Public Health in Practice 8 (2024) 100548

Contents lists available at ScienceDirect

Public Health in Practice

journal homepage: www.sciencedirect.com/journal/public-health-in-practice

Embedding work coaches in GP practices: Findings from an interview-based study in the UK☆

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ARTICLE INFO

Keywords:
Work coaches
Disability employment advisors
Employment
General practice
Fit note

ABSTRACT

Background: The integration of work coaches (WCs) and disability employment advisors (DEAs) into General Practitioner (GP) practices in the UK aims to address the interplay between health and employment by facilitating access to employment support, especially to people with disabilities and health conditions affecting their ability to work. This study seeks to explore the perspectives and perceptions of WCs, DEAs and GPs regarding the benefits and challenges of embedding WCs and DEAs in GP practices.

Methods: Data was collected between May and July 2023 through semi-structured interviews with four GPs, four WCs and four DEAs working in NHS GP practices. The interviews were audio-recorded, transcribed verbatim and thematically analysed using the Thematic Framework method. Emergent themes were pre-structured and classified as perceived benefits, barriers and challenges or drivers and strategies.

Results: The integration of WCs & DEAs within GP practices was perceived by respondents as fostering a direct collaboration between professionals as well as a greater openness of patients which benefited patients, WCs/DEAs and GPs. While all respondents emphasised the various benefits, they also identified several barriers and challenges. The implementation stage was perceived as particularly challenging, especially by WCs and DEAs, whereas the lack of human, financial and logistical resources hindered the service beyond this stage. Several strategies and drivers to support the service were identified, including the importance of receiving support from all professionals involved as well as making the service visible to both healthcare professionals and patients.

Conclusion: Embedding WCs and DEAs in GP practices emerges as a promising approach which can benefit patients, GPs and WCs/DEAs. Exploring patients' perspectives directly is crucial to fully assess this type of service and identify any additional challenges and benefits.

1. Introduction

The Dahlgren-Whitehead model places work conditions and unemployment among the key social determinants of health [1,2]. Similarly, the UK government identifies employment as one of the most important determinants of physical and mental health [3]. Being unemployed long-term is associated with a lower life expectancy and poorer health [4]. Currently, unemployment rates in the UK stand at 3.7 % [5], and almost 1 in 3 and around 1 in 5 of the working-age population have a long-term health condition [6] or a mental health condition [7]. Health issues among working-age people are estimated to cost £100bn and sickness absence costs employers £9bn a year. Employees' poor mental health costs the UK £45bn each year, with London being the worst affected region [8].

Obtaining the right advice is essential in addressing the economic and ill health effects of both unemployment and poor working

☆ Link to target Journal:• Occupational Medicine | Oxford Academic (oup.com)• Perspectives in Public Health: Sage Journals (sagepub.com).

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https://doi.org/10.1016/j.puhip.2024.100548
Received 26 April 2024; Received in revised form 2 September 2024; Accepted 3 September 2024
Available online 12 September 2024

conditions, particularly for those with chronic illnesses and disability. Jobcentres or Citizen Advice Bureaus offer advice on benefits and employment [9]. In 2013, the Department of Work and Pensions (DWP) introduced the role of Work Coaches (WCs), which is a very similar to the previous Job Center Plus (JCP) Adviser [10]. Disability employment advisers are work coaches who specialise in providing support and advice to those who have a disability or long-term health condition. Both DEAs and WCs roles aim to provide skilled advice and guidance to those wanting to return to work, as well as identify benefits and support for those who are unable to return to work. Although DEAs and WCs are not healthcare professionals, they are trained to signpost to relevant health services where required.

A report carried out on behalf of the DWP and published in May 2023 [11] posited that WCs provide the most effective support to those closer to the labour market. However, limitations were identified particularly among recipients who were more likely to face additional barriers to employment due to their health or caring responsibilities. In addition, when based in JCP, these specialists only reach a proportion of the eligible service users, due to lack of awareness or fear of stigma. Further, only up to 50 % of the UK workforce has access to specialist Occupational Health (OH) advice, which is not part of the NHS provision [12]. Vulnerable workers, including those in insecure employment and exposed to poor working conditions, are also less likely to have access to OH advice and support. Conversely, all working-aged people have access to primary care in the UK and therefore tend to turn to their General Practitioners (GPs) and other healthcare professionals for support for work-related illnesses [13].

However, physicians often receive limited OH training [14] and lack time to offer adequate OH advice to complement the provision of 'fit notes' [15], which replaced the sick note in 2010 to encourage GPs to make shared management plans with patients to help them get back to work and prevent unnecessary sick leave [16]. However, a recent analysis showed that almost 95 % of fit notes are signed as 'not fit' for work without the recommendation of any adjustments or advice to help keep patients in work [17]. Almost one-third of fit notes are signed off by GPs for five weeks or longer [17], by which time 20 % of people will never return to work [18].

To address these issues, several initiatives sought to integrate vocational advisors in general practices since the mid-90s in the UK [19]. Evidence suggests that these placements can benefit patients by facilitating access to welfare advice and health related benefits which had not been claimed due to stigma or lack of awareness of eligibility [19,20]. In some cases, the service led to improved patients' health and quality of life by reducing anxiety and stress caused by adverse socioeconomic circumstances [16,21]. By reducing sickness absence, the integration of vocational advisors has also been shown to have significant financial and societal benefits [22]. Finally, these initiatives can reduce GPs' workload by providing an alternative resource to refer patients for welfare advice [9]. However, the integration of vocational advisors has also raised criticism and concerns, in particular, due to fears of an increased workload for GPs [23] but also a risk of pathologising the unemployed, especially in the case of patients with mental health issues [24].

The existing evidence looks predominantly at Citizen Advice Bureaus in primary care, whose role is to provide general life advice to patients and deal with social matters [25]. Conversely, DEAs/WCs's role is more focused. Some GP surgeries still have Citizen Advice services, but their scale has been cut back and their locations vary geographically. More recently there has been a move toward social prescribers within practices and the PCN's which perform similar roles to Citizen Advice Bureaus in primary care. Citizens Advice Bureau have calculated that 19 % of GP consultations are for non GP related matters and that costs according to their estimates £400mn a year [26].

The integration of WCs and DEAs into primary healthcare settings remains understudied in the UK and empirical evidence is scarce. The aim of this study was to investigate the perceived benefits, drivers and challenges of integrating WCs into primary care according to WCs and GPs currently involved in such initiatives in the UK. Given the limited literature on this topic, this work is a first step towards a deeper understanding of the potential of this service delivery model and could help uncover broad themes that can guide further research.

2. Methods

2.1. Study design

We used an applied qualitative research study approach utilising semi-structured interviews with GPs, DEAs and WCs to explore their perceptions of the benefits and challenges of integrating WCs and DEAs into general practice.

2.2. Data collection

Participants were selected through convenience sampling. Potential participants were contacted by email via professional networks. All those who matched the inclusion criteria and expressed interest in participating received a participant information sheet outlining the research project's objectives along with interview details. Included participants provided written informed consent for interviews and audio recordings through email and verbal confirmation prior to the interviews. Respondents were assured of their voluntary participation and their right to withdraw at any point.

MEA, a female medical doctor (MBBS) with a Masters in Public Health, conducted all interviews via Microsoft Teams between 23 May and July 26, 2023 with no one else present. All interviewees were unknown to the interviewer prior to the study. Each interview, lasting between 30 and 45 min was guided by two sets of interview questions specifically designed for GPs and WCs/DEAs, respectively **(Appendix 1).** No repeat interviews were carried out. Interviews were audio-recorded, transcribed verbatim and thematically analysed. Only three authors had access to the complete transcriptions of interviews, which were saved on password-protected Imperial College London's secure online environment: MEA (MD, MPH), AEO (MSc, MPA, PhD) and ERS (MA), all mixed methods researchers. MEA and AEO are mixed methods researchers with prior experience in conducting qualitative research while ERS is a social scientist with a Masters in Social Sciences and extensive experience in conducting and analysing qualitative research. Transcripts were not returned to participants, and no feedback was requested from them regarding the analysis. All co-authors supported the development of the study protocol, study design, data collection and/or data analysis, and were experienced in conducting qualitative research. The semi-structured inteview guide was reviewed internally by the research team and departmental colleagues (GPs and primary care professioanls) but did not involve patients. The first interview conducted was used to refine the topic guide by identifying most relevant questions & missing themes.The Consolidated Criteria for Reporting Qualitative Research (COREQ) was used to guide reporting of the study **(Appendix 2).**

2.3. Data analysis

A thematic analysis was conducted on interview transcripts by identifying codes and constructing themes. ERS and MEA led the content analysis using Nvivo 14 and following the Framework Method [27]. Given the exploratory nature of the study and limited evidence available on the topic, no theoretical framework was chosen a priori. Emergent themes were initially pre-classified as benefits and barriers. However, the inductive reasoning allowed to identify several strategies and drivers which emerged during analysis and were added as a third main theme. The preliminary findings were discussed with the broader research team to refine the themes and codes identified and to select main, recurrent themes to be presented.

2.4. Ethics

The study received a favourable opinion from the Imperial College Research Ethics Committee (ICREC), reference number #6707744.

3. Results

3.1. Participant characteristics

A total of 12 respondents were interviewed, including four GPs who referred patients to the in-practice service and eight WCs/DEAs who received service users within GP practices in the UK. Participants (GPs, WCs and DEAs) all worked in different practices except for 2 work coaches who both worked in the same 3 practices. Detailed participant characteristics are outlined in Table 1.

3.2. Perceived benefits

Respondents appeared very enthusiastic about the service, highlighting a variety of benefits. Mainly, the presence of WCs and DEAs within the GP practices allows for direct collaboration between professionals while providing a safe and accessible space for clients to open up to the WCs/DEAs. Professional and personal benefits were also reported, including a decreased workload for GPs. Key themes and subthemes are presented in Table 2, with all supporting quotes provided in **Appendix 3**.

3.3. Advantages of being in the GP practice

A key strength of working in GP practices identified by WCs was the GP surgery itself, which appeared to be a safer, more comfortable setting than the JC. This helped people open up to WCs and DEAs:

> *"The practice offers an environment where people feel comfortable to open up, they feel more comfortable and relaxed within a familiar and safe setting. And especially for people with anxiety, we find that they're more open to us and we're going to have a sort of more meaningful conversation"* (DEA 3, F)

The physical presence of WCs/DEAs within the GP practice also fostered their direct collaboration with GPs and other HCPs with most WCs/DEAs reporting joining clinical meetings to discuss patient cases, but also GPs calling them for advice and WCs/DEAs reporting back to GPs about the patients, thus allowing for the direct, easy sharing of information between different professionals.

> *"I previously never had a relationship with the job centre, so it provides with a direct link with DWP (…) I happen to overlap the day that he works so I can talk to him directly about patients I have in mind or he can feedback about patients that he's seen and he's just there really accessible. And you know, if I have any queries and benefit-related things, he can just answer those things. So it's really wonderful having him on site"* (GP 1, F)

Table 1
Participants' characteristics.

	N	(%)
Total	12	(100)
Gender		
Female (F)	10	(83.3)
Male (M)	2	(16.7)
Employer		
NHS	4	(33.3)
Jobcentre Plus	8	(66.7)
Designation		
General Practitioner (GP)	4	(33.3)
Work Coach (WCA)	4	(33.3)
Disability Employment Advisor (DEA)	4	(33.3)

Table 2
Perceived benefits of in-practice WC/DEA service.

Theme	Sub-theme	
Advantages of being in the GP practice	Creation of a direct link between WCs/DEAs & HCPs	
	A safe & comfortable space for patients to open up	
Benefits for patients	Appropriate & accessible support	Multiple access points
		More adequate & less medicalised support
		High demand
	Positive impact	Positive feedback
		Access to work and/or benefits
		Improved health
Benefits for GPs & other HCPs	Decrease demand & workload	
	Improved knowledge	
	Positive experience	
Benefits for WCs/DEAs	Access to broader population & preventative approach	
	More personalised, holistic support than at the JCP	
	Professional development & satisfaction	

4. Benefits for patients

Respondents felt that the in-practice service provided more appropriate and accessible support to patients, and that this in turn led to improvements in their health and employment situation:

> *" It's a much more specific service and more valuable to direct people to them rather than be having lots of appointments with the GP who isn't the right person necessarily to deal with a work-related issue or help them to get back into work"* (GP 1, F)

The direct collaboration between professionals was thought to support a more integrated, holistic approach to patients and to reduce over medicalising some of the issues. By helping to *"address the root cause of the issue"* (WC4, F), WC and DEA respondants reported improved health and wellbeing of patients and a reduction in the issuance of repeat fit notes:

> *"We've had people that have gone from being off work sick long-term to returning into employment and even looking at career progression."* (DEA 3, F)

This was confirmed by several GPs as illustrated by the following comment:

> *"Some patients have taken longer than others, but his [WC's] advice and expertise is beyond what we could provide ourselves as GPs because of both our skill set and also because of our time constraints as well in terms of needing to give time to other patients for medical needs as well (…) so we suggest that they have an appointment to review things with [the WC] to consider if it's still appropriate for them to have a fit note or to extend it any further because sometimes, under the time pressures, it has happened that a patient perhaps has been issued a fit note when maybe that wasn't the appropriate thing to do at the time. And actually, what they needed was a review and a discussion about consideration of other options such as graduated return or return to work with some restrictions rather than just a fit note stating they are not fit to work at all."* (GP 2, F)

The greater accessibility of the service was supported by the variety and multiplicity of potential access points:

> *"[patients] can self-refer (…) and the GP can refer into that service or we can identify customers ourselves from our work coaches caseloads that might be appropriate to ask them to book into the service as well, so there's lots of different ways that we can look to get a patient booked in"* (DEA 3, F)

Finally, respondents reported receiving positive feedback from patients and highlighted the high demand and level of attendance to the appointments.

5. Benefits for GPs & other HCPs

GPs considered this service benefited them directly by reducing their workload through task-shifting non-medical cases to WCs/DEAs and reducing the need for recurrent visits. In addition, the presence of WCs and DEAs was associated with an improved knowledge of GPs regarding occupational health and employment since they could ask them questions directly and, in some cases, receive more formal training. These perceived benefits resulted in GPs' high satisfaction, with all respondents supporting the implementation of the service in other practices.

5.1. Benefits for WCs/DEAs

According to WCs and DEAs, working within a GP practice improved the accessibility of their services, thus allowing them to reach a significantly larger audience, including individuals who were previously unaware of the Jobcentre's offerings or people who were currently employed but needed work adjustments to prevent them from going off sick, developing further health issues and possibly needing benefits. This allowed for a timelier, more preventative intervention:

> *"We see a lot of employed people who are off sick from work. So they're given an early intervention to stop a lot of the financial problems kicking in (…) For example, somebody who's paid for six months while they're on sick leave might not access the job centre support until they're 28–29 weeks into the process, by which time obviously you've got a lot of other issues that are built up there. So by engaging early in the fit note process, in the first few weeks that person is off, we can sort of nip the issues in the bud so they don't develop into bigger problems than what they had originally "* (WC 2, M)

They also reported having longer appointments than at the Jobcentre, which allowed for more in-depth and personalised analysis of the issues at stake:

> *"When you have 30 minutes, you'll get an awful lot out of that person, especially in the different environment. And you feel like you're doing more to help them."* (WC 1, F)

This observation was also shared by GPs, as illustrated in the comment below:

> "*We see that this service is very separate to the DWP so I think we see them [WCs and DEAs] offering a different role, probably a more supportive role and a more sort of holistic view to people rather than the way that the job coaches usually deal with patients within the job Centre"* (GP 4, M).

Finally, several WCs and DEAs showed a very high level of professional satisfaction, often expressing a deep sense of fulfilment, feeling that they made a substantial difference in people's lives:

> *"I think you learn so much and you learn to work so differently. And you've got responsibility for that person. They're not just another 10 minute appointment coming through the door. How do we develop this person? How do we make them grow? It's a great job. It is a fantastic job. It's ridiculously, ridiculously busy, but as an actual job, it's so rewarding."* (WC 2, M)

6. Challenges and limitations

All participants highlighted challenges and limitations to the service, especially relating to interprofessional collaboration and WCs/DEAs' work capacity. Key themes and sub-themes are presented in Table 3, with all supporting quotes in **Appendix 4**.

6.1. Barriers to interprofessional collaboration

For WCs and DEAs who had been involved in the promotion and implementation of the service, this process was presented as particularly difficult and time-consuming. As summarised by WC 2, *"Initially the problem is generally getting the foot in the door"* and as detailed by another:

> *The problem we have is when we're making the telephone calls to try and speak to the practice manager or the GP, we struggle to get through on the phone (…) We often leave messages, send emails and that's the biggest barrier actually: getting yourself an appointment to see somebody face-to-face"* (DEA 1, F)

The same respondent suggested *"a top-down approach in the NHS to advertise and to promote our service [would help] so that we're not trying to get in from the bottom up"* (DEA 1, F).

Getting GPs and patients onboard and engaged was another challenge at all stages, with some respondents reporting limited interactions with GPs, due to a lack of awareness of GPs but also of a limited willingness to engage, which in turn limited the number of referrals of patients.

Table 3
Perceived limitations & challenges of in-practice service.

Limitation/challenge	Aspect
Barriers to interprofessional collaboration	Promoting & implementing the service
	Limited engagement of GPs and patients
Limitations to WCs & DEAs' work capacity	Limited financial & human resources
	Logistics: lack of space & inadequate IT resources
	Impact of Covid 19

6.2. Limitations to WCs & DEAs' work capacity

Another significant challenge and barrier to the sustainability and expansion of the service related to the limited funding made available as well as the lack of commitment at the policy level, which creates uncertainty about the service's future but also limits its expansion:

> *"Obviously, we've always got one eye on the fact that they could say tomorrow "we're pulling this because XY&Z (…) and we need you back in the job centre". (…) Now when you're marketing this service to a new surgery and you're saying "well, we've been here for 14 years, or however long we've been there, but I can't tell you I'm going to be here in six months, which realistically, I can't". Evidence would suggest that it would, but to have a role that was funded, and you can say "this is an ongoing service", it makes it a lot easier to market"* (WC 2, M)

Limitations in funding of service affected their work capacity in varying ways. Some practices only had one or two WCs or DEAs operating per practice, working on a part-time basis, usually offering weekly, biweekly or even monthly appointments. Most respondents considered the offer insufficient to meet the demand:

> *"Obviously, there's limited capacity for one person to be able to do everything, and so I would say that, as more people need the service and use the service like everything, unless there is additional funding to increase the capacity of the service, then you could see that it may become less effective and less valuable if people have to wait longer to have the help"* (GP 2, F)

The lack of space and dedicated rooms in the GP practice further limited the work capacity of WCs and DEAs, with the Covid-19 pandemic heightening these limitations:

> *"He currently does a session every other week. We would probably be able to offer him much more work to do, but unfortunately, we're a bit limited with the rooms in our practice, but we would love it if he could offer more services"* (GP 1, F)

Several respondents mentioned issues accessing internet access as another significant obstacle, as it prevented them from accessing

relevant personal information as well as online translation tools when receiving someone not fluent in English.

Finally, one of the DEA respondents raised the issue of mental health training, not so much to support patients but actually to prevent professionals from being too severaly impacted themselves:

> *"I personally would like to know more about, you know, mental health and things like that because we have a lot of information on mental health but we're not formally trained in mental health. And I do think it would be useful because we do get a lot of people that are in distress. We sign post to a lot of support services and things like that. But also obviously these things can take a toll on our own health and well-being, and they do have a lot of support available to us and that's kind of reactive. So we can access that support as well if we need it, if it's starting to impact our health and well-being. But it would be nice to have a better understanding to prevent that from happening in the first place."* (DEA 3, F)

This comment highlights the importance of considering the mental health of both providers and users of the in-practice service. While WCs and DEAs can sign post patients to support services, their mental health training remains limited which may affect their own mental health, as commented above, but also possibly the support they can provide to patients, since they might also miss early signs of distress or mental health issues.

6.3. Drivers and strategies

Participants highlighted a number of enablers and strategies to streamline processes and embedding WCs and DEAs in primary care. Key themes and sub-themes are presented in Table 4.

6.4. Making the service visible

WCs and DEAs insisted on the necessity of making the service visible to both HCPs and patients in order to raise awareness when introducing the service but also later on to maintain the demand. With GPs, face-to-face interactions appeared crucial, either by attending clinical meetings or having more informal "catch-ups" with HCPs:

> *I think initially when you set it up, you've got to make sure that you're visible. What we've always done is that when we've started at a new surgery, we've given WCs more time than we think they need so that you can spend more time talking to the doctors, talking to the nurses, going to the meetings. Generally, a lot of the GPs meet for a coffee in the morning, where they do like a case conference. We always try and go into those meetings initially when we set up just so we're visible. And I think it's - I want a better expression - but it's making sure they know your face because I think certainly what a lot of our GP will say is they're not necessarily aware of our service* (WC 2, M)

One of the respondents highlighted how these interactions also contribute to building trust with the other professionals working at the practice:

> *We regularly go into meetings; we've attended coffee mornings as well so we can speak to people there. We can kind of build that trust in those relationships with the therapists and social prescribers, and they know that we're another source of support for people if they're struggling* (WC 4, F)

Visibility to patients is also primordial, especially considering that these initiatives remain marginal and the GP practice is not the obvious location to receive employment support. To do so, respondents reported mobilising a variety of tools, including flyers and banners in the practice. One respondent also reported installing a table in the GP practice waiting room at the early stages of the initiative to directly approach patients and inform them about the support they could provide them. Text messages and emails sent out by the practice constituted another efficient channel to keep patients informed patients of the service.

Table 4
Perceived drivers & strategies to embedding WCs and DEAs in general practices.

Driver/Strategy	Aspect
Making the service visible	To GPs & HCPs, especially via F2F meetings
	To patients, especially via text messages & printed info
Receiving support from other professionals	Support & mutual referrals with social prescribers
	Support from practice managers
	Support from DWP managers

6.5. Receiving support from other professionals

WCs and DEAs also emphasised the importance of receiving the support of other professionals working at the GP practice. Of particular importance was the support of the social prescribers and the practice managers.

Several respondents mentioned mutual referrals with social care practitioners & social prescribers as particularly positive and supportive of the integration of the service:

> *"We have a really good relationship with the social care practitioner at that GP surgery. I can share concerns or queries with the social care practitioner, and they contact us with details of their vulnerable customers that they were working with and obviously with the customers consent and we would often work together anyway"* (DEA 3, F)

Practice managers were also perceived as playing a significant role, especially in facilitating the service implementation and sustainability by informing GPs about the service: "*When you get your practice manager behind you, your appointments are full. I've always had full appointments, which has been really good*" (WC 1, F). Support from GPs appeared more variable across practices.

7. Discussion

7.1. Summary of main findings

This study identified several perceived benefits, drivers and challenges of integrating WCs and DEAs into GP practices according to an interdisciplinary workforce involved in such initiatives in the UK. Respondents perceived this integration as fostering a direct collaboration between health and social care professionals as well as a greater openness of patients to WCs. These led to improvements in patients' health, employment situation and access to benefits as well as GPs' workload and knowledge on the topic. All WCs and DEAs appeared enthusiastic and appreciative of this opportunity as it gave them access to a broader population and allowed for a more personalised approach than in the JCP setting. However, several barriers were identified by respondents, including the implementation stage which was perceived as particularly challenging by WCs/DEAs. Once embedded, their work capacity often remained limited due to the lack of specific funding for this role, which resulted in restricted human and logistic resources, even more so following the COVID-19 pandemic. In some cases, the interprofessional collaboration was hindered by a lack of awareness of and interactions with GPs, while a few respondents mentioned the reluctance of some patients to approach the service as a potential challenge. In response to these challenges, respondents identified several strategies and drivers. WCs and DEAs stressed the importance of making the service visible both to HCPs and patients through multiple channels, including face-to-face meetings, text messages, emails, flyers and banners. The collaboration with and support of several professionals, including practice managers, GPs, social prescribers and DWP managers, was also deemed essential to this service's successful implementation and delivery,.

7.2. Comparison with existing literature

This research adds empirical evidence relating to the integration of DWPs into general practices in the UK. Our findings are in line with previous studies, which found that these placements can benefit patients by facilitating access to welfare advice and health-related benefits which had not been claimed due to a lack of awareness of eligibility [20,28] while also reducing GPs' workload by providing an alternative resource to refer patients for welfare advice [9]. In particular, the study by Greasley et al. [19] found that the integration of vocational advisers fostered greater interagency working, improved access to welfare advice, improved health and quality of life of patients and a reduced burden on GPs & primary care workers. The authors also highlighted the relation between the level of uptake and the attitude of practice staff towards the service, hence the importance of receiving their support. Finally, the service was also perceived by respondents as particularly beneficial to patients with mental health problems.

7.3. Study implications

At the policy level, our findings support the integration of employment advisors within healthcare settings. Policymakers should consider revising existing frameworks to facilitate this integration, potentially through increased funding, policy support, and the establishment of collaborative networks between healthcare providers and employment services. While the presence of employment advisors in GP practices can foster a more comprehensive and holistic understanding of patients' needs, such understanding would likely be further increased by providing additional training and educational modules on occupation health for healthcare professionals.

While promising, the implementation of this model is not without challenges. Addressing human, financial and logistic resource constraints, as well as guaranteeing institutional support both at the NHS and DWP levels, appear essential. Future research and evaluations should focus on longitudinal studies to assess the enduring impact of such integrations, particularly in terms of long-term patient health and employment outcomes. Most importantly, future studies should investigate patients' perspectives and experiences resulting from their engagement with these services, as these may diverge from those reported by health and social care professionals.

7.4. Study strengths and limitations

Our study offers updated evidence regarding the perceived benefits, drivers and challenges of integrating WCs into primary care. While some findings remain similar to previous studies, our study provides additional insights regarding the barriers (logistical issues, limited capacity of WCs and challenges of the implementation stage) as well as the strategies put in place to address them, especially the importance of making the service visible to HCPs and patients. The principal limitation of this study is the relatively small sample size which may affect the generalizability of the findings and does not guarantee data saturation. Due to the limited resources and timeframe for the research study, we only interviewed those who responded to our invitations and consented to take part in the study. Since participation in the study was voluntary, we acknowledge that some bias may have crept in on the assumption that those most favourable to the presence of WCs and DEAs in GP practices expressed interest and consented to take part in the interviews. However given that the aim of this study was to explore emergent themes, the data collected was deemed satisfactory and sufficient to identify several key areas of interest for future research. We also acknowledge that although the analysis presented was broad, we did not interrogate the emergent themes further. However, as embedding WCs and DEAs in general practices is a relatively new initative, this research lays the groundwork for further study. In addition, primary care is evolving constantly and in some parts of the country mental health professionals, physiotherapists and other members of multidisciplinary teams are situated within general practice. As this work did not extend to mapping out and studying the impact of referral pathways between WCs and DEAs and specific members of the primary care team, nor WCs and DEAs and secondary care, this could and should be explored in future studies. Finally only the perspective of providers was captured, with patients' experiences mediated by their testimony. Future research should investigate patients' perspective directly to identify their own barriers, drivers and strategies. Another important issue to be addressed in future research when considering the patients' and professionals' perspectives, relates to the perceived risk of pathologising the unemployed associated to the presence of WCs & DEAs within general practices.

8. Conclusion

Integrating WCs and DEA within GP practices can help bridge the gap between healthcare and employment support, particularly for individuals with disabilities or long-term health conditions. Our findings show that this integration is positively perceived by WCs, DEAs and GPs as a way to enhance accessibility to employment services, promote interdisciplinary collaboration, reduce GP workload and positively impact professionals and patients. This service shows potential to support the employment aspirations of individuals, especially those with health issues and disabilities, ultimately contributing to a more equitable and inclusive society. More research is needed to assess patients' perspectives and their own experiences with the service.

Ethics

The study received a favourable opinion from the Imperial College Research Ethics Committee (ICREC # 6707744). Participants consented to take part before the start of the interviews. Participants were free to withdraw from the interview at any time. Interview data was pseudonymised. The interviews were transcribed with the principle of anonymity in mind, and transcriptions were not outsourced, therefore no confidentiality agreements were required. All data generated or analysed during this study are included in this published article.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors. AEO, MK, MEA and ERS are partly supported by the National Institute for Health and Care Research (NIHR) Applied Research Collaboration (ARC) North West-London. The views expressed are those of the authors and not necessarily those of the NHS, NIHR or the Department of Health and Social Care.

Patient and public involvement

No patients were involved.

Author contributors

All authors (SP, KV, MK, MLE, LS, ERS and AEO) provided substantial contributions to the conception, design acquisition and interpretation of study data and approved the final version of the paper. SP and AEO took the lead in planning the study with support from co-authors. ERS, MK and MLE carried out the data analysis with support from AEO. AEO is the guarantor.

Data sharing statement

The data that support the findings of this study are available from the corresponding author, SP, upon reasonable request.

Competing interests

None declared.

Declaration of competing interest

No conflicts of interest have been declared.

Acknowledgements

Authors would like to thank all the respondents for participating in the interviews and sharing their experiences and perspectives.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.puhip.2024.100548.

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