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Supporting occupational health and wellbeing professionals

Guidance for WorkWell and Workplace Health Provision (WHP) in establishing Work–Health Interface Services

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Overview

In 2025, the Society of Occupational Medicine (SOM) produced a WorkWell Trailblazer Briefing to bring together the emerging evidence base and inform investment priorities at WorkWell trailblazer sites. This update follows the publication of the Keep Britain Working: Final Report in November 2025.

WorkWell, together with the newly announced Workplace Health Provision (WHP) concept, represents core infrastructure on the path to achieving universal access to occupational health.

SOM maintains that all employers and working-age people must have timely access to high-quality specialist work and health support for case management, health promotion, and ill-health prevention. This is essential for sustainably reducing economic inactivity driven by ill health. Unfortunately, currently over 50% of UK employees lack access to occupational health services.

This scale of provision requires a workforce model that uses trained, and supervised, non-clinical professionals to lead and coordinate case management, for high-quality and timely triage and escalation. Early national pilots have shown that this tiered model of care is both safe and effective.

Both WorkWell (government-funded) and WHP (proposed to be employer-funded) share a common blueprint for the foundational layer of work and health support:

- Delivered by appropriately trained, and clinically supervised, non-clinical professionals
- Delivery of longitudinal case work, unlocking the potential of continuity of care
- Multiple referral routes (healthcare, Jobcentre Plus, employers, individuals in work, individuals out of work)

WorkWell and WHP must be built around and held to robust standards of training, supervision, and governance. Triage and escalation must be supported by further tiers of clinical expertise. These layers create both the supervision and the specialist referral capacity required for workers and potential workers, whether they self-refer, are referred by employers, or are redirected from treating clinicians, Jobcentre Plus or other services.

At the highest tier, accredited consultants in occupational medicine should provide specialist work and health advice. An intermediate tier is likely to include occupational physicians, occupational health nurses, and allied health professionals, with their skills being matched to the nature of the case. As WorkWell and WHP evolve, these clinical layers will need to be fully integrated into service design.

Key points

Use a tiered model
Non-clinical staff must have clearly defined pathways for escalation to specialist resources so that all levels of case complexity can be safely managed within the service.

Invest in robust triage
Ensure all undifferentiated service users are assessed and directed to the appropriate tier of support.

Train non-clinical staff
Equip those delivering longitudinal case work with expertise in non-clinical aspects of work and health and, critically, the capability to identify when clinical input is required. Use training programmes from accredited providers such as the SOM Essentials in OH Series and the SOM Foundation Course in Work & Health and the Certificate in Work & Health.

Provide ongoing supervision
Use individual and group supervision to support decision-making for non-clinical staff and non-specialist clinicians.

Implement clear clinical governance
Maintain accountability for the quality, safety, and continuous improvement of services. The Society of Occupational Medicine recommends a national clinical director for work and health to provide UK-wide programme governance oversight, supported by a team of senior occupational health clinicians at integrated care board level.

Embed evidence generation
Ensure data quality and analytic capacity to support rapid learning, service iteration, and informed investment decisions. Data from WHP may flow into the Workplace Health Intelligence Unit, which will be established as a result of the Keep Britain Working: Final Report.

Case studies to illustrate the value of these principles

1. Clinical Signposting Through Work–Health Conversations

Case summary:
Mr A goes to his GP with low mood and is referred to a non-clinical WorkWell advisor for support with finding work. During his WorkWell consultation, he reports loss of appetite and unintentional weight loss, which he associates with his low mood.

Standalone non-clinical model:
In a purely non-clinical WorkWell service, the non-clinical WorkWell advisor may not have the clinical insight, supervision, or remit to determine whether the symptoms related to Mr A's known low mood require separate clinical escalation. As a result, the work-focused support continues, and the potential significance of his weight loss may go unaddressed.

Model with clinical supervision:
In a service with structured clinical oversight, the WorkWell advisor raises the case in group supervision with an occupational health physician. The clinician identifies that the degree of weight loss is clinically significant and warrants urgent medical assessment. Mr A is proactively signposted back to his GP for investigations, reducing the risk of delayed diagnosis and ensuring appropriate care while continuing to receive work-related support.

Key learning point:
Clinical supervision enables early identification of health risks that may otherwise be missed in non-clinical settings, supporting the relationship between work and health and improving safety and patient outcomes.

2. Clinical Risk and Management at the Work–Health Interface

Case summary:
Ms B works as a lifeguard and has a history of migraines. During severe episodes, she struggles to concentrate on monitoring swimmers, a safety-critical aspect of her job. As a contractor, she receives no sick pay, leading her to self-refer to WorkWell for support with reducing her sickness absence.

Standalone non-clinical model:
Within a non-clinical WorkWell offer, advisors may find it challenging to define safe working parameters for someone in a safety-critical role. Without clinical assessment, they cannot determine whether Ms B is safe to work during prodromal or post-migraine phases, nor can they rule out other underlying causes or consider ways to optimise her migraine management. This limits the support they can provide and risks unsafe advice.

Model with clinical triage and escalation:
In a service with clinician involvement, Ms B would receive early clinical triage. An occupational health physician could determine safety-critical fitness parameters and adjustments. Clinical assessment might also reveal opportunities for better symptom control, for example through signposting Ms B to her GP to discuss prophylactic treatment if indicated, directly supporting her goal of reducing her sickness absence.

Key learning point:
When health conditions interact with safety-critical work, it is essential to have early clinical input so that advice is risk-appropriate.

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