit note-box options) albeit that the information is pertinent. It remains to be seen whether this guidance will attract attention and action.	Guidance	Physicians
Anon (2007) (21) UK	**Advising Patients About Work** (guidance leaflet + 1-page version for GPs and HCPs) 'Advising Patients About Work' is a DWP sponsored 6-page leaflet, primarily for GPS but equally appropriate for all HPCs. It was produced to provide HPCs with an understanding of the work-health relationship, as part of the Government's then Health	Guidance	GPs + HCPs

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
Written guidance material	Work Wellbeing agenda. The text introduced the beneficial aspects of work for health, focused on common health problems and the advantages of accommodation at work (in contrast to sickness absence). The guidance advocated discussion of the relationship between work and health and provision of suitable advice to the patient. To this end, key topics were outlined along with questions to ask during the consultation, supplemented with discussion of, and reference to, the supporting scientific evidence. To illustrate the content, the text of the 1-page version is convenient: "For most adults of working age, including people with disabilities and many common health problems, there is strong evidence that (return to) work: • promotes recovery and aids rehabilitation • improves physical and mental health and well-being • reduces social exclusion and poverty *The beneficial effects of work generally outweigh any risks of work* * There is strong evidence1 that long periods out of work can cause or contribute to: • higher consultation, medication consumption and hospital admission rates • 2 to 3 times increased risk of poor general health • 2 to 3 times increased risk of mental health problems • 20% excess mortality *The longer anyone is off work, the lower their chances of getting back to work.* * Sickness certification is a major clinical intervention with potentially serious long-term consequences. * Two-thirds of sickness absence, long-term incapacity and ill-health retirement is now due to 'common health problems' – mild/moderate mental health, musculoskeletal and cardio-respiratory conditions. Much of this should be preventable. * Common health problems can often be accommodated at work, if necessary with appropriate adjustments and support. * Planning and supporting return to work, in partnership with patients, are important parts of clinical management." This publication actually formed part of a series of 3 6-page evidence-informed guidance leaflets, freely available in PDF format. They were commissioned variously by DWP and		Workplace + workers

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
	industry to address the perceived need for simple information and advice on the relationship between work and health. Each contained the same core messages but written in language suitable for different audiences: 'Work and Health' is for managers and professionals in and around the workplace (sponsored by DWP and industry); 'Health and Work' is for workers (and is supplemented with a priced 20-page booklet). All 3 leaflets were developed collaboratively with the relevant audiences, and were evaluated and amended before publication. The intention at the time was that these leaflets would be broadcast among and between the players, and form a resource that all 3 groups could use to encourage health-work conversations, and support use of the fit note. [In the event, the initiative ground to a halt, though all the publications remain available from TSO]. Linked to: Burton, K and Waddell, G. Health and Work (advice leaflet and booklet for worker/patients). London, TSO, 2007 Waddell, G and Burton K. Work and Health (advice leaflet for workplaces). London, TSO, 2007 [See also Parker et al 2015, feasibility trial]		
Black (2008) (74) UK Policy Review	**Working for a healthier tomorrow. Review of the health of Britain's working age population** This review sought to establish the foundations for a broad consensus around a new vision for health and work in Britain. That vision can only be achieved with the active commitment of all the key players (HCPs, people; workplaces/employers). The review noted key challenges, among which is that GPs [and by extension, other HCPs] often feel ill-equipped to offer advice to their patients on remaining in or returning to work. Their training has to date not prepared them for this and, therefore, the work-related advice they do give, can be naturally cautious. It was recommended that GPs and other healthcare professionals should be supported to adapt the advice they provide, where appropriate doing all they can to help people enter, stay in or return to work. It was advised that Government should launch a major drive to promote understanding of the positive relationship between health and work among employers, healthcare professionals and the general public. [This highly influential review achieved much, but the need to help health professionals to understand and deliver advice on the positive relationship between work and health remains largely unrealised].	Gov't policy	Various

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
Black, C. and D. Frost (2011) (75). DWP UK	**Health at work – an independent review of sickness absence** To help reduce the 140 million days lost to sickness absence every year, the government set up a review of the sickness absence system. One of the key recommendations was that Government should fund a new Independent Assessment Service to provide advice about how an individual taking sickness absence could be supported to return to work. It should be provided by approved health professionals, and should usually be accessed when an individual's absence spell has lasted around 4 weeks. This was proposed to improve the effectiveness of medical certification and encourage early positive intervention.	Gov't policy	Various
Burton and Waddell (2007) (48) UK	**Health and Work** (advice leaflet and booklet for worker/patients). This was part of a series of 3 6-page evidence-informed guidance leaflets, freely available in PDF format. They were commissioned variously by DWP and industry, each containing the same core messages but written in language suitable for different audiences: 'Work and Health' is for managers and professionals in and around the workplace (sponsored by DWP and industry); 'Health and Work' is for workers (and is supplemented with a priced 20-page booklet). All 3 leaflets were developed collaboratively with the relevant audiences, and were qualitatively evaluated and amended before publication. The intention at the time was that these leaflets would be broadcast among and between the players, and form a resource that all 3 groups could use to encourage health-work conversations, and support use of the fit note. [In the event, the initiative ground to a halt, though all the publications remain available from TSO] Linked to: Anon. (compiled by G Waddell, K Burton). Advising patients about work (guidance leaflet for GPs and other healthcare professionals). London, The Stationery Office, 2007 Waddell, G and Burton K. Work and Health (advice leaflet for workplaces). London, TSO, 2007 [See also Parker et al 2015 feasibility trial]	Guidance	n/a
Burton, K., et al. (2013) (7) DWP UK	**Telephonic support to facilitate return-to-work: what works, how, and when?** To inform the advice service proposed by Black and Frost (2011), a review was commissioned to provide an evidence base for the use of telephonic assessment and support to facilitate timely return to work for people with common health problems.	Gov't policy	Various

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
	Robust evidence was found that, when properly implemented, telephonic case management approaches can aid early return to work and reduce overall case costs.		
Canadian Medical Association (1997/2013) (76) Canada Professional policy statement	**The treating physician's role in helping patients return to work after an illness or injury (1997, update 2013)** The CMA recognises the importance of a patient returning to all possible functional activities relevant to his or her life as soon as possible after an injury or illness, and notes the increasing level of responsibility placed on the treating physician in the RTW process. This policy document addresses the role of the treating physician in assisting patients to return to work after illness or injury. It is stated that the treating physician's role is to diagnose and treat the illness or injury, to advise and support the patient, to provide and communicate appropriate information to the patient and the employer, and to work closely with other involved health care professionals to facilitate the patient's safe and timely return to the most productive employment possible. It is recognised that fulfilling that role necessitates an understanding of the patient's roles in the family and workplace. It also requires the treating physician to understand the importance of the employee-employer relationship, and give appropriate support. There is also a need to understand the roles of RTW coordinators, other HCPs, and HR in promoting and assisting RTW. The role of the employer is recognised, particularly in the provision of modified work arrangements, along with the importance of communication (between all 3 players – worker, employer, and clinician) and coordinating actions. [The focus is on the treating physician, who is unlikely to be an occupational specialist. Nevertheless, the expectations are substantial. The policy explains the expectations but does not provide detail on how RTW support should be initiated or implemented].	Clinical guidelines	Various
Cardone, A (2017) (52) Supplement Dudley C, Donnaloja V, Steadman K. A guide for health care professionals to have conversations on work with people	**Having the conversation about work with people with multiple sclerosis: a guide for healthcare professionals** A guide for healthcare professionals on having conversations about work with people with MS has been developed through the 'Ready for Work' project [1]. Work should be considered as a clinical outcome. The focus should be on what patients can do, rather than what they cannot do, at work. Effective communication is fundamental in supporting patients' return to work. The 'Ready for Work' project was implemented by the Work Foundation and the European Multiple Sclerosis Platform (EMSP). Taking the position that 'good' work is beneficial to all, including individuals, employers and the community, the Foundation	Guidance	MS HCPs

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
with multiple sclerosis. Why and how should HCPs talk to people with MS about work?	develops evidence and translates it into a language that is accessible for policymakers and other stakeholders in the form of policy papers and factsheets. The guide for Health Care Professionals to start the conversation about work with people with MS was produced to reflect the current wide range of evidence about the inter-relationship between health and work, a relationship which neurologists and other healthcare practitioners have a key role in addressing. The guide was developed based on solid academic evidence. An extensive literature review and policy mapping activity was performed, involving an expert panel that included neurologists, MS nurses, patients and advocates. Feedback was obtained from people with MS. The guide has been endorsed by the European Committee for Treatment and Research in Multiple Sclerosis (ECTRIMS) and Rehabilitation in Multiple Sclerosis (RIMS). The 'Ready for Work' guide can be downloaded from the Work Foundation [2] and EMSP [3] websites. www.theworkfoundation.com/wp-content/uploads/2017/02/414 ReadyForWork-MS-HCP-Guide.pdf Effective communication between healthcare providers and people with MS Healthcare practitioners play a vital role in helping people with MS understand and manage their condition, including supporting them in returning to work and being productive in society. Effective communication is fundamental. It can help improve adherence to treatment and healthy behaviours, both of which facilitate the ability to work. Returning to work requires a partnership approach, involving collaboration between the individual, the employer and the clinician. Work should be discussed as a recovery goal with people with MS. Early and effective intervention is important to ensure that people with MS can go back to work as soon as possible. The type of work a person with MS does must also be considered when deciding on treatment options. The treatment selection process may provide an ideal opportunity to start the conversation about work. People with MS may inquire about how and when to disclose their condition to their employer; this is a highly personal decision. Issues for discussion include the need for workplace disclosure before the person can receive support from colleagues and employers and, conversely, the fact that disclosure may incur the risk of discrimination. It may be appropriate to suggest that the patient seeks professional advice from a patient organisation or trade union. Although various health and work policy stakeholders are involved in workforce health (Figure 1), healthcare professionals have a key role in addressing the topic of work with their patients.		

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
Clarke, J and Fletcher, A (2018) (77) Evaluation Report UK	**Working Well (GMCA).** As part of the Greater Manchester (GM) devolution agreement, the Working Well project was launched to support people with health conditions and/or disabilities who were long-term unemployed to return to employment. The project was soon expanded to include GP recommendations as routes into the programme, and currently Working Well Mental Health IAPT support is being provided by GM West NHS Trust. In 2018, Working Well was continued as a localised version of government's new Work and Health Programme (DWP/DH, 2016). A new Early Help programme geared to support and advise individuals with health conditions or disabilities who are at risk of falling out of work, or are newly unemployed due to their health complications and/or disabilities is planned for 2019.	Evaluation	GPs / IAPT
Department for Health and Social Care (2018) (78). UK	**Prevention is better than cure. Our vision to help you live well for longer** This document sets out a vision for putting prevention at the heart of the nation's health. Government's mission is to improve healthy life expectancy so that, by 2035, there are at least 5 extra years of healthy, independent life, while closing the gap between the richest and poorest. The workplace is referred to as a setting for prevention and health promotion, in recognition that work is linked to health, and that HCPs need to change their approach and mind set from treating symptoms to the whole person within their environment. Better integration between health and employment support services to help people with health conditions to enter and stay in work is called for.	Gov't policy	Various
Department for Work and Pensions (2013) (79). UK	**Fitness for work: Government's response to 'Health at work – an independent review of sickness absence.** The government accepted a number of the recommendations from the Black and Frost (2011) review, including the introduction of an occupational health assessment and advice service that GPs, employers and workers could access/refer to after 4 weeks sickness absence from work.	Gov't policy	Various
Department for Work and Pensions and Department of Health (2016) (80). UK	**Improving Lives: The Work, Health and Disability Green Paper**. This sets out the nature of the problem and why change is needed by employers, the welfare system, and healthcare providers as a whole-system. Some of the relevant areas for action included reinforcing work as a health outcome in commissioning decisions and clinical practice, ensuring good quality conversations about health and work, and improving how fit notes work.	Gov't policy	Various

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
Department for Work and Pensions (unpublished) (81) UK	**The fit note in practice: benefits and challenges: An evidence synthesis** A major initiative to influence a cultural shift in understanding of the health-supportive aspects of work, the fit note replaced previous sickness certification to allow doctors to provide advice to their patients about how they might be able to return to work while they recover. The fit note was also intended to facilitate a discussion with employers to support employees in work/to return to work as soon as possible, and in relation to the implementation of the NICE 2009 guidance, it was suggested that the fit note raised the stakes in consultations for conversations about work and the implications of prolonged absence (Gabbay et al, 2011). Since it was introduced, DWP have commissioned several studies to evaluate its use, the most recent concluding that the fit note has facilitated GP discussions with patients around returning to work, but the detail and quality of these varies considerably. Also see Hann and Sibbald, 2011.	Evaluation	GPs
DWP-DHSC (2017) (2) UK Command paper	**Improving lives. The future of work, health and disability** Government response to Green Paper reflecting their stated vision of having one million more disabled people in work over the next 10 years. This replaces the pledge to halve the disability employment gap outlined in the Green Paper. The strategy emphasises the need to join up the 3 relevant settings – the workplace, welfare and healthcare, which in itself has implications for the communication between all 3. But there are separate stated aims for each 3 systems, and those for the healthcare system are: • healthcare professionals ready to talk about health barriers to work; • timely access to appropriate treatments; • effective occupational health services, within but also beyond the NHS, giving access for everyone including small businesses and the self-employed; • a focus on prevention and early intervention. "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. A consultation should include discussion about when it is possible for them to return to work; what adjustments might be necessary; and how to manage their health condition or disability in work. This is part of a broader effort to think differently about disability and health - including focussing more on what the person can do rather than what they can't,	Gov't policy	Various

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
	as well as trying to find solutions to the challenges the health condition presents to the patient's life, including work". "To help support and prompt conversations about work we want to encourage the more routine collection of employment status on current health data systems – in as light touch a way as possible" [Conversations about work in healthcare settings, and promoting 'work as a health outcome' are current key government positions. Several areas of activity/proposed activities, but no definitive outcomes yet. Links directly to the need for our project – perhaps too early to say?]		
Gabbay et al (2011) (82) UK Guidelines	**NICE guidance on long-term sickness and incapacity** Sickness absence is a growing concern, and GPs remain at the centre of solutions to manage certification and signposting for advice and support. The guidance, originally published in 2009, was intended for primary care services and employers. It identified early intervention, multidisciplinary approaches, and a workplace component as important components of effective interventions to reduce sickness absence. It advised that HPCs should consider the impact of intervention and management on work ability for patients of working age. GPs need to be more aware of their patients' employment (or worklessness, and the impact of health and illness on the central aspect of their lives. Initiatives such as the fit note raise the stakes in consultations for conversations about work and the implications of prolonged absence. [This guideline is under review/update. Presumably, there will be the opportunity to consider any required changes in HCP behaviours that are needed to better engage patients in conversations about work and health]. While clinical and other guidelines maybe necessary for changing HPCs behavior, they are not sufficient.	Clinical guidelines	Various
Gloster, R., et al. (2018) (83) Department for Work and Pensions	**Fit for Work: Final report of a process evaluation** The Fit for Work Service was the Government's implementation of the Black (2008) proposal for an occupational health assessment and advice service for employees who were on (or at risk of entering) long-term sickness absence, defined as 4 weeks or more, via a referral through their GP or employer. Participation was entirely voluntary. Employees giving their consent took part in a biopsychosocial assessment, primarily conducted by telephone. After assessment, a Return to Work Plan would be produced, with recommendations for self-care, workplace adjustments, and/or signposting to further specialist support and therapy services to assist the employee's return to work. With the employee's consent, the plan could be shared with their employer and/or GP. Following very low referrals, Fit for Work came to an end in 2018. However, employers,	Evaluation	GPs/ employers

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
	employees and GPs continue to have access to the same Fit for Work helpline, website and web chat, which offer general health and work advice, as well as support on sickness absence. Employers found the service helpful and easy to use, but GP awareness of, and engagement with the service was generally low. [Arguably, the service was not marketed adequately, and the provider was not given adequate funding or support with staff training. The latter created questions over correctly identifying individuals' obstacles to work, the quality of return to work plans, a paucity of workplace contacts, and limited follow-ups].		
GOV.UK (2015). Department for Work and Pensions.	**National Educational Programme for GPs.** Supported by the RCGP, this national programme was intended to guide GPs on the use of the fit note. The intention was to provide training to around 10% of GPs, with an expectation that the messages would gradually propagate through the profession. The evidence-informed one-day training events were delivered by a dedicated team who covered topics such as the work-health relationship and motivational interviewing as well as the practicalities of the fit note. Evidence-based guidance (developed and evaluated with GPs and sponsored by DWP) was sent to all GPs to support the training programme and assist discussions about work and health (Waddell and Burton, 2007).	Education	GPs
Hann and Sibbald (2011) (23) UK DWP	**General Practitioners' attitudes towards patients' health and work** Based on questions in the General Practitioner Worklife Survey. The authors concluded that GPs across Great Britain essentially agree that work is generally beneficial for people's health and that worklessness is generally detrimental. Most GPs felt that they had a proactive role to play in helping patients return to work. A majority of GPs agreed that the fit note had had a positive impact on the quality of their consultations and outcomes for patients. Positive impacts were more likely to be reported by GPs who reported higher levels of confidence in dealing with patient issues around a return to work. The vast majority said there was a lack of good local services to which they could refer patients for advice and/or support about a return to work. 10% of GPs in England had had training in health-work in the past year (20% in Wales and Scotland): those who had training were more confident in dealing with issues around return to work. It was noted that GPs with low levels of job satisfaction had more negative views on work and health. Most of the GPS agreed that the fit note had had a positive effect on the quality of consultations and outcomes for patients. [It seems that the GPs wished for good local services to which they could refer to support the RTW process, but there is no information on how that affected their consultations].	Gov't research	GPs

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
Department for Work and Pensions (2008) (84)	**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.** The government's response to the above report set out plans to change attitudes towards health and work. These included replacing sickness certification with the fit note, a related national educational training program for GPs, the Fit for Work Service pilots, and embedding employment advisors in IAPT and GP surgeries.	Gov't policy	Various
ICF 2017 (35) UK PHE	**Mapping the coverage of health and work topics in healthcare and business undergraduate and postgraduate degree courses in England** This study for PHE was based on the recognition that (a) GPs, while recognising they have a role in helping work ability, many do not feel confident; (b) too many employers do not consider health and wellbeing their role; (c) the importance of health and wellbeing in work needs to be covered in undergraduate and postgraduate training. In essence, the study found that health and work topics were not well covered (across a variety of measures) during training, both in HCP studies and in business studies. The research suggests there is a need to promote the importance of all health and work topics to HEI course leaders. Among other things, it is particularly essential to highlight the importance of work as a tool for improving health, as course leaders may be encouraged to include more content on health and work if they perceive it to have significant positive health outcomes. [This study indicates a past issue that perhaps underlies the current relative lack of HCPs seeing work as an important health outcome. It points to the need to rethink some aspects of HCP training if the work-health agenda. Whether that will transpire to be both necessary and sufficient remains to be seen].	Education	Various
Jurisic et al (2017) (46) American College of Occupational and Environmental Medicine	**The Personal Physician's Role in Helping Patients with Medical Conditions Stay at Work or Return to Work** A comprehensive position paper with guidance for personal clinicians around their role in minimising life and work disruption resulting from new injury or illness, changes in chronic health conditions and existing disabilities, or the advance of age. It is important for the clinician to appreciate the (now) recognised benefits of work. It is implicit that the role will involve conversations about health and work. The clinician should encourage patients to minimise life disruption due to health problems – this includes finding ways to stay at work, or returning as soon as medically appropriate using transitional work arrangements. Numerous clinical actions are recommended,	Clinical guidance	Physicians

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
USA	including detailed recommendations for graded activity increases, including work. This requires discussion with patient and employer, as well as providing information and advice. Personal clinicians are in a good position to influence patient and employer expectations, identify obstacles to working, help find transitional work arrangements/modified work to facilitate RTW. These issues should be discussed/tackled early in the course of treatment. [While considerable detailed guidance for the clinician is given, which necessarily involves conversations between patient and clinician, it is expected those conversations should, can, and will happen (assuming local system obstacles are not preventive)]. [This is at typical example of clinical guidance where the role of clinicians at the work-health interface is discussed and action is advocated on the basis that work is important for health and that work should be a clinical outcome. In common with many other clinical guidelines where work is considered, it is assumed the actual clinical conversations will take place – the interest is on what the clinician can and should do].		
Kosny et al (2016) (25) Institute for Work and Health Canada	**The role of health-care providers in the workers' compensation system and return-to-work process: Final Report** In general terms, while HCPs have a key role in RTW, pressure on time, administrative challenges and limited knowledge about the workplace can thwart meaningful engagement. It was found that HPCs dealt well with the workers' compensation system for workers with visible acute injuries and the like, but struggled with patients who had multiple injuries, gradual onset illness, chronic pain and mental health disorders - the HCPs found the systems confusing and ill-suited. Administrative hurdles, disagreements about medical decisions and lack of role clarity impede the meaningful engagement of health-care providers in RTW, which results in challenges for injured workers. The authors concluded the study raises questions about the appropriate role of health-care providers in the return-to-work process. They recognised that general practitioners (and other non-occupational HCPs) who have not had training in the area of occupational health or disability management and do not understand how the workers' compensation system functions are likely to struggle with this role. It was noted that although HCPs recognised that RTW is important, they suggested there were instances when early RTW was not appropriate, with many describing instances (such as pain) when they felt that early RTW might ultimately delay recovery and have a negative impact on long-term RTW outcomes, and individual circumstances come into play. The authors recommended that workers' compensation policy-makers, health-care providers, along with other stakeholders (such as injured workers, employers, unions),	Gov't policy	Various

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
	engage in a dialogue to identify clear guidelines related to the role of health-care providers in the workers' compensation and RTW process. [Although this review concerned the Canadian workers' compensation system, factors that may impeded meaningful and helpful discussions that HCPs may have about RTW seem somewhat generic: a combination of role identity/lack of (suitable) knowledge and system barriers].		
Main et al (2012) (41) UK Narrative review	**Engaging patients in their own care for back care: the role of education and advice in the prevention of chronic pain and disability** HCP's attitudes and beliefs are linked to their reported practice behaviour such as advice to patients about returning to work. Those with high biomedical orientations and low behavioural orientations are much more likely to advise continued work absence than those with high behavioural and low biomedical orientations. Colloquial myths, which act as obstacles to recovery and participation are still held by some HCPs, irrespective of discipline. 'The growing body of literature suggests that the attitudes, beliefs and preferences of HCPs, might serve as a barrier to optimal patient outcomes.' [When HCP beliefs are based on a biomedical orientation and colloquial myths, they themselves become an obstacle for recovery and return to work for the patients that they encounter].	Guidance	Various
Martin et al PHE- RCOT (2018) (36) UK Research report	**Health and Work Champions: a pilot training programme. Project evaluation report** Royal College of Occupational Therapists and Public Health England 'Health and Work Champions Project', featuring peer-to-peer education to shift healthcare culture around work and health. Pilot project, using Health and Work Champions, within NHS organisations across England, to deliver peer-to-peer training sessions to NHS colleagues. Training, delivered by the Champions, designed to (1) provide information on the work-health relationship and benefits of employment for patients; (2) encourage colleagues to ask questions about work as part of routine functional assessment; (3) develop colleagues' skills to offer brief advice and refer/signpost patients for work-related support. Training in taking on the role of a Champion given to range of HCPs (n= 487). Training was developed as a standardised 1 hour (half didactic PowerPoint, half case study) session – in reality, for this pilot, the case study often not used and PowerPoint tended to be less than 30 minutes.	Evaluation	Various

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
	The Champions were tasked with targeting medics and nurses as a priority and one in 4 of the participants were Medics (25%), closely followed by Occupational Therapists (23%), Physiotherapists (16%) and Nurses (14%). The evaluation was to assess the impact of the training on those who were trained and the impact of taking on the role of Health and Work Champion, on the individuals concerned. Summary of the findings in relation to the evaluation objectives: • The training had a positive impact on attendee's knowledge of: o the link between work and health and the potential benefit of employment for patients/service users o how to raise the work question • The training did not impact the attendee's knowledge of: o how to develop work-related health outcomes o when / where to signpost to specialists and other resources. • The training positively influenced the attendee's confidence in relation to engaging in work conversations and taking steps towards supporting / guiding patients/service users with work problems. • The training had no impact on supporting patients / service users in achieving work-related health outcomes through specific interventions, such as providing work related advice to patients / service users or referral to work services. • The role of champion had a high positive impact on the Champions' personal and professional development. Suggested that future evaluators could: (a) audit a random sample of patient / service user records to establish any work-related practice changes; (b) ask patients whether they have been asked about work during routine appointments (subject to ethical considerations). It was concluded that the training has been effective in raising awareness of the benefits of work, in providing information about how to ask questions about work and raising confidence to ask those work questions. It was recommended that the Health and Work Champions project is continued		

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
National Institute of Clinical Excellence (2009) (85)	**Workplace health: long-term sickness absence and incapacity to work.** Relevant recommendations included healthcare commissioners ensuring GPs have referral mechanisms to occupational health services, and that HCPs incorporate DWP's 'Advising Patients About Work' leaflet (Anon, 2007). The guidance advocates provision of suitable advice to patients to help them stay in work/return to work and identified early intervention, multidisciplinary approaches, and a workplace component as important components of effective interventions to reduce sickness absence. It advised that HCPs should consider the impact of intervention and management on work ability for patients of working age, and that GPs need to be more aware of their patients' employment (or worklessness, and the impact of health and illness on the central aspect of their lives. While the guidelines recognise that HCPs are in a prime position to administer the latest evidence-based advice on work, there is only sparse and conflicting evidence demonstrating the successful implementation of guidelines, a phenomenon observed across several different countries (Bartys and Stochkendahl, 2018). These guidelines are currently being updated and is due to be released in 2019.	Clinical guidelines	Various
Parker et al (2015) (37) UK Research report	**Work for Health Programme. Healthy Work Conversations. Project Evaluation Report** Greater Manchester GMPHN commissioned project.: (1) to train 180 Allied Health Professionals (AHP) and Psychological Wellbeing practitioners (PWP) on principles of Work for Health and use of advisory fitness for work assessments; (2) enable and empower AHPs and PWPs to transfer principles into practice and cascade to teams; (30 to influence and change practice. Training covered rationale for work as a health outcome, importance of early conversation about work, identification of obstacles to work and health, planning for staying at/return to work, and liaison with key stakeholders. Programme was well received. A meaningful positive shift in in practitioner perceptions and intentions to change practice, along with increased confidence about having healthy work conversations. Follow-up found some change in practice and reinforced the shift in confidence levels. Recruitment across 9 of 10 GM Local Authorities was not problematic: considerable interest from practitioners. Delivery was single day training. Training content: this seems to be in the original proposal – suggest Chris can add an outline here. Basically, study shows it is possible to train HCPs in healthy work conversations, and that the training is likely to have a positive effect on intent, confidence and practice. Roll	Evaluation	AHPs

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
	out (with modifications) and inclusion of other professions as well as workplace is recommended. [Starts from the rationale that HCPs sometime will give inappropriate advice about health-work, that approaches to work rehabilitation are inconsistent (at practitioner and community levels, that HCPs do not routinely include work as a health outcome, that there is a mismatch between attitudes and beliefs of service users v HCPs over who should start the conversation about work, and lack of clarity about what they should do once the topic is raised.		
Parker et al (2015) [unpublished] (50) UK Research Report	**Evidence-based information and advice to reduce sickness absence: a feasibility study for a clinical trial in physiotherapy practice** A series of evidence-informed leaflets, 'Health and Work', 'Work and Health', and 'Advising Patients About Work' were developed by Waddell and Burton (2007), commissioned by The Department of Work and Pensions and other stakeholders. The purpose of the leaflets is to address myths and educate the public, employers and healthcare professionals, with a view to influencing sickness absence behaviours. These have been end-user evaluated for comprehensibility and acceptability (Waddell and Burton, unpublished data). This feasibility study will test out the research methods and design for a larger multi-centre RCT that will examine the effectiveness of the Waddell and Burton (2007) series of leaflets when added to routine physiotherapy management. It is hypothesised that the information and education they provide will empower physiotherapists and patients with MSDs to change their beliefs and behaviours in relation to work and health and decrease sickness absence levels due to MSDs. There are potential long-term gains here also, influencing future work related behaviours in any subsequent recurrence or new MSD. This feasibility study was not intended to test the effectiveness of the leaflets. A randomised controlled trial of the leaflets in physiotherapy practice is feasible, with modifications to the original protocol based on lessons learned. Sample size calculations were performed, and data are available from the authors to inform a future trial. [The value of this project is to introduce the 3 leaflets, which were specifically commissioned and developed to address the issue of encouraging health-work conversations among the key players (worker; workplace; healthcare. The leaflets are available as free PDF downloads from TSO. See also Anon (2007)].	Commissioned research	AHPs

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
Pearce-Smith, N PHE (2018) (86) UK Evidence briefing	**Knowledge and Library Services (KLS) Evidence Briefing. What is the impact of job loss and unemployment on the physical and mental health of older adults, and how can they be supported back into work?** This briefing (based on summary of best available evidence 2006-Feb 2018) looks at how job loss and unemployment impacts on the health of older adults, and how professionals can support them to return to work. GPs have a vital role in supporting the health or working people and enabling them to stay in or return to work. Unclear role definition, lack of training in occupational issues, and lack of communication with workplace are barriers. Enablers include high worker motivation, positive employer-worker relationship, availability of suitable modified duties, and GP education on occupational issues. Lack of collaboration (understanding) between stakeholders is a barrier to conversation as well as RTW. [Generically, the conclusions are that older workers should be supported to remain in or return to work, and that HCPs (in this case GPs are the focus) have pivotal role. There are, though barriers to health-work conversations]. [Several online learning resources for GPs on work-related ill-health and RTW have been developed including: Electronic, Experiential, Learning, Audit and Benchmarking (EELAB), The Health and Occupation Reporting (THOR) network, Health e-Working and the Health and Work Training Resource. See PHE (2018b)]	Commissioned research	GPs
Pearce-Smith, N PHE (2018) (28) UK Evidence briefing	**Knowledge and Library Services (KLS) Evidence Briefing. What are the methods for improving mental or physical health after a transition from unemployment to employment in those with a long term condition or disability?** This briefing (based on summary of best available evidence 2008-March 2018) looks at the recent evidence on interventions for improving mental or physical health on returning to work, for those with a long-term condition or disability. It is acknowledged that supporting people with chronic conditions can result in improved health, work, and economic outcomes. GPs, RTW professionals and other stakeholders do not always collaborate. Recommendations for healthcare professionals assisting in RTW for people with long term conditions include: earlier diagnosis and interventions, timely appointments, asking working age patients about their employment aspirations as early as possible, increasing clinical assessments of the impact of comorbidities, and signposting patients to self-management support resources which focus on employment outcomes.	Commissioned research	Various

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
	[Generically, the conclusions are that people with long-term conditions should be supported to remain in or return to work, and that HCPs have pivotal role: the article gives a few recommendations regarding the health-work conversation]. [This briefing has been written to inform the development of a series of work-related e-learning modules - see PHE (2018a)].		
PHE (2018) (32) UK Policy report Survey	**Embedding Work as a Health Outcome Professional Survey. How far are we?** As part of PHE's programme to support HCPs to feel confident in promoting work as a health outcome, this survey aimed to understand attitudes, knowledge and practice around health and work across HCPs. Web-based anonymous survey with possible selection bias to respondents who have an interest in the topic. AHPs 64% (mostly OTs); doctors 7%; nursing 25% Key findings: HCPs understand the relationship between work and health, and the majority (of respondents) are already asking about employment status as part of clinical histories. 95% agreed that work was generally beneficial for health. 87% agreed that worklessness was detrimental for health. About 9% agreed that the NHS has a responsibility to support people working with health conditions in the workplace. Attitudes to health and work were similar across HCP groups. The majority of respondents agreed that HCPs do play a role in discussing health and work with patients. The majority of doctors, registered nurses, and allied health professionals agreed it was part of their role to signpost to work-related information, but less than half of nursing/healthcare assistants agreed. Training in health and work during undergraduate study was limited apart from among OTs. Over three-quarters had had no training in the last 12 months. The data were consistent with the assumption that only HCPs whose role directly involves occupational health would receive any training in clinical conversations on health and work. The data support the idea that OTs are already well placed to have conversations with patients about the health benefits of work, due to their understanding of the relationship and their existing training in this area. Lack of time (mainly for doctors) is a barrier to health-work conversations, so professions with longer clinical contact times are in a better position to offer in-depth discussions. Although most respondents were confident about discussing health	Commissioned research	Various

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
	benefits of work, they were less confident about referral to local resources, suggesting a need for larger joined-up systems. The need for training was a recurring theme. Those with recent training were more likely to see conversations about work as part of their role, and more confident over signposting.		
Sinclair et al (2012) (87) DWP UK	**Evaluation of Occupational Health Advice Lines evaluation: Final report** This service was designed to provide small and medium-sized businesses (SMEs) with access to early and high quality occupational health (OH) advice. It ran as a telephone-based service across Great Britain, and was made available to GPs after the launch of the Fit Note to assist with any queries they had about OH issues related to their patients. At the end of the pilots in 2011, it was reported that employers found the service helpful, but GPs calling about patients made relatively limited use of the service, making up 6 per cent of all calls.	Evaluation	GPs and employers
Solutions Research (2018) (38) UK Research report	**Work as a Health Outcome Report** Two research projects were commissioned by the WHU between September 2017 and June 2018 to understand the culture and mindset of a range of different HCPs, including AHPs around work as a health outcome. This report details the findings of both projects (qualitative market research and stakeholder workshop). Key insights include: • Despite an appreciation of the benefits work, the idea of working being a specific outcome is not necessarily the key driver within consultations, and HCPs invariably frame conversations about work based on clinical indicators and judge readiness to work on this basis. • A range of factors impact on discussions with patients, and influence the priority of work-related discussions within a consultation, and the complexity of these discussions. These factors include the following: o HCP role and remit o Setting - primary versus secondary care o HCP confidence in the subject matter and in occupational health o Condition specific issue such as severity, history, stage etc o Patient relationship with HCP o Patient goals and receptiveness to returning to work	Commissioned research	Various

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
	○ HCP time available ○ HCP desire to avoid patient conflict • HCPs and AHPs appear to be supportive of encouraging patients who present an open door to work, if it is suitable within the patient's recovery, has a health benefit to the patient, or is a patient goal. There is a fine balance however, when it comes to patient presentations and HCPs want to be clinically led in their discussions. • Although OTs are identified as particularly keen to actively encourage patients back into work, other HCP and AHP groups can be less keen to engage in detailed discussions about work and logistics as they do not feel they have the up to date knowledge or the time to dedicate to this. Certain HCP/AHP groups therefore may feel better suited to providing support, encouragement, and signposting to the relevant sources of information rather than pro-actively encouraging work. • Employers were identified as an unknown entity, with some cynicism over the impact of any recommendations to employers. Ultimately, if either the patient or the employer does not wish to do anything, then the HCP is unable to force action. • HCPs identified a wide range of potential solutions and wider strategies that they believed could help to support better conversations and outcomes around work and health. These are clustered into 3 broad categories, summarised below: ○ Cultural awareness: to address issues around mindset; this included ideas for the public and HCPs as well as patient information ○ Fundamental solutions: to address problems around time, knowledge and capacity; this included ideas around funding support, a tiered service and community resources ○ System change solutions: to address problems around process issues; this included ideas around changes to the fit note and patient input into the fit note When shown 3 typologies of approach (firm negotiator; soft negotiator; non-interventionist) most of the sample identified with the more passive approaches, offering soft encouragement, not pushing work unless it was an overt patient objective. Additionally, they did not see themselves well informed to give detailed information. Essentially, the HCPs/AHPs said they did not want their role to include involvement with the detail practicalities of RTW, which would take time away from their clinical role. Overall, they saw themselves as facilitators focused on support, opening conversations, and signposting rather than giving concrete advice.		

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
	Patient-facing literature was positively received and could be used as part of a conversation or given out to patients so they had something practical to take away. It was thought that work-supportive literature could be helpful for those HCPs who felt uncomfortable raising the work issue or who were short on time or knowledge. It was felt that up to date information and advice would be useful for the HCP to read as well as the patient. In addition, the HCPs felt that in order to support patients effectively, they need to know where to signpost patients to what was available locally. [The overriding theme seems to be that HCPs/AHPs accept the potential benefit of working, but are reluctant to let a health-work conversation interfere with their clinical role. They feel somewhat bereft of knowledge, and want help (literature and signpost destinations) in dealing with the work issue].		
Sylvain (2017) (88) Canada	**Supporting a return to work after a work stoppage due to a depressive disorder: why and how to do it in primary care?** The purpose of the article is to provide guidance to primary care providers by answering the following question: Why and how should primary care providers support RTW after a work stoppage due to a depressive disorder? A lot of the content refers to evidence about why. The how section talks about RTW coordinators and issues relating to the workplace. In addition: "These practices involve the active participation of the person in sick leave and his supervisor, but the participation of health care workers is also very important. For example, they can help to implement these practices by encouraging the person who is off work to maintain contact with their work environment, whether with colleagues or supervisors". [Of some relevance albeit the focus is more about the content and purpose of the conversation than initiating it].	Guidance	Primary care
Tran, A PHE (2018) (47) UK Evidence briefing	**Knowledge and Library Services (KLS) Evidence Briefing. Does remaining in work benefit those with musculoskeletal conditions?** This briefing recognises the health benefits of work generally, and the need for supporting people with musculoskeletal disorders to return to work. RTW support should include the development of guidelines/checklists on how HCPs can engage with employers and workplaces, supervise vocational issues, and provide long-term follow-up in relation to the patients' work.	Commissioned research	Various

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
	[Generically, the conclusions align with a need for HCPs (along with other stakeholders) to support people with musculoskeletal problems to remain in or return to work, but little evidence presented on just how that support can be initiated and given].		
Waddell and Burton (2007) (49) UK	**Work and Health** (advice leaflet for workplaces). This was part of a series of 3 6-page evidence-informed guidance leaflets, freely available in PDF format. They were commissioned variously by DWP and industry, each containing the same core messages but written in language suitable for different audiences: 'Work and Health' is for managers and professionals in and around the workplace (sponsored by DWP and industry); 'Health and Work' is for workers (and is supplemented with a priced 20-page booklet). All 3 leaflets were developed collaboratively with the relevant audiences, and were qualitatively evaluated and amended before publication. The intention at the time was that these leaflets would be broadcast among and between the players, and form a resource that all 3 groups could use to encourage health-work conversations, and support use of the fit note. [In the event, the initiative ground to a halt, though all the publications remain available from TSO]. Linked to**:** Anon. (compiled by G Waddell, K Burton). Advising patients about work (guidance leaflet for GPs and other healthcare professionals). London, The Stationery Office, 2007 Burton, K and Waddell, G. Health and Work (advice leaflet and booklet for worker/patients). London, TSO, 2007 [See also Parker et al 2015 feasibility trial]	Guidance	Various
Waddell et al (2008) (9) UK Policy Review	**Vocational rehabilitation: what works, for whom, and when?** This review defined vocational rehabilitation as "whatever helps someone with a health problem to stay at, return to and remain in work". Effective vocational rehabilitation depends on work-focused healthcare *and* accommodating workplaces. To make a real and lasting difference, both need to be addressed and coordinated. It requires both healthcare and workplace elements to take a proactive approach to helping people with health problems return to work (rather than focusing on 'treatment' and 'sickness absence management' respectively). Vocational rehabilitation should be underpinned by education to inform the public, health professionals, and employers about the value of work for health and recovery. [While the report called for help to provide advice, training and support for HCPs, it did not actually spell out what was meant by work-focused healthcare, but it is implicit that	Commissioned research	Various

Authors (date) (ref) Country Type	Key features [Reviewers' comments in square brackets]	Topic	HCP
	work-focused healthcare involves a more than a conversation about work; rather it is about offering positive advice about work and health, and liaising with the employer. There is a clear need to have some form of communication bridge between healthcare and the workplace].		
Walker-Bone Black (2016) (89) UK Editorial	**The importance of work participation as an outcome in rheumatology** A firm statement is made: "In the meantime, we as clinicians should resolve to ask every patient we see with a musculoskeletal disorder—are you working? And what is preventing you from working? And we should prepare ourselves to have knowledge of the relevant local employment resources if we uncover an unmet need in our patients. We owe it to our patients as individuals and to our society as taxpayers."	Guidance	Rheumatologists
Williams and Birkin (2011) (17) UK Editorial	**Communication style: help or hindrance in facilitating return to work?** Starts from Bandura's theory: 'Perceived self-efficacy refers to beliefs in one's capabilities to organise and execute the courses of action required to produce given attainments'. In the workplace setting, self-efficacy is an individual's belief that they can do what is needed to do the tasks of the job in hand, whatever that is, whether it is returning to work after sick leave or looking for a job. If being absent from work lowers self-efficacy and low self-efficacy is linked to inactivity and inability to take positive steps to return to work, occupational physicians should avoid lowering individual self-efficacy through the use of inappropriate language. Argument is made that the term 'barriers' is unhelpful. More acceptable alternatives may be obstacles or challenges, but the important point is that if it is negatively framed, the effect will be detrimental. That is 'bad' communication. The key to 'good' communication is empathy, the 2-stage process involving firstly an understanding of another person's situation and secondly communicating that understanding back in a supportive way. Additionally, the concept of identifying capability and not concentrating on incapacity is a useful fundamental underlying principle of the fit note. Practitioners need to take care with their selection of words within the context of attendance management discussions, return to work interviews and organisational sickness absence policies. [It seems that the fundamental lesson here is that health-work conversations will likely have negative consequences if communication styles and language are inappropriate. Terminology that is common among HCPs may have negative connotations for patients. Just initiating the health-work conversation is not sufficient – it needs to be initiated and followed through in a careful positive empathetic manner].	Guidance	Various

Appendix 3: search results

<table>
<tr><th colspan="4">Search Results</th></tr>
<tr><td>Identification</td><td>Records Identified through database searching = 2119</td><td>→</td><td>Additional records identified through other sources = 143</td></tr>
<tr><td rowspan="2">Screening</td><td>Records screened by title=2262</td><td rowspan="2">→
→</td><td>Records (titles) excluded (duplicates / irrelevant) = 2025</td></tr>
<tr><td>Records selected for abstract review = 237</td><td>Records (abstracts) excluded = 93</td></tr>
<tr><td>Eligibility</td><td>Records selected for full text review = 144</td><td>→</td><td>Records (full text) excluded = 65
- Not HCP conversation about work = 40
- Non healthcare setting = 5
- Routine discussion about work = 5
- Focused on cancer (review/ RCT complex interventions) = 6
- Out of date range = 3
- Not available/ non English = 3
- Protocol only = 3</td></tr>
<tr><td rowspan="2">Included</td><td colspan="3"><u>Records selected for inclusion = 79</u>
Empirical literature = 41; Grey literature = 38
↓ ↓</td></tr>
<tr><td>- Qualitative Design = n=17
- Quantitative Design = n=14
- Mixed methods = n=1
- Reviews / other = n=9</td><td colspan="2">- Guidance Material n=6
- Policy review n=3
- Editorial / supplement n=3
- Evidence briefing n=3
- Research/evaluation report n=14
- Gov’t report n=5
- Professional position statement n=2
- Guideline n=2</td></tr>
</table>

Appendix 4: stakeholder characteristics

Survey Respondents

Practitioner	Number
Nurse, including research, advanced and other nurses	14
Physiotherapist	22
Occupational Therapist	5
GP	6
Commissioning Project Manager	1
Clinical Psychologist	2
Senior Operations Administrator	1
Medical Doctor	1
Advanced Paramedic Practitioner	1
Consultant	1
Speech and Language Therapist	1
OH Nurse / OHA	2
Clinical Case Manager	1
Total	***58***

Practitioner Professional Group	Number
Physiotherapists (Total)	22
Physiotherapists (Occupational Health)	11
Nurse	15
GP	6
Other	16

Practitioner Speciality	Number
Occupational Health / Occ Health	10
Musculoskeletal / MSK	9
GP / General	7
Mental Health	4
Research	3
Pain Management	3
Post-Traumatic Stress	2
Brain Injury Rehabilitation	1
Rehabilitation	1
Diabetes	2
Manual Handling	1
N/A	1
Contraception and Sexual Health	1
Various/ service	4
Minor Illness and Injury	1
Speech, Language and Communication Needs	1
Falls Prevention	1
Midwifery	1
Oncology	2
District Nursing	1

Practitioner Work Setting	Number
Primary Care	26
Secondary Care / community	13
Private	6
Occupational Health	3
Medium Secure Forensic Adult Service	1
Education	1
Acute Hospital	1
Maternity	1
Various / service	4
Telephone Service	1
Industry	1
Assessment and Rehabilitation	1

Non-Practitioner	Number
NIHR Senior Research Nurse	1
Physiotherapy Lecturer / Lecturer	3
Practice Manager	1
Professor Emerita	1
N/A	2
Total	***8***

Interview Participants

Practitioner	Number
Physiotherapist, including specialist and consultant	3
GP, including portfolio GP	3
Consultant Liaison Psychiatrist	1
Occupational Therapist	1
Total	***8***

Practitioner Speciality	Number
Occupational Health	3
Musculoskeletal / MSK	1
GP / General	1
Mental Health	1
Drug and Alcohol	1
Rehabilitation	2

Non-Practitioner	Number
Researcher	4
Managing Director in FFW related service	1
Lecturer / PG Trainer	2
Director of a rehab provider	2
Head of Health Improvement (Local Authority)	1
OH / software developer	1

PHE medical / GP champion	3
Project Co-ordinator	1
Assistant Director for Employment (Combined Authority)	1
Clinical Director (NHS Trust)	1

Appendix 5: description and narrative evaluation of relevant initiatives

2008

Working for a healthier tomorrow. Review of the health of Britain's working age population (74). This review was one of the first times recommendations were made to Government that GPs and other HCPs should be supported to adapt the advice they provide, where appropriate doing all they can to help people enter, stay in or return to work. It was advised that Government should launch a major drive to promote understanding of the positive relationship between health and work among employers, healthcare professionals and the general public. This highly influential review achieved much, but the need to help health professionals to understand and deliver advice on the positive relationship between work and health remains largely unrealised.
Improving Health and Work: changing lives (84). The government's response to the above report set out plans to change attitudes towards health and work. These included replacing sickness certifications with the fit note, a related national educational training program for GPs, the Fit for Work Service pilots, and embedding employment advisors in IAPT and GP surgeries.

Vocational rehabilitation: what works, for whom, and when? (90) This policy review defined vocational rehabilitation as "whatever helps someone with a health problem to stay at, return to and remain in work". "Effective vocational rehabilitation depends on work-focused healthcare and accommodating workplaces". While the report called for help to provide advice, training and support for HCPs, it did not actually spell out what was meant by 'work-focused healthcare', but it is implicit that this involves a more than a conversation about work; it involves HCPs taking an interest in, and accepting responsibility for, addressing obstacles to work participation in the clinical encounter, offering positive advice about work and health, and liaising with the employer. It was established there was a clear need to have some form of communication bridge between healthcare and the workplace.

2009

Workplace health: long-term sickness absence and incapacity to work (85). Relevant recommendations included healthcare commissioners ensuring GPs have referral mechanisms to occupational health services, and that HCPs incorporate DWP's 'Advising Patients About Work' leaflet (21).The guidance advocates provision of suitable advice to patients to help them stay in work/return to work and identified early intervention, multidisciplinary approaches, and a workplace component as important components of effective interventions to reduce sickness absence. It advised that HCPs should consider the impact of intervention and management on work ability for patients of working age, and that GPs need to be more aware of their patients' employment (or worklessness), and the impact of health and illness on the central aspect of their lives.

While the guidelines recognise that HCPs are in a prime position to administer the latest evidence-based advice on work, there is only sparse and conflicting evidence demonstrating the successful implementation of guidelines, a phenomenon observed across several different countries (13). These guidelines are currently being updated and is due to be released in 2019.

2010

Statement of fitness for work (fit note) (91). A major initiative to influence a cultural shift in understanding of the health-supportive aspects of work, the fit note replaced previous sickness certification to allow doctors to provide advice to their patients about how they might be able to return to work while they recover. The fit note was also intended to facilitate a discussion with employers to support employees in work/to return to work as soon as possible, and in relation to the implementation of the NICE 2009 guidance, it was suggested that the fit note raised the stakes in consultations for conversations about work and the implications of prolonged absence (82). Since it was introduced, DWP have commissioned several studies to evaluate its use, the most recent concluding that the fit note has facilitated GP discussions with patients around returning to work, but the detail and quality of these varies considerably (81). The first systematic review of the literature evaluating the implementation and impact of the fit note found there to be very little quantitative research into the impact of this major policy change. It concluded that the fit note has been incompletely researched and not implemented as intended, and that widespread expectation or statutory requirement may be necessary to initiate the work conversation (64).

National Educational Programme for GPs (RCGP). Supported by the RCGP, this national programme was intended to guide GPs on the use of the fit note. The intention was to provide training to around 10% of GPs, with an expectation that the messages would gradually propagate through the profession. The evidence-informed one-day training events were delivered by a dedicated team who covered topics such as the work-health relationship and motivational interviewing as well as the practicalities of the fit note. Evidence-based guidance (developed and evaluated with GPs and sponsored by DWP) was sent to all GPs to support the training programme and assist discussions about work and health (Anon, 2007 – compiled by G Waddell and K Burton). This programme was recently delivered to rheumatology teams in order to increase their knowledge, skills and confidence in supporting work related issues. Workshops for rheumatology teams will be extended throughout the UK, managed by BSR with local champions to help increase learning into everyday practice (61).

Occupational Health Advice Lines (92) . This service was designed to provide small and medium-sized businesses (SMEs) with access to early and high quality occupational health (OH) advice. It ran as a telephone-based service across Great Britain, and was made available to GPs after the launch of the Fit Note to assist with any queries they

had about OH issues related to their patients. At the end of the pilots in 2011, it was reported that employers found the service helpful, but GPs calling about patients made relatively limited use of the service, making up 6 per cent of all calls (87).

2011

Health at Work – an independent review of sickness absence (75). To help reduce the 140 million days lost to sickness absence every year, the government set up a review of the sickness absence system. One of the key recommendations was that Government should fund a new Independent Assessment Service to provide advice about how an individual taking sickness absence could be supported to return to work. It should be provided by approved health professionals, and should usually be accessed when an individual's absence spell has lasted around 4 weeks. This was proposed to improve the effectiveness of medical certification and encourage early positive intervention.

2013

Government response to the review of the sickness absence system in Great Britain (79). The government accepted a number of the recommendations from the Black and Frost (2011) review, including the introduction of an occupational health assessment and advice service for GPs, employers and employees to access/refer to after 4 weeks' sickness absence from work.

Telephonic support to facilitate return to work: what works, how, and when? (7) To inform the advice service proposed by Black and Frost (2011), a review was commissioned to provide an evidence base for the use of telephonic assessment and support to facilitate timely return to work for people with common health problems. Robust evidence was found that, when properly implemented, telephonic case management approaches can aid early return to work and reduce overall case costs.

2014

Working Well (93). As part of the Greater Manchester (GM) devolution agreement, the Working Well project was launched to support people with health conditions and/or disabilities who were long-term unemployed to return to employment. The project was soon expanded to include GP recommendations as routes into the programme, and currently Working Well Mental Health IAPT support is being provided by GM West NHS Trust. In 2018, Working Well was continued as a localised version of government's new Work and Health Programme (DWP/DH, 2016). A new Early Help programme (largely informed by the Fit for Work service) geared to support and advise individuals with health conditions or disabilities who are at risk of falling out of work, or are newly unemployed due to their health complications and/or disabilities is planned for 2019 (77).

2015

Fit for Work (94). The Fit for Work Service was the Government's implementation of the Black and Frost (2011) proposal of an occupational health assessment and advice service for employees who were on (or at risk of entering) long-term sickness absence, defined as 4 weeks or more, via a referral through their GP or employer. Participation was entirely voluntary. Employees giving their consent took part in a biopsychosocial assessment, primarily conducted by telephone. After assessment, a Return to Work Plan would be produced, with recommendations for self-care, workplace adjustments, and/or signposting to further specialist support and therapy services to assist the employee's return to work. With the employee's consent, the plan could be shared with their employer and/or GP. Following very low referrals, Fit for Work came to an end in 2018. However, employers, employees and GPs continue to have access to the same Fit for Work helpline, website and web chat, which offer general health and work advice, as well as support on sickness absence. Employers found the service helpful and easy to use, but GP awareness of, and engagement with the service was generally low (83). Healthy Work Conversations (GMPHN). Greater Manchester Public Health Network commissioned a project to train 180 Allied Health Professionals (AHPs) and Psychological Wellbeing practitioners (PWPs) on principles of work and health and use of advisory fitness for work assessments. The project aimed to enable and empower AHPs and PWPs to transfer principles into practice and cascade to teams. Training covered rationale for work as a health outcome, importance of early conversation about work, identification of obstacles to work and health, planning for staying at/return to work, and liaison with key stakeholders. The program was well received and a meaningful positive shift in in practitioner perceptions and intentions to change practice, along with increased confidence about having healthy work conversations were found. A follow-up found some change in practice and reinforced the shift in confidence levels.

2016

Health and Work Champions (RCOT/PHE). In a unique partnership between the Royal College of Occupational Therapists and Public Health England, 55 HCPs in England became Health and Work Champions. Champions deliver training in their NHS organisations to enable colleagues to routinely ask about employment and provide brief advice when delivering care to working age adults. Following the first phase of evaluation, in a 6-month period, 487 staff were trained and there was a statistically significant improvement in their knowledge and confidence to talk about employment in their clinical services (36).

Improving Lives: the work, health and disability Green Paper (80). This sets out the nature of the problem and why change is needed by employers, the welfare system, and healthcare providers as a whole-system. Some of the relevant areas for action included reinforcing work as a health outcome in commissioning decisions and clinical

practice, ensuring good quality conversations about health and work, and improving how fit notes work.

2017

Improving Lives: the future of work, health and disability (2). This response to the Green Paper reflected Government's stated aim of having one million more disabled people in employment over the next 10 years, replacing a previous pledge of halving the disability-employment gap. The Command Paper emphasises the need to join up the 3 relevant settings – the workplace, welfare and healthcare. Specific recommendations for healthcare are for HCPs to talk about health barriers to work with patients; providing timely access to appropriate treatments; having effective occupational health services, within but also beyond the NHS, giving access for everyone including small businesses and the self-employed; and having a focus on prevention and early intervention. As part of the government's strategy to widen fit note certification to other HCPs, the Command Paper committed to investigating the feasibility of the AHP Advisory Fitness for Work Report (95) for the purposes of Statutory Sick Pay (SSP). In 2018 the Joint Work and Health Unit (WHU) confirmed that the report is suitable medical evidence for SSP.

2018

Work as a Health Outcome programme (PHE). The Joint Work and Health Unit (WHU) has commissioned Public Health England (PHE) to implement its 'work as a health outcome' programme. The programme seeks primarily to promote healthcare professionals' (HCPs) understanding of the health benefits of good work and to enable HCPs with the tools, techniques and environment to have appropriate supportive conversations about work and health. To inform this programme, PHE commissioned a series of evidence reviews and stakeholder engagement.

It was found that several online learning resources for GPs are available, including: Electronic, Experiential, Learning, Audit and Benchmarking (EELAB), The Health and Occupation Reporting (THOR) network, Health e-Working and the Health and Work Training Resource (although these are largely for GPs working in occupational medicine), yet unclear role definition, lack of training in occupational issues, and lack of communication with the workplace are barriers for GPs to engage in conversations about work with patients. Enablers include high worker motivation, positive employer-worker relationship, availability of suitable modified duties, and GP education on occupational issues. A lack of collaboration (understanding) between stakeholders is a fundamental barrier to conversation as well as return-to-work outcomes (28). Recommendations for HCPs include: earlier diagnosis and interventions, timely appointments, asking working age patients about their employment aspirations as early as possible, increasing clinical assessments of the impact of comorbidities, and

signposting patients to self-management support resources which focus on employment outcomes (86).

Further support for HCPs has been suggested to the development of guidelines/checklists on how HCPs can engage with employers and workplaces, supervise vocational issues, and provide long-term follow-up in relation to the patients' work (47). In response to this, the Council for Work and Health have recently produced The Talking Work Checklist which aims to support GPs to better embed work conversations in their routine practice (53). The guide contains much useful evidence-informed information and advice for doctors and other HCPs. However, its format/presentation is text-dense. There is no one-page aid or checklist as such: rather the checklist comprises 10 items defining a (clinical consultation) process, each being linked to online guidance. A key aspect of the guide seems to be on ‘considering adjustments’, just what these adjustments might be and how they might be implemented are not obvious.

The most recent survey found that although most HCPs agree that work conversations should be part of the clinical encounter, only HCPs whose role directly involves occupational health/medicine would receive relevant training. Again, lack of time (mainly for doctors) was reported as a barrier to health-work conversations, so it was concluded that professions with longer clinical contact times are in a better position to offer in-depth discussions. Although most respondents were confident about discussing health benefits of work, they were less confident about referral to local resources, suggesting a need for larger joined-up systems (38).

Prevention is better than cure (78). This document sets out a vision for putting prevention at the heart of the nation's health. Government’s mission is to improve healthy life expectancy so that, by 2035, there are at least 5 extra years of healthy, independent life, while closing the gap between the richest and poorest. The workplace is referred to as a setting for prevention and health promotion, in recognition that work is linked to health, and that HCPs need to change their approach and mindset from treating symptoms to the whole person within their environment. Better integration between health and employment support services to help people with health conditions to enter and stay in work is called for.

Appendix 6: sample interview data with supporting quotes

Supportive conversations about work and health – where, when and between whom and do practitioners have the knowledge of good work and the confidence to initiate conversations and address the issues.

The interviewees had a clear understanding of the links between good work and health and the confidence to have conversations about work, some also suggested there is a need for HCPs in routine practice to develop knowledge and confidence in these areas. Professional judgement is used in deciding when to have the conversation, although some felt work should be raised early in the treatment process and some also advised talking to everyone whatever their work status. Although, it was also recognised that sometimes the nature of the condition led to the conversation taking place at a later stage in recovery. It was also advised that a dialogue should take place between the patient/employee, with the HCPs having a role in encouraging this to happen. The respondents suggested the content of the conversation, including providing general information about the link between good work and health, and myth busting.

Where

Respondents suggested conversations depend on where HCPs work, what they do and their role. There was also a suggestion that a confidential and private space is required to facilitate the conversation (n=2).

It was also indicated that the GP is likely to have a better impact than the Job Centre on productivity and outcomes because of the holistic approach taken, their role as advocate and their power (n= 2).

When

Conversations should occur when circumstances allow and when relevant, it was suggested this could be at any stage and would depend on the situation and the patient or professional judgement (n=4).

In contrast it was suggested that conversations need to take place as early as possible and that the employer should be involved early too (n=4). Or that every conversation should refer to work, HCPs should never exclude work questioning and should have the conversation wheever possible or throughout intervention (n=3).

> “We want people going into employment to get better.”

> "If we differentiate between people, we make them exceptions and they become exceptional as opposed to being the norm and work is normal."

For more complex or acute conditions for example ABI, the conversation might take place later in the recovery and with a person with acute MH issues work would be considered in the future (n=2).

> "Work could be damaging for them and their recovery but would bring it up, say not now but let's think about this in the future."

Whom

It was suggested that HCPs can talk to any service user at any point, even if declared unfit to work or they are far away from the workplace (n=5) but the level of the conversation is important (n=2) and the practitioner should not be forced to discuss it every time (n=1).

> "Nothing wrong with bringing it up – it's about being sensitive and not making assumptions about people."

HCPs should be communicating with the employer / encouraging the dialogue between the employer/ee, including identifying reasonable adjustments that can be discussed with the GP (n=5).

One interviewee suggested caution when someone was bereaved and to avoid the topic in extremely sensitive circumstances, while 2 said HCPs should talk to people with cancer, as patients want someone to talk about the future, their recovery and getting back to normality.

There was recognition from 1 interviewee that conversations can be hampered by assumptions, in that HCPs should not disregard people because they are young, retired or out of work.

Knowledge and confidence

HCPs should refer to work as part of normal life, demonstrate the link between good health and work and discuss how working well can improve future health. They should identify how good work fits with the treatment, including recovery through work rather than being fully fit to work (n=8).

> "We do use the quotes about work being good for us – good opener – makes people laugh and stimulates some conversation."

It was also suggested that HCPs should deal with myths such as types of jobs and their impact on health, a person needs to be fully fit to work or RTW and they should liaise with employers about fit note myths (n=3).

The point was made that work can mean voluntary work and education, for example, not just paid employment and therefore the same conversation should be had with children about school and the retired about volunteering / leisure.

Overall, the interviewees suggested that HCPs require a knowledge of evidence base around work, the benefits of work and the link between work and health. It was also suggested that any training needs to develop both confidence and competence.

> “Confidence in understanding procedures.”

References

1. Health Education England. Making Every Contact Count: NHS; [Available from: https://www.makingeverycontactcount.co.uk/] Accessed 4th March 2019
2. Department for Work and Pensions, Department of Health. Improving Lives: The Future of Work, Health and Disability London: The Stationery Office. 2017
3. National Institute of Clinical Excellence. Behaviour Change: Individual Approaches PH49. 2014.
4. Goldsmith MR, Bankhead CR, Austoker J. Synthesising quantitative and qualitative research in evidence-based patient information. Journal of epidemiology and community health. 2007;61(3):262-70.
5. Pawson R, Greenhalgh T, Harvey G, Walshe K. Realist review--a new method of systematic review designed for complex policy interventions. Journal of health services research and policy. 2005;10 Suppl 1:21-34.
6. Silverstein R, Julnes G, Nolan R. What policymakers need and must demand from research regarding the employment rate of persons with disabilities. Behavioral Sciences and the Law. 2005;23:399-448.
7. Burton K, Kendall N, McCluskey S, Dibben P. Telephonic support to facilitate return-to-work: what works, how, and when? London: Department for Work and Pensions; 2013.
8. Waddell G, Burton AK. Is work good for your health and wellbeing? London: The Stationery Office: Department for Work and Pensions; 2006.
9. Waddell G, Burton AK, Kendall NAS. Vocational rehabilitation – what works, for whom, and when? London: TSO: Vocational Rehabilitation Task Group; 2008.
10. Kim H, Sefcik JS, Bradway C. Characteristics of Qualitative Descriptive Studies: A Systematic Review. 2017;40(1):23-42.
11. Thoomes-De Graaf M, Scholten-Peeters W, Duijn E, Karel Y, De Vet HCW, Koes B, et al. The Responsiveness and Interpretability of the Shoulder Pain and Disability Index. Journal of Orthopaedic and Sports Physical Therapy. 2017;47(4):278-86.
12. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Research in Psychology. 2006;3(2):77-101.
13. Bartys S, Stochkendahl M. Work-focused Healthcare for Low Back Pain. International Society for the Study of the Lumbar Spine Online Textbook 2018.
14. Johnston V, Jull G, Sheppard DM, Ellis N. Applying principles of self-management to facilitate workers to return to or remain at work with a chronic musculoskeletal condition. Manual Therapy. 2013;18(4):274-80.
15. Nilsen S, Malterud K, Werner EL, Maeland S, Magnussen LH. GPs' negotiation strategies regarding sick leave for subjective health complaints. Scandinavian Journal of Primary Health Care. 2015;33(1):40-6.
16. Schrooten I, de Jong MD. If You Could Read My Mind: The Role of Healthcare Providers' Empathic and Communicative Competencies in Clients' Satisfaction with Consultations. Health Communication. 2017;32(1):111-8.
17. Williams N, Birkin R. Communication style: help or hindrance in facilitating return to work? Editorial. Occupational Medicine 2011;61:380-2.
18. 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.

19. Shaw WS, Main CJ, Johnston V. Addressing occupational factors in the management of low back pain: implications for physical therapist practice. Physical therapy. 2011;91(5):777-89.
20. Darlow B, Fullen BM, Dean S, Hurley DA, Baxter GD, Dowell A. The association between health care professional attitudes and beliefs and the attitudes and beliefs, clinical management, and outcomes of patients with low back pain: A systematic review. European Journal of Pain. 2012;16(1):3-17.
21. Anon. Advising Patients about work. (guidance leaflet for GPs and other healthcare professionals). London: The Stationery Office; 2007.
22. Bartys S, Frederiksen P, Bendix T, Burton K. System influences on work disability due to low back pain: An international evidence synthesis. Health policy (Amsterdam, Netherlands). 2017;121(8):903-12.
23. Hann M, Sibbald B. General Practitioners Attitudes towards patients health and work. 2010-12. 2011.
24. Johnston V, Nielsen M, Corbiere M, Franche RL. Experiences and perspectives of physical therapists managing patients covered by workers' compensation in Queensland, Australia. Physical therapy. 2012;92(10):1306-15.
25. Kosny A, Lifshen M, Yanar B, Tonima S, MacEachen E, Furlan A, et al. The role of healthcare providers in the workers compensation system and return-to-work process: Final report. Toronto: Institute for Work and Health; 2016.
26. 26. Nilsing E, Söderberg E, Berterö C, Öberg B. Primary Healthcare Professionals' Experiences of the Sick Leave Process : A Focus Group Study in Sweden. Journal of Occupational Rehabilitation. 2013;23(3):450-61.
27. 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.
28. Pearce-Smith N. What are the methods for improving mental or physical health after a transition from unemployment to employment in those with a long term condition or disability? Evidence Briefing. London: Public Health England; 2018.
29. Pincus T, Greenwood L, McHarg E. Advising people with back pain to take time off work: a survey examining the role of private musculoskeletal practitioners in the UK. Pain. 2011;152(12):2813-8.
30. Poitras S, Durand MJ, Cote AM, Tousignant M. Use of low-back pain guidelines by occupational therapists: a qualitative study of barriers and facilitators. Work (Reading, Mass). 2011;39(4):465-75.
31. Poitras S, Durand MJ, Cote AM, Tousignant M. Guidelines on low back pain disability: interprofessional comparison of use between general practitioners, occupational therapists, and physiotherapists. Spine. 2012;37(14):1252-9.
32. Public Health England. Embedding work as a health outcome - professional survey. How far are we? London: GOV.UK; 2018.
33. Werner EL, Cote P. Low back pain and determinants of sickness absence. The European Journal of General Practice. 2009;15(2):74-9.
34. Cohen D, Marfell N, Webb K, Robling M, Aylward M. Managing long-term worklessness in primary care: a focus group study. Occupational Medicine (Oxford, England). 2010;60(2):121-6.
35. ICF CSL. Mapping the coverage of health and work topics in healthcare and business undergraduate and postgraduate degree courses in England. Public Health England; 2017.
36. 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.

37. 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.
38. Solutions Strategy Research Facilitation Ltd. Work as a health outcome: report. Solutions; 2018.
39. Darlow B, Dowell A, Baxter GD, Mathieson F, Perry M, Dean S. The enduring impact of what clinicians say to people with low back pain. Annals of family medicine. 2013;11(6):527-34.
40. Ikezawa Y, Battié MC, Beach J, Gross D. Do clinicians working within the same context make consistent return-to-work recommendations? Journal of occupational rehabilitation. 2010;20(3):367-77.
41. Main C, Burton A. Engaging patients in their own care for back care : the role of education and advice in the prevention of chronic back pain disability In: Hasenbring M, Rusu A, Turk D, editors. From acute to chronic back pain: risk factors mechanisms, and clinical implications Oxford: Ocford University Press; 2012. p. 433-52.
42. Simmonds MJ, Derghazarian T, Vlaeyen JW. Physiotherapists' knowledge, attitudes, and intolerance of uncertainty influence decision making in low back pain. The Clinical journal of pain. 2012;28(6):467-74.
43. Stochkendahl MJ, Larsen OK, Nim CG, Axén I, Haraldsson J, Kvammen OC, et al. Can chiropractors contribute to work disability prevention through sickness absence management for musculoskeletal disorders? - a comparative qualitative case study in the Scandinavian context. Chiropractic and Manual Therapies. 2018;26(1).
44. Stratil R, Swincer M. Work-related back pain study : measuring biopsychosocial risk factors. A discussion paper2012. Available from: https://trove.nla.gov.au/work/185697663?qandversionId=202187836.
45. 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.
46. Jurisic M, Bean M, Harbaugh J, Cloeren M, Hardy S, Liu H, et al. The Personal Physician's Role in Helping Patients With Medical Conditions Stay at Work or Return to Work. Journal of Occupational and Environmental Medicine. 2017;59(6):e125-e31.
47. Tran A. Does remaining in work benefit those with MSK conditions? Evidence Briefing. London: Public Health England; 2018.
48. Burton K, Waddell G. Health and Work (advice booklet for worker/patients). London: The Stationery Office; 2007.
49. Waddell G, Burton AK. Health and Work (advice leaflet for worker/patients). London: The Stationery Office; 2007.
50. Parker C. Evidence based information and advice to reduce sickness absence: a feasibility study for a clinical trial in physiotherapy practice University of Salford; 2015.
51. Munir F, Kalawsky K, Wallis DJ, Donaldson-Feilder E. Using intervention mapping to develop a work-related guidance tool for those affected by cancer. BMC Public Health. 2013;13:6-.
52. Cardone A. Having the conversation about work with people with multiple sclerosis: a guide for healthcare professionals. Neurodegenerative Disease Management. 2017;7(6s):41-4.
53. Ahuja D. Talking Work: A guide for Doctors discussing work and work modifications with patients. London: Council for Work and Health; 2019.
54. Singh R, O'Hagan F. "Apping Up": Prospects for Information Technology Innovation in Return to Work Communication. Journal of occupational rehabilitation. 2019;29(1):104-18.
55. James C, Southgate E, Kable A, Rivett DA, Guest M, Bohatko-Naismith J. The return-to-work coordinator role: qualitative insights for nursing. J Occup Rehabil. 2011;21(2):220-7.

56. Myhre K, Marchand GH, Leivseth G, Keller A, Bautz-Holter E, Sandvik L, et al. The effect of work-focused rehabilitation among patients with neck and back pain: a randomized controlled trial. Spine. 2014;39(24):1999-2006.
57. Sennehed CP, Holmberg S, Axen I, Stigmar K, Forsbrand M, Petersson IF, et al. Early workplace dialogue in physiotherapy practice improved work ability at one-year follow-up-WorkUp, a randomised controlled trial in primary care. Pain. 2018;159(8):1456-64.
58. Wynne-Jones G, van der Windt D, Ong BN, Bishop A, Cowen J, Artus M, et al. Perceptions of health professionals towards the management of back pain in the context of work: a qualitative study. BMC Musculoskeletal Disorders. 2014;15:210-.
59. Buchbinder R, Gross D, Werner E, Hayden J. Mass Media Campaigns for the Prevention of Back Pain-Related Disability. In: Rashiq S, Schopflocher D, Taenzer P, Jonsson E, editors. Chronic Pain: A Health Policy Perspective. Health Care and Disease Management 2008.
60. Buchbinder R, Jolley D, Wyatt M. Population based intervention to change back pain beliefs and disability: three part evaluation. BMJ. 2001;322(7301):1516-20.
61. Cohen D, Khan S, Marfell N. Fit for work? Evaluation of a workshop for rheumatology teams. Occupational Medicine (Oxford, England). 2016;66(4):296-9.
62. Coole C, Watson PJ, Drummond A. Low back pain patients' experiences of work modifications; a qualitative study. BMC Musculoskelet Disord. 2010;11:277.
63. Demou E, Gaffney M, Khan F, Lando JK, Macdonald EB. Case management training needs to support vocational rehabilitation for case managers and general practitioners: a survey study. BMC Medical Education. 2014;14:95.
64. Dorrington S, Roberts E, Mykletun A, Hatch S, Madan I, Hotopf M. Systematic review of fit note use for workers in the UK. Occupational and environmental medicine. 2018;75(7):530-9.
65. Hughes JL. Chronic fatigue syndrome and occupational disruption in primary care: is there a role for occupational therapy? British Journal of Occupational Therapy. 2009;72(1):2-10.
66. Meunier J, Fautrel B, Roquelaure Y, Claudepierre P. Work-related discussions between French rheumatologists and their rheumatoid arthritis patients. Occupational Medicine (Oxford, England). 2016;66(6):454-9.
67. Morrison T, Thomas R, Guitard P. Physicians' perspectives on cancer survivors' work integration issues. Canadian Family Physician Medecin De Famille Canadien. 2015;61(1):e36-e42.
68. Olsson D, Alexanderson K, Bottai M. What positive encounters with healthcare and social insurance staff promotes ability to return to work of long-term sickness absentees? Scandinavian journal of public health. 2016;44(1):91-7.
69. Petersen KS, Momsen AH, Stapelfeldt CM, Olsen PR, Nielsen CV. Return-to-work intervention during cancer treatment - The providers' experiences. European Journal of Cancer Care. 2018;27(2):e12793.
70. Sturesson M, Edlund C, Falkdal AH, Bernspång B. Healthcare encounters and return to work: a qualitative study on sick-listed patients' experiences. Primary Health Care Research and Development. 2014;15(4):464-75.
71. Wells M, Williams B, Firnigl D, Lang H, Coyle J, Kroll T, et al. Supporting 'work-related goals' rather than 'return to work' after cancer? A systematic review and meta-synthesis of 25 qualitative studies. Psycho-oncology. 2013;22(6):1208-19.
72. Wrapson W, Mewse AJ. Does the doctor or the patient control sick leave certification? A qualitative study interpreting patients' interview dialogue. Family Practice. 2010;28(2):202-9.
73. Yagil D, Eshed-Lavi N, Carel R, Cohen M. Health care professionals' perspective on return to work in cancer survivors. Psycho-oncology. 2018;27(4):1206-12.
74. Black C. Working for a healthier tomorrow. London: Department for Work and Pensions; 2008. https://www.gov.uk/government/publications/working-for-a-healthier-tomorrow-work-and-health-in-britain

75. Black C, Frost D. Health at work – an independent review of sickness absence London: Department for Work and Pensions; 2011.
76. Canadian Medical Association. The treating physicians role in helping patients return to work after an illness or injury 2013.
77. Clarke J, Fletcher A. Working well: Evaluation Report. A qualitative evaluation of the Greater Manchester Combined Authority Working Well programme. SQW; 2018.
78. Department for Health and Social Care. Prevention is better than cure. Our vision to help you live well for longer. London: GOV.UK; 2018. https://www.gov.uk/government/publications/prevention-is-better-than-cure-our-vision-to-help-you-live-well-for-longer
79. Department for Work and Pensions. Fitness for work: the Government response to 'Health at work – an independent review of sickness absence'. London: GOV.UK; 2013.
80. Department for Work and Pensions, Department of Health. Improving Lives The Work, Health and Disability Green Paper. London: GOV.UK. 2016
81. Department for Work and Pensions. The Fit Note in Practice: Benefits and Challenges An Evidence Synthesis. Unpublished.
82. Gabbay M, Taylor L, Sheppard L, Hillage J, Bambra C, Ford F, et al. NICE guidance on long-term sickness and incapacity. The British journal of general practice : the journal of the Royal College of General Practitioners. 2011;61(584):e118-24.
83. Gloster R, Marvell R, Huxley C. Fit for Work: Final report of a process evaluation. London: Department for Work and Pensions; 2018.
84. Health Work Wellbeing. 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: Department for Work and Pensions; 2008. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/210858/hwwb-improving-health-and-work-changing-lives.pdf
85. National Institute of Clinical Excellence. Workplace health: long-term sickness absence and incapacity to work. NICE Guideline. 2009. https://www.nice.org.uk/guidance/ph19/resources/workplace-health-longterm-sickness-absence-and-incapacity-to-work-pdf-1996184939461
86. Pearce-Smith N. What is the impact of job loss and unemployment on the physical and mental health of older adults, and how can they be supported back in to work London: Public Health England; 2018.
87. Sinclair A, Martin R, Tyers C. Evaluation of Occupational Health Advice Lines evaluation: Final report. London: Department for Work and Pensions; 2012. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/191745/793summ.pdf
88. Sylvain C, Durand M-J. [Supporting the return to work following sick leave for a depressive disorder: why and how?]. Sante Mentale Au Quebec. 2017;42(1):305-18.
89. Walker-Bone K, Black C. The importance of work participation as an outcome in rheumatology. Rheumatology. 2016;55(8):1345-7.
90. Waddell G, Burton A, Kendall N. Vocational Rehabilitation: what works for whom and when. 2008.
91. Department for Work and Pensions. Fit Note. London: GOV.UK; 2010. https://www.gov.uk/government/collections/fit-note
92. Department for Work and Pensions. Fit for work: Occupational Health Advice Line [Available from: https://fitforwork.org/] Accessed 4th March 2019.
93. Greater Manchester Combined Authority. Working Well [Available from: https://www.greatermanchester-ca.gov.uk/what-we-do/work-and-skills/working-well/] Accesed 4th March 2019.

94. Department for Work and Pensions. Fit for Work guidance. London: GOV.UK. https://www.gov.uk/government/collections/fit-for-work-guidance
95. Allied Health Professionals Federation. Allied Health Professions Advisory Fitness for Work Report. The Chartered Society of Physiotherapy; The Society of Chiropodists and Podiatrists; College of Occupational Therapists; 2013. http://www.ahpf.org.uk/files/AHP%20Advisory%20Fitness%20for%20Work%20Report.pdf