Public Health England

Protecting and improving the nation's health

Work as a Health Outcome: a qualitative assessment of the influence of the Health and Work Champions pilot programme and the clinical consensus statement.

Evaluation Report

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: Michelle Lloyd and Alison Benson, Solutions Strategy Research Facilitation Ltd

Published October 2020
PHE publications
gateway number: GW-1608

PHE supports the UN
Sustainable Development Goals

Contents

Glossary of terms

AORMC	Academy of Royal Medical Colleges
AHP	Allied Health Professional
AHPF	Allied Health Professional Federation
CCG	Clinical Commissioning Group
DHSC	Department of Health and Social Care
DWP	Department for Work and Pensions
EHIE	Employers, Health and Inclusive Employment Directorate
GP	General Practitioner
GMC	General Medical Council
HCP	Healthcare Professional
HEE	Health Education England
HWMC	Health and Work Medical Champion
ICS	Integrated Care System
NHSE/I	NHS England and NHS Improvement
OT	Occupational Therapist
PLT	Protected Learning Time
PHE	Public Health England
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
RCOT	Royal College of Occupational Therapists
WAAHO	Work as a Health Outcome
WHU	Joint Work and Health Unit

Executive summary

The Department for Work & Pensions (DWP) and Department for Health & Social Care (DHSC) Joint Work and Health Unit (WHU) commissioned Public Health England (PHE) to lead a programme of work focused on embedding work as a health outcome within routine clinical practice. This was designed to support the delivery of the Government's 2017 strategy set out in 'Improving Lives: The Future of Work, Health and Disability'.

In December 2019, a qualitative evaluation of two workstreams within the programme was commissioned: the Health and Work Medical Champion pilot (HWMC pilot), and the creation of the new clinical consensus statement in April 2019. This evaluation took place between December 2019 and April 2020 and involved in-depth interviews with stakeholders involved in both projects.

Contextual findings across evaluation

The 'work as a health outcome' (WAAHO) agenda is recognised as making slow steady progress over the last 10 to 20 years. Although it is not felt that there has been a particular step change in progress recently, there is a sense that this agenda has started to gain wider momentum despite the backdrop of challenging political and clinical environments.

A recurrent theme found across this evaluation is that the two systems of 'health' and 'work' services are still felt to operate quite separately. One impact of this is the challenge faced by organisations or individuals who wish to work more collaboratively in building meaningful connections. Another contextual theme is the perceived importance of training GPs further on the topic of WAAHO, given the importance of the patient/GP relationship in raising these issues, and consequently in supporting better use of the fit note within general practice.

New 2019 Consensus Statement

PHE, in collaboration with leaders across medical professions, built on the 2008 Health and Work Consensus Statement[1]; the aim was to develop a new statement for action to inspire, empower and support healthcare professionals to realise the potential of 'work as a health outcome'. The statement was signed by the umbrella organisations

[1] [1] 2008 Healthcare Professionals Consensus statement (page 67) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/209782/hwwb-working-for-a-healthier-tomorrow.pdf

Academy of Medical Royal Colleges (AORMC), Royal College of Nursing (RCN) and Allied Health Professionals Federation (AHPF).

The collaborative reworking and launch of the new consensus statement in 2019 (see Appendix 1) has been received positively. The new statement is regarded as a well written, clear statement of intent, with important additional information in the form of the four actions and the consideration of healthcare staff wellbeing. The success of the statement feels more about awareness raising and supporting the growing momentum than galvanising direct action. It provides important symbolic evidence of the importance of the programme across clinical disciplines and government. The three main umbrella body signatories deliver a sense of gravitas which has been very important in usage of the statement as a credibility tool.

However a key theme noted across the evaluation is that it is hard to translate the statement into practical actions that resonate across the wider professional audiences. Without this practical aspect, there is a risk that the consensus statement will not be taken further and actioned by on the ground clinicians. There is also a sense that although some organisations have used it widely as a credibility tool, it could be promoted and followed up more across organisations and amongst grassroots healthcare professionals (HCPs).

A theme raised across the evaluation is how to engage busy practitioners in the WAAHO agenda when they have many competing priorities. Ways of including the subject in training are suggested, as well as e-learning formats, and practical, action-oriented tools that deliver quick and easy to access information with a clear call to action.

Health and Work Medical Champions (HWMC) pilot:

Between January 2019 and March 2020, PHE ran a pilot involving three HWMCs based in three pilot regions (East Midlands, North East, London), each contracted to work eight hours per week. This pilot was preceded by a pre-pilot to inform the workstream. In this pre-pilot one HWMC worked eight hours per week in London for twelve months. The aim of the pilot was to work with local and regional NHS leaders to support increased capacity and appetite to integrate brief advice on health and work into clinical practice across the local or regional NHS landscape.

Overall, set within the context of the limitations of its small size and short timeframes, the HWMC pilot is considered successful by both stakeholders and champions alike.

The limiting factors that need to be taken into account are that there were only three HWMCs, working in three different geographical locations, for one day a week over the

time of the pilot, without administration support. All champions were given a degree of autonomy around how best to approach the role and meet the outline objectives.

The pilot does appear to have created a sense of momentum, helping to raise the profile of WAAHO generally and supporting the delivery of some of the key outcomes set. These include the training of HCPs, relationship building between primary care settings and JobCentre Plus settings as well as contributing to the promotion and setting of the WAAHO agenda at a commissioning level. Many of the successes are however described as at the early stages of the process of change, building awareness and creating new dialogues, relationships and ways of working across the system.

A key success is the role the HWMCs have played in helping to bridge the gap across the health and work landscape and being a catalyst for positive change. As a result, the HWMCs have been able to create a common voice around key messages, promote the WAAHO agenda, keep it up the priority list for stakeholders and help bring stakeholders together.

The medical background of the HWMCs, who were all highly experienced, with specific expertise in occupational health is highlighted as a key driver to the success of this role. Stakeholders point to the credibility that the GP professional status and expertise brings, their knowledge of the health system and their ability to forge meaningful links with senior stakeholders as well as deliver peer to peer training. The personal passion for the subject, engaging personalities, excellent communication skills and contacts that the champions themselves brought with them are also considered very important.

There is disappointment amongst stakeholders and HWMCs about the end of the pilot and concern about the potential loss of momentum that may subsequently occur, particularly given the time needed to implement and embed change. The model of having a HWMC working locally is believed to work well, however there is some discussion about the optimum funding mechanism and ownership of the role and how this might work in the future. The evaluation suggests that local goals and aspirations are important to be built into any future working, so that there is local buy-in and flexibility.

The HWMC role has shown what can be achieved and that there is an appetite for joint working, linking together the health and work systems. Ongoing training of HCPs and the promotion of the WAAHO are considered important to continue to maintain the profile of this agenda and to encourage it to become a key priority.

Evaluation background and approach

Background

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) funded Public Health England (PHE) to implement a 'work as a health outcome' (WAAHO) programme spanning three years (2017/18 to 2019/20). The programme seeks to promote healthcare professionals' (HCPs) understanding of the health benefits of good work and encourage HCPs to have supportive conversations about work and health. This involves supporting change behaviours in HCPs and enabling them to take action to support their patients to remain or return to work. HCPs are not being asked to become specialists on employment support, benefit systems or work adaptations, but to initiate conversations to prompt the patient to seek and engage with support from other sources, such as their employers and to signpost patients to other help. Although Primary Care is the first point of contact with patients, the WAAHO agenda is seen as a collaborative responsibility for all HCPs, including Secondary Care practitioners who are involved in the different touchpoints of a patient care pathway.

The WAAHO programme had seven workstreams that focused on articulating the ambition around the work and health agenda, understanding HCP behaviour, creating a supportive environment in which to progress the agenda and building the capability of the HCP workforce. Resources designed to build workforce capability as part of the WAAHO programme include the Work and Health eLearning programme, the Health and Work medical undergraduate curriculum and a standardised training package via a peer-to peer-training model delivered in collaboration with the Royal College of Occupational Therapists (RCOT).

Two of the seven workstreams within the WAAHO programme were the Health and Work Medical Champion (HWMC) pilot and the creation of a new clinical consensus statement on Health and Work. This evaluation report focuses on the requirement to evaluate these elements of the programme in terms of their success in meeting the overall objectives of the programme. Instilling behavioural change is a complex area that is governed by many factors and typically takes time, therefore a caveat to this evaluation is the difficulty in attributing the impact of specific activities identified on behaviour change amongst wider HCP audiences.

The Health and Work Medical Champion pilot (HWMC)

The HWMC pilot was one of the seven workstreams within the WAAHO programme. The HWMC pilot initially ran as a three-month pre-pilot in January 2018 in London with

one GP working one day a week ie eight hours, in the London region. The pre-pilot was then extended for a further nine months. In January 2019, the main pilot began with expansion to two other regions ie the East Midlands and the North East and two additional GPs (still working one day a week), were recruited. These regions were chosen because they both have high disability employment gaps and comprised a mix of rural/urban areas. At the beginning of the main pilot, the HWMC previously working in London began working in the East Midlands region whilst the two newer HWMCs took up the posts in London and the North East regions.

All three GPs recruited as HWMCs had experience working as occupational physicians and had also held health leadership roles in worklessness or workplace health either in the NHS or the Royal College of General Practitioners (RCGP). The pilot ended in March 2020 having run for approximately fifteen months.

The role involved working in collaboration with PHE, NHS England and NHS Improvement (NHSE/I), the Joint (DHSC and DWP) Work and Health Unit and other organisations to achieve the following goals:

- influence commissioners about the importance of the work and health agenda;
- promote the work and health agenda via targeted communications;
- engage and build wider support networks in their location;
- highlight good practice evidence around health and work;
- provide standardised training about health and work to HCPs; and
- contribute to health and work in wider forums.

HWMCs received support from both the PHE National Health and Work Team and in some cases PHE staff in their host regions with reviewing presentations and articles and in making some connections with relevant stakeholders.

This evaluation focuses on the work of the champions in the twelve months between January 2019 and January 2020 as only one HWMC was in post prior to 2019.

The 2019 Healthcare Professionals' Consensus Statement for Health and Work

In 2008, leaders across various healthcare professional disciplines developed a consensus statement on health and work[2] which outlined the importance of work for good physical and mental health, to prevent ill health, in helping people recover from

[2] 2008 Healthcare Professionals Consensus statement (page 67) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/209782/hwwb-working-for-a-healthier-tomorrow.pdf

illness and in providing social functioning benefits. This statement was signed up to by 37 HCP bodies.

In autumn 2017, PHE invited representatives from various medical professions to join a group to build on the work started a decade ago by co-designing a new consensus statement that would incorporate a statement for action to inspire, empower and support healthcare professionals to realise the potential of 'work as a health outcome'. The aims were to:

- build on the 2008 statement through the Delphi process[3] with a focus on changing culture and practice
- provide a shared narrative for unilateral and multilateral action planning
- agree process and leadership for monitoring and reporting actions.

The process of developing the 2019 consensus statement ran from December 2017 to May 2018 with meetings chaired by the then Deputy Chief Medical Officer, Professor Gina Radford. The approach taken to develop the statement was collaborative with 40 organisations involved in its development. Endorsement of the consensus statement came from the three umbrella bodies who represent most healthcare professions – Academy of Medical Royal Colleges (AOMRC), Royal College of Nursing (RCN) and Allied Health Professionals Federation (AHPF).

In the six-month period between September 2018 and March 2019, PHE worked closely with the AORMC and the Faculty of Occupational Medicine to organise a conference to launch the new consensus statement (see appendix) alongside the e-learning programme on health and work. A conference was held in April 2019 and a summary report of the Good Work is Good for You conference was produced by the AORMC.

Overall objectives of the evaluation

PHE commissioned Solutions Research to investigate views about the new Health and Work Consensus Statement for Action and to conduct a qualitative evaluation of the HWMC pilot.

Ultimately the aim of this evaluation is to inform PHE decision making about how and to what degree the HWMC pilot and consensus statement have helped to progress WAAHO programme aims, and how programme objectives might be best achieved in the future through gaining an understanding of:

- the enabling factors for success of the HWMC role;
- any barriers to the HWMC role;

- the value of having a clinician as the HWMC and what value this adds to the role specifically;
- views about the new Health and Work Consensus Statement for Action[4]; and how this has supported the programme;
- research-led recommendations to support future decisions in both these areas.

The detailed objectives of this qualitative evaluation in terms of the HWMC pilot are to:

- evaluate the success of the programme from a qualitative perspective
- provide an understanding of whether the objectives of the role of the HWMCs have been met.
- explore the four areas of HWMC activity outlined in the evaluation brief: influencing commissioning; promoting the agenda (communication); highlighting good practical evidence; and training clinicians.
- within each of these areas, provide details of the specific tasks that have been undertaken, the deliverables achieved and what the perceived impact of these have been.
- understand the impact of having clinicians in the role of champions – how does this contribute to the programme delivery and success overall?
- understand the key learnings and insights that will enable PHE to understand how the programme might be developed in the future.

The detailed objectives in terms of the new Health and Work Consensus Statement for Action are to:

- explore views about the progress made on the WAAHO concept and the practice of ‘work as a health outcome’ within umbrella organisations and member organisations.
- understand the degree to which the clinical Consensus statement has been an important aspect of the ‘work as a health outcome’ movement relative to other programme activity or other interventions.
- understand what interventions, support and activity stakeholders would value in the future to support the ongoing development of the concept and practice.

Methodology and sample

A qualitative approach was adopted for both these pieces of evaluation. Qualitative approaches are open and discursive in their exploration of project objective areas. A qualitative methodology allows for an in-depth examination of attitudes. Qualitative samples are purposive and quota-driven in nature; they are designed to reflect the range of audiences of interest to a study. They therefore do not have quantitative

[4] https://www.aomrc.org.uk/news-and-views/healthcare-professionals-consensus-statement-on-health-and-work/

accuracy in terms of identifying proportions of populations holding stated views. For these methodological reasons, it is not appropriate to present qualitative findings in terms of the numbers of respondents expressing certain views.

The method for the HWMC pilot evaluation involved in-depth qualitative interviews with the three HWMCs themselves, and nineteen stakeholders who have each engaged with one of the champions. This included a small number of HCPs who have had direct contact with the HWMCs as part of the programme they have delivered. Two of the HWMCs were interviewed face to face and one was interviewed by telephone. The stakeholder interviews were also conducted by telephone. The HWMCs were interviewed first to provide a context for the stakeholder interviews. Interviews with the HWMCs lasted between one and two hours and interviews with the stakeholders between 45 minutes and an hour.

The method for the Consensus statement evaluation included qualitative interviews with the three umbrella organisations which endorsed the statement and represent most healthcare professions – Academy of Medical Royal Colleges (AOMRC), Royal College of Nursing (RCN) and Allied Health Professionals Federation (AHPF), and seven member organisations which participated in the development of the statement. The interviews were mainly conducted by telephone with two interviews conducted face to face. Interviews lasted between 30 minutes and an hour.

All of the interviews were recorded and a thematic analysis was conducted. Thirty-four interviews were conducted in total.

HWMC pilot interview sample

The three HWMCs – one interview was conducted with each Health and Work Medical Champion.

DWP / JobCentrePlus x 4 interviews:
- employment and skills leads
- disability Employment advisors and team lead based in JobCentre Plus
- operational leaders

PHE Regional teams x 3 interviews:
- regional lead health and wellbeing roles
- workforce development

Public health x 1 interview:
- consultant, non clinical role, remit in health and work

Local stakeholder – NHSE/I x 1 interview

CCGs x 2 interviews
- Commissioning roles for population health and personalised care

Medical and health specialists x 4 interviews:
- physiotherapist specialising in occupational health
- organisational psychologist (DWP funded project on mental health and work)
- GPs and GP registrars
- physiotherapist specialising in occupational health, working in private sector

Charity x 1 interview:
- focus on specific long-term health condition

Representative member organisations x 2 interviews:

National stakeholders – NHSE/I x 1 interview

Consensus statement evaluation sample

Umbrella organisations:
- RCN - Royal College of Nursing x 3 interviews
- AHPF - Associated Healthcare Professionals Federation x 1 interview
- AOMRC - Academy of Medical Royal Colleges x 1 interview

Member organisations – one interview with each of the following organisations:
- Council for Work and Health
- Faculty Occupational Medicine
- Royal College of Psychiatrists
- Royal College of Occupational Therapists
- Royal College of Surgeons
- Faculty of Intensive Care Medicine
- RCGP

The interviews were conducted between 16 December 2019 and 5 April 2020 by Michelle Lloyd and Alison Benson (both of Solutions Research).

Research ethics

This evaluation project was carried out according to the Market Research Society's Code of Conduct and Ethics (www.mrs.org.uk/standards/code-of-conduct). The Code of Conduct was applied to all areas of the project.

The stakeholders for the HWMC pilot evaluation were recruited to take part firstly through direct invitation from one of the three HWMCs or from PHE. The stakeholders for the Consensus statement evaluation were recruited to take part through initial invitation from PHE to their organisation. Once respondents had agreed to participate, Solutions Research contacted them with further information about the project and to set up a suitable time for the interview once they had consented to participate. Interviews were scheduled at a time and place convenient for respondents taking into account their schedules.

In advance of the interviews, discussion guides and stimulus material were created for both pieces of evaluation. These were tailored to the different audiences and agreed with PHE before use. These guides were used flexibly so that each interview was open ended and discursive.

All data collected from individuals was stored in line with GDPR.

Limitations of the HWMC Evaluation

While all three of the HWMCs in the pilot were trying to achieve the same aims, each individual HWMC had autonomy to decide on their priorities, focus and approach, based on their experience, networks and their location. As a result, individual stakeholders had different experiences of the HWMC pilot depending on which champion they were working with and different models were explored. This constrains the ability to make general assessments or draw conclusions about the overall influence of the HWMC pilot activity as each role differed by individual HWMC.

The evaluation also showed that there was no one clear pathway for the HWMCs to achieve connections with their stakeholders - a range of methods and channels were used. Again, this has implications for the evaluation - since there was no ‘one size fits all model’ used by all the HWMCs - this evaluation is not assessing one model of working.

The short time frame for the pilot adds further constraints to the evaluation. The full pilot comprising three HWMCs ran for approximately fifteen months and the evaluation could only focus on the work of the champions in the twelve months between January 2019 and January 2020 as only one HWMC was in post prior to 2019 and this evaluation had to be undertaken and completed by March 2020. It was felt by stakeholders and the HWMCs that the impact would be hard to assess within such a short timeframe of activity.

It should also be noted that as the contacts for the stakeholder interviews for both projects were provided by the HWMCs and PHE, there is the potential for bias towards the programmes due to the selection process. As respondents were more likely to be

engaged with the programmes, this evaluation does not therefore include the views of people who are less engaged with the programmes, and it does not include HCPs who may have been influenced by the programme delivery eg through training or new initiatives, but are not involved in a more strategic role. Steps were however taken to limit the potential bias caused by recruitment. These included providing information about the project aims and objectives to respondents before the interview, highlighting the importance of understanding both the strengths and the weaknesses of the programmes from their perspectives, and confirming that quotes would be anonymised. In addition, the names of the stakeholders who were put forward by the Champions and who participated in the evaluation were not shared with PHE.

The wider context

WAAHO and progress

The WAAHO agenda is recognised by respondents in this evaluation as making slow and steady progress over the last 10 to 20 years. There is a view that the health service will need to undergo a considerable degree of change in attitudes and behaviour around patient employment, and as a result, it is believed that change will not occur quickly. Notwithstanding this, there is a widespread perception of a broad positive momentum in the WAAHO agenda over the long term, and this is despite the backdrop of challenges within both the clinical and political environment.

Indeed, some respondents working in leadership roles linked to health and work within their specific organisations believe that real change is taking place and believe that their role has been instrumental in helping to achieve this. They point to increasing numbers of conversations taking place around the WAAHO agenda; that there is increasing recognition of the issues around work and health; and that many new programmes have been put in place to bring about change.

This positive momentum is considered to have many drivers and supporting factors which have led to a greater awareness of the importance of good work for health and wellbeing, and to the development of HCP skills. The involvement of PHE and The Joint Work and Health Unit is recognised as an excellent opportunity to bring the issue more to the forefront and there is a sense of appreciation that the government is actively promoting the agenda.

The development of the consensus statement and its wider endorsement by the AOMRC, RCN and the AHPF to evidence their support of the agenda, is for many seen as a culmination of this gathering momentum.

Challenges of separate systems on work and health

While it is felt that progress has been made in the last 20 years – the two systems of ‘health’ and ‘work’ services are still felt to operate separately. One impact of this is the challenge faced by organisations or individuals who wish to work more collaboratively in building meaningful connections. There is evidence that forming relationships or contacts outside of their own area of work is difficult and that there is little common sharing of knowledge and understanding of roles and remits outside their own areas of expertise.

Each type of partner faces specific challenges in giving due focus to both employment and health issues.

Primary care services

A widespread issue noted in the evaluation is the importance of the patient/doctor relationship. Given the relatively limited access to occupational health within the workplace other than in large organisations, GPs and primary care providers are recognised as the key gatekeepers to conversations around work and health issues currently. However GPs in particular are likely to focus on health issues with their patients, and are not felt to have the time, capacity or knowledge to engage sufficiently in employment related issues, particularly when faced with complex situations. In addition, their role as trusted health advisors is not always felt to be compatible with conversations about returning to work which can at times be challenging, for example if the patient is not receptive, or concerned about benefit claims. GPs are currently not felt to be well equipped or trained in the details around employment such as the benefits system and work adaptations and relatively few have specific training in occupational health.

A key theme that emerges in the evaluation is the importance of training GPs further on this topic, and in supporting better use of the fit note within general practice. Some stakeholders suggest that consideration should be given to taking the fit note out of the hands of GPs, particularly for complex cases.

Some respondents highlight that there are insufficient links currently between primary care providers and DWP services such as Jobcentre Plus. Whilst they highlight signs of growth within primary care of non-clinical roles (eg social prescribers) that could play a part in supporting employment outcomes, awareness and understanding of these roles and in particular how they work in practice, is not always guaranteed.

Commissioning and strategic roles in local areas

A wide range of potential partners who carry out strategic functions work in local areas including PHE local and regional teams, public health consultants, Local Authorities, Health and Wellbeing Boards, Integrated Care Systems (ICSs), specialist charities with medical interest and Clinical Senates. The focus of each of these stakeholders is however very different depending on their specific remit. As a result, health, wellbeing and the WAAHO agenda may only be part of their wider role and they have many competing issues requiring their time and prioritisation. Consequently, a key issue noted for these roles is a lack of capacity.

Employment focused, eg Jobcentre Plus

These stakeholders focus on work and benefit related issues including encouraging people back into the workplace, training and ensuring they have the appropriate benefit support. The evaluation suggests these audiences are becoming more and more aware of the importance of links between the health and work spheres and the benefit this could bring to their customers. They recognise that their own settings, such as Jobcentre Plus environments, are not necessarily conducive to conversations about health issues and work with claimants. However they may not currently feel they have sufficient contacts to reach out to the health 'sphere', nor sufficient understanding of the health landscape, which would help them develop the right links and services. The information that would be beneficial to them includes understanding the GP context such as demands on GP time, the realities of patient consultations and the changing nature of general practice. In addition, understanding of medical conditions and strategic issues such as the agenda of bodies such as the NHS and PHE would also be helpful.

The evaluation highlights that connections between stakeholders are hard to forge across these disparate systems. The range of ways, as outlined below, that the HWMCs themselves developed relationships with the stakeholders interviewed is testament to this challenge.

Formal introduction - the HWMCs made contact with stakeholders through existing work-related channels and networks.

Existing personal contacts of HWMC – where the HWMCs share an interest in the area of expertise with the stakeholder, and a public profile. In the case of the pilot HWMCs, each have a public profile and wide existing network through previous/other work prior to the advent of the pilot. This means their existing networks are extensive and they could use them to make contact with a wide range of stakeholders.

Contact instigated by the HWMC – in some cases the HWMCs made new contacts specifically for this work. This was achieved by a number of routes including networking, conferences, committees, or cold calling to create contacts.

Word of mouth – **introduction through other contacts** – this demands a third party to match interests, seek out the HWMCs and make connections. It demands that the HWMCs have a high profile and that there is an awareness of their role.

Opportunistic meeting/introduction – this requires the HWMCs to network extensively to ensure these more spontaneous ad hoc meetings occur as often as possible.

The new 2019 consensus statement – main findings

Chapter summary:

The production and launch of a new consensus statement in 2019 has been received positively. The new statement is regarded as a well written, clear statement of intent, with important additional information in the form of the four actions. It is seen as a valuable update on the previous statement. The fact that the statement signals healthcare staff health and wellbeing is also considered important.

The success of the statement, however, is seen more in terms of awareness raising and supporting the growing momentum of the WAAHO agenda, than in terms of galvanising action on its own. It provides symbolic evidence of the perceived importance of the WAAHO programme across clinical disciplines and government. The three main umbrella body signatories deliver a sense of gravitas which is believed to significantly help the organisations who have been trying to promote the WAAHO agenda.

While it can be seen as a statement of intent with an important set of principles, the consensus statement is felt to lack practical advice. Without this practical aspect, there might exist a risk that it will not engage clinicians 'on the ground' as they will not know how to action it. There is also a sense that while some organisations have used it widely as a credibility tool, it has not been pushed sufficiently within organisations, and particularly to the grassroots HCPs, and this in turn has also limited its impact.

Role of healthcare professional umbrella organisations and member organisations

The Umbrella organisations (including AOMRC and AHPF) in health and care represent members' views on cross specialist issues and engage and support Royal Colleges to represent a joint collegiate view (Note: the Consensus statement falls into this aspect of their role). Their role is described as communicating with and encouraging member organisations rather than individual practitioners, but they are not in a position to directly influence or tell members what to do and what to distribute. It is seen as the role of the

individual Colleges and professions to choose how to disseminate, share and influence their own members and whether or not to set a topic as a priority.

In comparison, the member organisations' (eg the Royal Colleges) role is arguably more directional - it includes keeping their members (often HCPs) informed about information, news, best practice and new learning in their field, and in the case of the RCN also being a trade union. The member organisations may also have a role in setting and advising the GMC on training. Some member organisations also have different faculties or specialities within them which are likely to have variable interest in work and health issues.

Engagement with WAAHO agenda

Across both umbrella organisations and member organisations there appears to be a range of engagement with and activity around the WAAHO agenda. At one end of the scale are those organisations that are actively promoting the WAAHO agenda with external audiences and see it as an integral part of their long-term strategy. Other organisations consider the WAAHO agenda as equally important to their strategy but focus their attention internally, looking to see that the members in their remit are prioritising the agenda. At the other end of the scale, it appears that there are organisations that are less engaged with the agenda and although individual members may consider it important, the organisations may be doing less to promote the agenda currently. For these latter organisations, the WAAHO agenda is typically only one of many subjects that need to be raised with and considered by their members. They note therefore that although important, the WAAHO agenda may not be prioritised by members given that there are so many other competing concerns and interests.

Importance of the clinical consensus statement to the work as a health outcome agenda

The widespread perception of the new consensus statement among the umbrella and membership organisations interviewed is that it is an important document that has value in terms of raising the WAAHO agenda. However despite its symbolic value there is some criticism that it is not readily translatable into a tool for practical guidance and action.

The task of reviewing the previous consensus statement was welcomed across the stakeholders interviewed, as evidence in the field was considered to have moved on since its creation, so the previous statement was regarded as out of date. The very process of updating the document enabled constructive discussions between umbrella organisations and member organisations to agree the issues and wording of the statement. This process of collaboration was felt to be important in itself for raising WAAHO as a relevant issue and delivering greater visibility for the agenda across

members and organisations. Reaching an agreement on the importance of this issue across the three umbrella bodies representing the NHS workforce is recognised as a significant achievement.

Attitudes to the statement and launch

Reactions to the actual statement are mostly positive - it is appreciated as an excellent way to bring together the current thinking in the field, in a concise summary. The four principles are considered particularly important, relevant and an improvement on the previous statement.

While most of the reactions to the statement are positive, the style however can be criticised by some. These more critical voices call for a less wordy, more practical, action oriented version including more evidence. They express concerns that it may not be relevant to all HCP audiences and that the format and content may not communicate well at a grass roots level.

The launch of the consensus statement was perceived as fitting the significance of the topic and is described as a significant and worthwhile event. It is praised for being well organised and having a wide range of interesting workshops and speakers including the opportunity to hear from the three HWMCs. Presenting the consensus statement as part of a wider agenda and therefore framing it within the broader context of work and health, was felt to be a positive approach.

Perceived influence of the statement

Respondents across the evaluation recognise that the influence of the Consensus statement is hard to establish. It is described as an important symbolic document, a consolidation of views with a key benefit being the co-ordinated ‘voice’ of the three umbrella organisations, which delivers much needed gravitas. It demonstrates that the three important umbrella organisations representing such a wide range of HCPs, along with the Government are taking this issue seriously and are behind the agenda. This is felt to be particularly important for organisations who are already passionate about the WAAHO agenda, and who already play a key role in promoting the agenda within their members and externally. This new statement is credited with having an important role in creating a wider and louder voice for these organisations and professions, such as OTs, giving their message extra credibility.

The organisations that have been using the consensus statement most proactively believe that it has helped to build awareness, create higher visibility, initiate conversations and subsequently to help support a shift in culture. Other organisations, who are less closely connected to the WAAHO agenda, attribute a more symbolic and less practical value to the consensus Statement. They see it as a more theoretical

document that has not changed practice, but has helped reinforce the current momentum on the wider WAAHO agenda. These organisations tend to have found less proactive use for the statement although they may have distributed it to relevant members.

Despite its important symbolic value, the new consensus statement is not seen for the most part as a practical tool for galvanising action. There is therefore a sense that it has probably not been influential to practice amongst 'grass roots' practitioners for several reasons. Firstly, there are some views that it has not been promoted sufficiently on an ongoing basis and secondly because busy practitioners are hard to reach. Finally, respondents believe that the consensus statement needs to be made more 'real', action oriented, and more relevant to individual roles so that it can become a practical tool. It is also noted that there is currently no built-in way of measuring the success of the statement or review date, and no follow up guidelines.

The HWMCs share similar views about the role of the consensus statement and its wider impact and have used it in a variety of ways to help promote and support the wider WAAHO agenda and their objectives. Across the wider stakeholder sample in the HWMC pilot evaluation there is varied awareness of the consensus Statement. Those working more closely with the national agenda are more familiar with the statement and have seen it used to promote the WAAHO agenda. Other stakeholders who are working more at the grass roots levels and within the 'work' sphere had no specific awareness of it or examples of when it had been used.

A number of alternative suggestions were offered as ways to increase the influence of the statement and these included the potential to embed it more, linking it to wider initiatives like the NHS Interim People Plan, NHS Long Term Plan, NHS/I's prevention agenda and broader prevention work therefore making it more mainstream. Other suggestions for its promotion include: providing articles for umbrella bodies' websites for a member bulletin that could be adapted by each professional body; case studies of how it has been implemented and impact; resources to support HCPs talking directly to patients; guidance on how to integrate it with other work and competing priorities.

Other valued interventions, resources and activities

A range of examples of different interventions, resources and activities to support the WAAHO agenda, (including the consensus statement and supporting resources), were discussed and shown to respondents. This included examples of:

- Health Education England (HEE) and PHE e-learning resources
- conferences – PHE and other organisations
- blogs and articles across different trade press
- Talking Work resource

Appendix 2 lists some of the activities PHE undertook to promote the consensus statement and supporting resources.

The evaluation highlights that there is inconsistent awareness of the range of resources available about the WAAHO agenda which also promote the consensus statement. Few in the sample have actually used the full range of PHE resources, although some organisations signpost them on their websites and communications. Examples were given of how links to the PHE/HEE e-learning tools were being shared alongside information about the consensus statement, and also at conferences. Some of the organisations represented in the evaluation, have developed their own resources for the use of their members and wider interested parties.

A crucial theme raised across the evaluation is how to reach on the ground, busy practitioners who have many competing priorities, and who are unlikely to be clear about how best to support the agenda. Consideration needs to take account of: the best channels to reach them; the format of the materials, the role they are being asked to take; and the practical actions they can take.

There is a perception that having a range of materials is important as different audiences and individuals respond to different types of resources according to their interest levels and their available time:

- articles, blogs, conferences work well for raising the issue up the agenda
- e-learning is seen as important for developing understanding through training
- practical tools and tips work well to help instil a change in practice, even in small ways

Organisations are already using a range of online channels to communicate information about the WAAHO agenda, for important or ‘key’ messages. This includes emails from leaders within organisations, via Twitter, newsletters and websites. Articles in the trade press are still seen as important channels alongside member organisation blogs. Some respondents challenge the effectiveness of online communications however, as these communications can feel easy to dismiss if not directly relevant to the recipients’ specific line of work or interest. Face to face engagement is felt to work well in conferences, workshops, training and engagement exercises - but once again there may be an issue of only preaching to the converted who are already interested enough to attend. In all cases it is seen as hard to reach those who are not directly involved or specifically interested in the health and work sphere already.

E-learning is recognised by some organisations as a good tool to deliver training and development, particularly for those with an existing interest in the subject, but it may again fail to engage those who have less immediate interest or who are time pressed.

Overall, respondents highlighted the importance of including the subject of WAAHO on the curriculum via the GMC and of access to CPD routes for existing practitioners to improve understanding. In addition there are calls for more practical tools that deliver quick and easy to access information on WAAHO with clear calls to action and suggestions for patient engagement. Suggestions include creating short videos, short leaflets or one pagers with key facts and actions.

Suggestions for other activity to promote the work and health agenda

To complement existing activity aimed at building a healthcare professional's capability around work and health issues, respondents pointed to the potential benefits of further engagement with the general public, employers, NHS employers and cross-sector collaboration on work and health.

Engaging with the general public, potentially via a communications campaign, was mentioned as a potential way to encourage interest and engagement in the importance of good work as a good health outcome. This is seen as having the potential to pave the way for discussions they may subsequently have with their practitioners. Likewise engagement with employers is also considered important so that they fully appreciate the value and importance of a good working environment and workplace adjustments.

Co-operation and cross-organisational activity is noted as important in promoting the WAAHO agenda as it helps to break down barriers between the different work and health systems. Considering how to further support and encourage ways to promote collaborative working was therefore highlighted. The Joint Unit can be praised for its role as a cross-government body that makes this cooperation across different spheres a priority, and the involvement of bodies such as the Royal Colleges is considered important. Furthering collaboration including charities and representation groups can also be suggested.

Further communications activity aimed at the NHS might also have value and is highlighted by respondents. Both 'top down' and 'bottom up' communications are considered important in promoting the WAAHO agenda. Having grass roots activity and enthusiasm, alongside national figures communicating the importance of the agenda are both seen as good ways of raising awareness. A broader communications campaign could be useful to promote the WAAHO agenda to HCPs, for example a roadshow around Trusts, with campaign materials that can be used to communicate and reinforce the message. Consideration of how to also better use existing levers within the system can be suggested. This includes for example the regular logging of data about patients' work status, or approaches such as incentives or targets for HCPs and commissioning bodies.

The health and wellbeing of the NHS workforce is often raised in the context of the consensus statement. There is a recognition that NHS staff themselves are under a great deal of pressure and that the impact of their work on their health is not always as good as it could be. It is therefore seen as important that the NHS as an employer leads by example in terms of the WAAHO agenda.

The HWMC pilot – main findings

Chapter summary:

Overall, set within the context of the limitations of size and time, the Health and Wellbeing Medical Champions (HWMC) pilot is considered as a success by both stakeholders and champions alike. A key success is the role the HWMCs have played in bridging the gap across the fragmented health and work landscape and being a catalyst for positive change. As a result, the HWMCs have been able to create a common voice around key messages, promote the WAAHO agenda and keep it up the priority list for stakeholders. They have had some fundamental successes in supporting the promotion and setting of the agenda with national, regional and local bodies.

Training is another area of success with positive feedback provided around building knowledge, dispelling myths, and tactical training such as on the completion of the fit note and managing difficult patient conversations.

A key part of the success of the pilot has been the medical background of the HWMCs themselves who were all GPs, alongside their personal passion and vibrant personalities.

The pilot does appear to have created a sense of momentum, helping to raise the profile of WAAHO generally. It has delivered some specific outcomes such as training of HCPs, relationship building between primary care settings and JobCentre Plus settings and contributing to the promotion and setting of the WAAHO agenda. However it is hard to attribute more tangible outcomes to the HWMC pilot itself within the short time frame of its existence. Despite this, there is disappointment about the closure of the pilot across HWMCs and stakeholders alike and concern about the potential loss of momentum created.

Overall attitudes to the HWMC pilot

Feedback from the HWMCs themselves and the stakeholders interviewed about the pilot programme was generally positive. The HWMCs are very positive about what they

individually and collectively managed to achieve during the pilot, and there are indicators of where their work has managed to have an impact so far. The stakeholders are also mostly positive about the influence the pilot has had in terms of supporting their own roles and tactical changes or quick wins – for example integrating tips from training into practice, and some have also seen signs of strategic and wider systemic change occurring. There is a perception that the HWMCs have helped to support and shape the agenda around WAAHO during the timescale of the pilot.

Critical to the success of the programme is that the HWMCs are all GPs with added skills and qualifications around occupational health. This is a key driver of the perceived success of the pilot, as their experience brings credibility and expertise to the role. Stakeholders point to their knowledge of the health world and their ability to forge meaningful links with senior stakeholders. For many stakeholders, GPs are the missing link in the system and accessing this audience is especially challenging, and so having a GP as an HWMC is seen as hugely beneficial.

However, notwithstanding this positivity, in many ways the success of the pilot is hard to evaluate. This is in part due to the different modus operandi of the HWMCs themselves. In addition although there was an overall strategic objective for the pilot set at the beginning, common deliverables for the HWMCs were developed months into the role in collaboration with the HWMC to assist them in their work and help provide some measures of activity. Another evaluation challenge is that some of the perceived successes of the pilot involve the pre-cursors of behaviour change - the successes include building awareness of the WAAHO agenda and creating new dialogues, relationships and ways of working across the system.

This evaluation of the pilot also needs to be qualified and judged against the limitations which the pilot faced - all the HWMCs were working in a challenging environment with limited capacity for a relatively short period of time.

Barriers to success of the pilot

The limitations and barriers to success of the pilot itself include:

Pilot set up and delivery

The small number of HWMCs (3) and the limited allotted time of 1 day a week, 8 hours per day is considered across the sample to be too little time to be able to achieve significant and sustainable success. The role was challenging to fit around other work commitments and the champions needed to be very flexible in their approach to manage the competing demands on their time. In reality this meant that they were available across other days, were flexible in terms of times for meetings, following up, attending events etc. Each HWMC in the pilot committed more time to the pilot than the

time allocated. Administrative support would have been hugely beneficial, freeing up the champions' time to focus on the key activities and deliver support as the HWMCs had to spend time on organisational activities such as setting up meetings

It is also felt that the length of the pilot (fifteen months) was too short to deliver on the original objectives. Stakeholders and HWMCs recognise that working to bridge the gap between the work and health spheres and to make the appropriate connections with the key individuals takes time. They can express concerns that this will be challenging to sustain if there is no designated and accountable individual to drive the work forwards.

The role limitations in terms of number of days also means that HWMCs have not been able to get involved in everything they would have liked to and equally some stakeholders were not able to access them as much as they would have liked. The role also took time to settle into and define the key areas of focus given the breadth and openness of the original outline objective which meant there was some lack of clarity at the beginning. All the HWMCs were given a degree of autonomy around how best to approach the role reflecting their own skills, expertise and the challenges in each local area, resulting in different approaches. The additional clarity through the provision of the statement of works which was shared once the pilot was up and running was helpful in shaping the objectives.

The focus of the three HWMCs was slightly different as follows: (please note this is not a definitive list of activities)

Midlands:

- working with commissioning partners, ICS and East Midlands Senate
- training clinicians via a specific training programme developed by HWMC
- communications and marketing including presenting at conferences and writing articles and blogs
- liaison with DWP and other partners

North East:

- working with DWP and PAS
- working with commissioning partners, ICS
- training HCPs – train the trainer approach

London:

- working with a range of organisations including
    - Healthy London Partnership and accelerator programme
    - Jobcentre Plus /Direct Earnings Attachment and primary care
    - Association of Social Prescribers and link workers and PCN

- Royal College of Occupational Therapists and looking to embed PHE RCOT Health and Work Champions pilot[5] at NHS Trust level

Complex, separate health and work systems

The success of the pilot also needs to be placed in the wider context of the health and work systems and landscape within which it is was conducted. Irrespective of where they are located in the system, respondents in the evaluation reiterate the complexity and fragmented nature of the health and work systems. The challenge of creating connections across complex systems whilst influencing changes in practice, made it particularly difficult to effect meaningful change. Furthermore, GPs who are the key point of access for most of the general public to WAAHO service, are time constrained, lack the skills and/or incentives and motivation to make changes in this area.

Some respondents also commented that there are no formal targets for commissioners and practitioners alike around WAAHO which means that other issues can feel more of a priority to them.

There has also been a changing political environment during the course of the pilot, for example with a General Election and Brexit. HWMCs have had to work hard to identify inroads and drive interest against this backdrop.

Summary of success across key work strands

The key work strands of the HWMC pilot as outlined by PHE are as follows:

- promoting and communicating the WAAHO agenda
- engaging regional and national partners (noted in previous research)
- influencing commissioning
- training and skills development
- highlighting good practice and evidence
- identifying research funders (noted in previous research)

Despite the limitations of the pilot and the complexity and constraints of the systems that the HWMC operated within, the HWMCs appear to have achieved a considerable amount in a relatively short timeframe.

There is a widespread perception that having an individual to champion the WAAHO agenda has helped to increase momentum in this field, despite competing priorities and shifting agendas. This constant voice is perceived as critical as whilst the WAAHO

[5] https://www.rcot.co.uk/promoting-occupational-therapy/health-and-work-champions-promoting-health

agenda is recognised as being important, for many stakeholders it has a low prioritisation and therefore, a champion helps keep the issue front of mind.

All three of the HWMCs have taken on the WAAHO agenda and shared this widely and feedback suggests these individuals are increasingly being seen as key voices and experts in this area. They have dedicated time to promote the agenda with national, regional and local bodies building meaningful connections and links with key agencies and individuals.

In terms of specific deliverables, training and skills development is perhaps the most distinctive and easiest to evaluate in terms of the courses and training delivered. The HWMCs did not engage with the training and skills development to the same extent and therefore whilst there has been success in this area it has not been given the same level of priority across the three pilot locations. The training in one region focused primarily on face to face GP and Registrar training, training in other locations took a 'train the trainer approach' and the training of non-medical stakeholders. Delivery of training by an experienced GP was considered a key factor for success as it felt credible and reflected the day-to-day reality of a GP.

Influencing commissioning is a broader, more collaborative role. Furthermore, there is a high degree of overlap between this influencing role and promoting the agenda and building awareness via engagement with different parts of the system. As a result of this overlap, success in these areas is harder to evaluate as the blurred nature means it is difficult to apportion a specific output to a particular activity. It is widely believed however, that in many ways it is these softer, less distinctive activities that will lay the groundwork for sustainable change at grassroots level.

A key area of success identified in relation to the HWMC pilot has involved bringing the health and work systems together and creating meaningful links. Feedback suggests the HWMCs have all managed to help bridge the gap between the health and work sectors and the connections that have resulted demonstrate the potential of the role to help support change in the system and new ways of working.

There were already signs before the HWMC pilot of impactful change at the local level including where DWP roles have been physically introduced into GP practices. This has led to sharing of caseloads by GPs and employment advisors, with reports of reduced pressure on GPs and different types of work related conversations within the clinical settings. This was a key area of focus in two of the three pilot areas where the HWMCs have successfully supported the development of these relationships through the provision of education, guidance and support to DWP teams, linking relevant organisations, sharing of the model across other organisations and helping to promote the model at a local and national level.

Across the three HWMCs, there has been collaboration with a wide variety of stakeholders across the health and work spheres. These include many examples of interactions across healthcare systems, employment support systems, charities and with individual practitioners (eg ICSs, Clinical Commissioning Groups, Local Authorities, public health teams, DWP and practitioners such as physiotherapists, organisational psychologists etc)

There are some good examples of successes where the HWMCs have been involved in supporting work which has led to WAAHO measures being adopted by ICSs and Clinical Senates.

Responses to the end of the pilot

The HWMC role was established as a one-year pilot within the wider WAAHO programme. When commenting about the success of the pilot and their attitudes to it coming to an end there was general disappointment about it finishing, and also a sense that a year-long pilot did not allow sufficient time for effecting meaningful, sustainable change in the local places they operated in. There was also a sense that there was more that could be done with momentum now building. Key questions raised include how sustainable the progress that has already been made will be once the HWMC role ends and how to maintain the contacts and networks already established. Concern can be expressed that aspects of the HWMC roles such as making links between the work and health spheres at a local level, training and education and driving through the agenda with commissioners, are less likely to be sustained without a dedicated individual to spearhead and retain the focus of this agenda. There is greater optimism for projects that have attracted their own funding or are now established.

The evaluation provoked some discussion about the ideal funding responsibility and ownership of such a role in the future. Although national funding demonstrates the importance of the role and agenda, it can potentially lead to conflicts within the role in terms of priorities if there are several national bodies all involved with the programme. There is an argument that a locally funded and ‘owned’ model may make it easier to deliver the local priorities and ensure the role is fully embedded in the local community and plans.

Overall, there is widespread agreement amongst most respondents that the concept of having a medical champion for the health and work agenda is a useful one although the cost of the current model can occasionally be raised as a concern. This evaluation suggests that there is an appetite for joint working and linking together this traditionally siloed workspace. It also suggests that the ongoing training of HCPs about the WAAHO agenda and fit note completion is important, as is the promotion of the agenda more broadly, as these help to increase momentum and support prioritisation of the agenda at a local level.

Detailed findings against the specific HWMC pilot objectives

Promote the work and health agenda via targeted communications

The HWMCs state that they have all contributed to wider forums about WAAHO as part of their role, and stakeholders are positive about the value of this profile-raising work. The ability of the HWMCs to have a single minded focus is seen as an important benefit, however respondents felt any achievements in profile raising will have been relatively limited given the context of this being a small pilot in a complex space. In addition as the HWMCs hold other roles alongside their role as champion, it can at times be hard to distinguish their specific impact in this role alone.

The very existence of a 'champion' focused on the WAAHO agenda is felt to have been beneficial in widening the profile and reach of the agenda, and also encouraging the prioritisation of the work and health agenda - keeping it 'top of mind'. The HWMCs have been involved in the delivery of several different conference presentations, internal presentations to local agencies/teams, writing papers and articles for the trade press, workshops, blogs and more generally 'spreading the word'. In addition, there is evidence of an increasing number of invitations the HWMCs reported being given to contribute on a broader basis.

Influencing commissioners about the importance of the work and health agenda

The role of the HWMCs involved the promotion of the agenda at a commissioning level and this was achieved through a range of different activities. Evaluating the impact they had in this area is challenging however due to the long term nature of the changes needed, and the complexity of the objective.

Delivery of this objective was achieved in a range of different ways including working with NHSE/I and PHE to promote the agenda to ICSs, CCGs, Clinical Senates, encouraging them to adopt specific action points around WAAHO. It also involved working with other local partners such as DWP/JobCentre Plus, primary care providers, interest groups, councils and charities supporting their relationship building and furthering their understanding of the health landscape. Overall, this work involved supporting existing initiatives as well as supporting the development of new initiatives.

The evaluation indicates that the HWMC objective of influencing commissioning partners was hard to deliver. Developing existing contacts and reaching out to new contacts to drive traction and engagement was very challenging and success in this area was dependent on more than just hard work by the champions, 'knocking on a lot of doors' to make connections. It appears that some contacts were more open to contact during the pilot period than others - the timing and funding needs to be right for local organisations to engage. Also varying local priorities add an extra challenge –

WAAHO may be deemed important, but more pressing local priorities can exist that reduce a local partners' prioritisation of WAAHO. In addition, lack of formal performance indicators about WAAHO may further demotivate partners to collaborate.

Working with health commissioners

Overall, stakeholders are positive about the role the HWMCs played in supporting the work to influence commissioning, again set within the limitations of the size and scale of the pilot. Overall this element of the role is described as being a catalyst, helping and supporting work that aimed to influence decisions happening at a strategic level. Examples of the input provided was the support in the creation of briefs and presentations to key bodies; they were able to access their contacts and link parties together; they helped to raise the profile of the health and work agenda via communications, training and workshops and during meetings. Importantly they provided resource dedicated to the issue; and being a peer, they brought credibility to the role.

Some examples of successes achieved in one of the regions over this time period that the HWMC was involved in include:

- three Integrated Care Providers / Partnerships committed to increase the strategic priority of health and work, including strengthening employment support via new NHS Social Prescribing Link workers and First Contact Practitioners as a result of the HWMC action
- Primary Care Networks to take up the offer of training by Public Health England's 'Work as a Health Outcome' clinical champion for Protected Learning Time (PLT), and GP registrar training as a result of the HWMC action
- the regional Clinical Senate have included a stated aim to make work/health one of their priorities for the next year

Working with DWP partners

The work with DWP partners is often highlighted as a key area of success for two of the HWMCs, particularly their role in helping to break down silos. HWMCs appear to play an important role in bridging the gap between work and health. To varying extents and dependent on the existing relationships between DWP and primary care providers in the regions, the HWMCs were credited with supporting the relationship building in the following ways:

The provision of education and guidance and support to DWP teams:

- in one region where the links between the systems were not well established, this role was noted by stakeholders as helping to educate and encourage the DWP

teams in pursuing and developing their relationship with primary care providers, 'glue-ing' the parties together

Linking relevant organisations together:

- through the sharing of relevant existing contacts and introductions to new roles eg social prescribing

Sharing of the model across other organisations and promotion of the model at a local and national level to help support its further development.

Linking interested parties

A part of the HWMCs role has involved supporting relevant organisations to link up together who otherwise could not find a way in to link up. This is particularly important given the siloed nature of the health and work spheres. The champions acting as a bridge between organisations with the same strategic objectives but who work in different spheres, is credited with helping to progress discussions and enabling people to work together more easily. It is hoped that this will help them move towards their shared goals more easily.

Provide standardised training about Health and Work to HCPs

The HWMCs have provided a range of support and training to facilitate the development of the WAAHO agenda. Training provided across the time period of the pilot has covered GP registrars, GP leaders and trainers, as well as input for potential pre-clinical training and training around specific conditions for non-clinicians, local services and charities. The benefits of this training are noted as helping to build increased awareness and understanding of the issue, as well as developing skills-based training.

A primary focus in one region has been the training of GPs and GP registrars and feedback on the sessions suggests this has been well received. This training package was developed and promoted due to awareness of the gap in the knowledge and confidence of GPs with respect to the WAAHO agenda. It covers information about the WAAHO agenda, practical advice on how to manage consultations and on working with the fit note, and links to other resources and support materials. GP Registrars are noted as particularly receptive to this training and appreciate the skills training and confidence building it delivers. The delivery of this training by an experienced GP is described as very important as it provides peer to peer credibility.

Success is also noted through the repeat invites and requests for longer sessions. There is some low level anecdotal evidence of changes in practice and that training focused on this theme has helped push WAAHO up the agenda for busy GPs.

Another example of training delivered is the use of a 'train the trainer' approach to help cascade the information to wider numbers of clinicians. There are also examples of the HWMCs working with individual charities in the development of a video training tool, work with Colleges such as the Royal College of Occupational Therapists, to deliver training to their members, and training DWP Disability Employment Advisors, OTs and conducting training alongside the Healthy London Partnership.

Highlight good practice evidence around Health and Work

The HWMC role is seen as very important in the highlighting of good practice across the health and work agenda. Good practice is seen as a common theme throughout the training they deliver, when they are promoting the WAAHO agenda, and in all their wider presentations. The HWMCs are also noted to have supported the promotion and communication of the model of employment support within surgeries at a local and national level. It is felt however, that HWMCs could make more use of case studies in the good practice evidence.

Future learnings and success factors

The model itself of having a medical champion for the health and work agenda working in a local area is believed to work well and there is some discussion about how to make this role work best.

How HWMCs add value

Despite the limitations of the HWMC pilot, it has shown that there is an appetite and a need for joint working, linking together this traditionally siloed workspace. The HWMCs in the pilot have shown that they can be an important catalyst to help push the WAAHO agenda forward by providing dedicated resource. The key ways the HWMCs add value are acting as a bridge between the health and work spheres, through their promotion of the WAAHO agenda both to commissioners and to on the ground clinicians, and through their training of HCPs and non-HCPs about the importance of the issue and practical information about how to take action.

There is concern expressed across the sample that without a medical champion the agenda will not move forward as quickly as it could, given the competing priorities of stakeholders and the divisions between the health and work spheres as they stand currently.

Capacity constraints of the champions

It was felt that working only eight hours each week for the duration of the pilot was too little time to achieve significant and sustainable success. Having more time to do the

work would have been beneficial. A further constraint was around lack of time for cross-fertilisation and sharing of learnings between the HWMCs themselves. Again, this could have been beneficial to ensure best practice was spread across the whole programme. A potential way forward would be to have a 'medical champion day' to collaborate and pool resources. Allocating administrative resource to the HWMCs to support with setting up meetings would also have been beneficial in terms of time management.

Pilot set up and evaluation

A key learning is that greater clarity is needed at the start of the pilot in terms of objectives and ways of working to ensure that the success of the programme can be measured. With clear objectives and goals and models of working, a programme of evaluation can be set up at the start to track progress against goals with set questions that can be used quantitatively at training events, conferences and other promotional events, and qualitatively with key stakeholders across the programme.

Importance of local knowledge and capacity

There is a perception that as each local area has different needs and is facing different issues, a 'one size fits all' HWMC model may not work. Having a champion with local knowledge and good contacts is key and having several champions may be needed in each area to have traction. It is felt that more time and investment and clearer objectives for the role at the outset would make the activity more influential, but also that being able to flex around local priorities, HWMC interests and contacts is helpful.

Funding and ownership

A question raised by some respondents when considering the future continuation of the programme is the management and funding of such a programme, which would additionally inform the setting of clear objectives. Should it be managed nationally, under the leadership of a specific department which would align its objectives to the role. Or should it be managed and funded locally which could potentially increase ownership and delivery at a local level, also allowing a flexible model tailored to the region. A third option, co-funding with both national and local partners, could also be explored.

The value of having a clinician as the champion

The clinical GP role of the HWMCs is seen as fundamental to the success of the role. Having this specific medical background is consistently regarded as a key benefit and invaluable part of the HWMC role by stakeholders and champions alike. It is the GP background that brings gravitas to the role, with their lived experience of working with patients and a deep knowledge of the health system. It also means they can deliver

training credibly as they are grounded in the reality and challenges of the GP setting. They can be realistic about completion of the fit note and about dealing with patients in challenging situations. They can also draw on real life examples to bring the training to life which is critical for training both GPs and non-GPs alike.

Key skills and personality

The success of this pilot is also attributed to the personality, passion and expertise of the individual champions who are respected clinicians known for their work in this field. Their enthusiasm for the subject, good local contacts and excellent communication skills helped make a success of the pilot.

Next steps

Both the Health and Work Consensus Statement and the Health and Work Medical Champion pilot have helped to create and raise the profile of the WAAHO agenda.

The Health and Work Consensus Statement is deemed an important symbol of the programme's significance. It is also seen as a successful tool in raising awareness and supporting momentum. Going forward, it may be useful to consider additional activities and/or resources that may increase awareness and the practical application of the principles in the Statement by clinicians on the ground.

Set within the context of the limitations of size and time, the HWMC pilot is considered as a success by stakeholders and champions alike. They have played an important role in bridging the gap across the fragmented health and work landscape and being a catalyst for change. It is recommended that the key success factors and barriers to success highlighted in this report are taken into account in future considerations of this role.

Appendix 1

2019 Healthcare Professionals' Consensus Statement for Action

Statement for Health and Work

The relationship between employment and health is enduring, close and complex. Working can give an individual a sense of fulfilment and purpose[1], and can be paid or voluntary. Being in work, staying in work and returning to work are all associated with improved mental and physical health, provided the work has security, realistic demands and a level of personal control – known collectively as "good work". Working in itself can have therapeutic benefits. Conversely, being unemployed can have negative impacts on health and wellbeing.

Working can be considered a health outcome in itself reflecting how well we are supporting individuals to adapt to or recover from their health challenges. The majority of health-related worklessness is not inevitable and with the right advice and support, many individuals can achieve their working potential.

People whose ability to work is at risk, including through ill health or disability, should be helped to remain in work or make a timely return to working. Individuals who have never worked and have the potential to do so should be supported to develop their aspirations and capabilities, so they can gain the health, self-worth and the social and economic benefits good work provides.

We recognise some individuals will be unlikely to achieve paid employment that provides economic independence but they shouldn't be denied the opportunity to contribute and participate through working in some form.

Healthcare professionals can work together with patients, as an integral part of patient care pathways, and with partners, to:

- Create a culture where good work is seen as a benefit to people
- Help promote the aspiration of working in patients
- Promote healthy life choices and lifestyles
- Discuss, where relevant, health risks, hazards and any adaptations in working environments
- Provide support to help patients enter, remain in or return to work when they are ready and able to
- Help patients access high quality sources of specialist support to enter or maintain work
- Contribute to reducing the social discrimination, harassment and victimisation associated with ill health or disability, both physical and mental.

A statement for Action: Four principles for all healthcare professionals:

We the undersigned commit to work over the next five years to support healthcare professionals to engage more proactively with, and advance the concept of, 'good work as a health outcome' across the health and care sector.

We will work together, as individual organisations and collaboratively, to enable every healthcare professional to:

1. Understand the health benefits of good work, and the long term effects of avoidable health related worklessness

[1] M. Marmot, 2010. *Fair Society Healthy Lives, The Marmot Review.*

1

Appendix 2

Activities undertaken to promote the 2019 HCP Consensus Statement

Action	Date
Good Work is Good for You Conference (consensus statement launch event)*	April 2019
NHS Health at Work News bulletin	May 2019
PHE's Allied Health Professionals Lead wrote a Health and work blog which mentioned WAAHO products	July 2019
Article "GPs have a key role to play in helping people back into work" published in GP Online*	July 2019
Article in Society of Occupational Medicine Newsletter*	Aug 2019
The Workplace Health session of PHE's All Our Health eLearning resource was updated to reference to the statement*	August 2019
Article "Linking work and health: the role of nurses" published on the RCN blog*	Sept 2019
'Work as a Health Outcome' poster at the Macmillan GP conference*	Oct 2019
The 2019 Royal College of General Practitioners (RCGP) Conference* • Symposium "GPs helping patients to remain in /return to work – why does it matter?" • Conference app sponsorship with links to the consensus statement	Oct 2019
Continuing professional development (CPD) module "How to support patients in getting back to work" in Pulse Magazine*	Jan 2020
The 2020 Health and Work Conference* • PHE Health and Work Exhibitor Stand featuring information on the consensus statement alongside other WAAHO products • Conference app sponsorship with links to the consensus statement • Email communication to all conference attendees with information on the consensus statement alongside other WAAHO products	March 2020

*These events/products also promoted the work and health e-learning program