Research Priority Setting Meeting for Occupational Health and Medicine 24th March 2026

Summary report

Meeting held at The Medical Society of London, Lettsom House, Chandos St, London W1G 9EB

Jointly produced with the support of National Institute for Health and Care Research and the Faculty of Occupational Medicine.

Venue hire and catering sponsored by the Colt Foundation.

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Workshop Summary Report: Future Research Priorities in Occupational Medicine and Occupational Health

1. Introduction and Objectives

The workshop brought together a wide range of stakeholders to identify and prioritise key areas for future research in occupational medicine and occupational health. The focus was on addressing recognised gaps in evidence that are critical to improving worker health and wellbeing. The aim of the workshop was, by prioritising the research uncertainties across the occupational health community, to:

- support researchers in targeting future funding applications to areas of greatest need, and
- inform research funders as to the highest priorities of those working in and receiving occupational health care.

The workshop was organised by the Society of Occupational Medicine, and was jointly produced with the National Institute for Health and Care Research and the Faculty of Occupational Medicine. The Colt Foundation sponsored the venue hire and catering. The workshop was facilitated by Victoria Thomas, an independent Adviser from the James Lind Alliance.

2. Approach and Process

Methodology

The workshop used a structured, participatory approach (a modified form of Nominal Group Technique – see below). It ran for 4 hours and had approximately 65 participants (see appendix 3). Participants attended on an invitational basis and were a mix of academics, physicians, clinicians, policy experts, third sector representatives, funders, and people with lived experience.

A seminal paper (Lalloo et al, 2018[1]) was shared with invited participants in advance of the workshop.

Introduction

The workshop opened with a welcome and introduction from Neil Greenberg, Professor of Defence Mental Health at the Institute of Psychiatry, Psychology & Neuroscience at King's College London, and President of the Society of Occupational Medicine.

Participants then heard from Dr Laura Cooke from the National Institute of Health and Care Research who outlined a recent survey undertaken with stakeholders in the occupational health field to describe their priorities for future OH research. Dr Cooke also described what current OH projects were current being funded by the NIHR as part of the Work and Health Research Initiative.

[1] Occup Environ Med . 2018 November 01; 75(11): 830–836. doi:10.1136/oemed-2018-105114. https://pubmed.ncbi.nlm.nih.gov/30121583/

Group allocation

All participants were randomly allocated to a thematic group in advance of the workshop. The group themes were determined through a merging of the findings from Lalloo et al and the recent work undertaken by the NIHR on behalf of the Society of Occupational Medicine (see above).

The groups were:

- Economic evaluation, cost-effectiveness studies & health services research
- Occupational disease / injury/ illness
- Artificial intelligence and automation
- Type of employment and the changing nature/ patterns of work
- Prevention and health promotion
- Leadership and management
- Occupational hazards to health and risk assessment
- Management of long-term conditions and disabilities

3. Nominal group technique[2]

The Nominal Group technique is a structured face-to-face group session with the purpose of achieving group consensus and action planning on a specific topic. It was originally developed by Delbecq et al (1975)[3]. It is a methodology that enables rapid decision-making, compromise and consensus, allows for all participants to contribute with equal status, and to move from individual input to group decision making.

The stages of the nominal group session are as follows:

- Introduction – facilitator introduces the purpose of the session, the rules and structure.
- Stage 1: individual responses
- Stage 2: clarification and consolidation – responses are read out and clarified one by one by participants, then similar/same items are merged under one response.
- Stage 3: ranking responses – participants rank their top responses individually in order of importance.
- Ranking results are calculated and shared with the group

Workshop approach

For the purposes of this workshop the following approach was taken:

- **Initial individual priority setting** – participants were asked to write down their one or two top research priorities on pre-prepared cards
- **Sharing and consolidation of individual priorities in small groups** (8 groups of approximately 8 people each) – participants then took turns to share their priorities, out loud, with their group members

[2] https://www.liverpool.ac.uk/media/livacuk/cll/eddev-files/iteach/pdf/guide_for_ELESIG_v1.pdf

[3] A.L. Delbecq *et al.* A Group Process Model for Problem Identification and Program Planning J. Appl. Behav. Sci. (1971)

- **Group discussions to identify broad research themes** – each group discussed the thematic issues arising from the individual priorities

- **Group prioritisation** – a collective process whereby each group identified two key topics to go forward to the next round.

This process resulted in a list of 18 priority research questions (2 per group, with some groups insisting on more than 2 priorities), reflecting consensus across participants. Groups were self-facilitating.

4. Ranked Research Priorities

Ranking

Following the identification of the 18 priority themes, the groups were reassigned to eight new groups (to prevent 'group think').

The eight new groups were asked to consider all 18 themes, and rank them in order of importance, with one being most important, and 18, the least.

Following the ranking exercise, the 18 different rankings from the 8 different groups were aggregated and averaged, (using a preprepared Excel spreadsheet), resulting in a collective ranking of shortlisted priorities across all groups and participants.

Top Priority Areas (1–6)

These represent the highest priority research needs:

1. **Healthy ageing workforce**
   Improve the health of an ageing workforce, particularly those in physically demanding roles, to extend healthy working lives.

2. **Young people and work**
   Understand young people's perceptions of meaningful work, their mental health and distress, how these interact, and what employers can do to support them.

3. **Management of long-term conditions**
   Identify effective multi-agency collaborations and define what data should be collected and shared to support workers with long-term health conditions and disabilities.

4. **Return on investment (ROI)**
   Evaluate the ROI for individuals, employers, and society of keeping people with long-term conditions in work, including system design, implementation, and sector variability.

5. **Prevention and long-term impact**
   Determine which health prevention initiatives deliver sustained impact (5–10 years) and how success should be measured.

6. **Access to occupational health (OH)**
   Improve timely, affordable access to OH services—particularly for SMEs—and evaluate ROI of different service delivery models.

High-Priority Areas (7–12)

7. **Non-standard workers**
   Address challenges faced by subcontractors and sole traders, and develop sector-specific approaches to protect and promote health.

8. **AI and data-driven OH**
   Explore how AI can enhance measurement, monitoring, workforce experience, tailored interventions, and standardised reporting.

9. **System interfaces**
   Define effective collaboration between health professionals, employers, and workers, including barriers and enablers.

10. **Interdisciplinary collaboration**
    Strengthen collaboration across disciplines to support evidence-based practice and cost–benefit evaluation.

11. **Job security and workforce transitions**
    Understand which jobs are at risk from AI, identify new roles, and examine demographic inequalities.

12. **Remote work impacts**
    Investigate long-term effects of remote working, particularly on younger workers.

Emerging Priorities (13–18)

13. **Whole-organisation approaches**
    Leverage internal roles (including non-health roles) to promote health and prevent ill health.

14. **Intervention effectiveness**
    Develop clear pathways linking interventions to real-world outcomes (health, economic, and work-related).

15. **Research capacity building**
    Address the critical need to strengthen occupational health research capability.

16. **Defining “good work”**
    Identify what constitutes good work, including predictive tools, risk identification, and effective support mechanisms.

17. **Burnout and wellbeing**
    Better understand and address burnout, including cynicism, exhaustion, and disengagement.

18. **Climate change and occupational health**
    Examine impacts of environmental factors such as heat, cooling, workplace design, uniforms, and PPE.

5. Cross-Cutting Themes

Several themes emerged across multiple priorities:

- Economic evaluation and ROI as a consistent evidence gap
- Changing nature of work, including AI, remote work, and non-standard employment
- Prevention and early intervention as key to long-term impact
- Inequalities in access and outcomes, particularly for SMEs and vulnerable workers
- Need for better data, measurement, and standardisation
- Importance of interdisciplinary and system-level approaches

6. Conclusions

The workshop highlighted potential areas for future occupational health research priorities:

- Supporting a diverse and changing workforce (ageing workers, young people, non-standard workers)
- Addressing long-term health conditions and sustainability of work
- Embedding economic evidence and real-world impact into research
- Harnessing technology and data to improve practice
- Strengthening systems, collaboration, and capacity

This can provide a strong basis for guiding future funding, policy development, and collaborative research initiatives.

Appendix 1 - Agenda – 24th March 2026

Research Priority Setting Meeting Occupational Medicine – 24th March 2026
The Medical Society of London, Lettsom House, Chandos St, London W1G 9EB
10:00-15:00
Jointly produced with the support of National Institute for Health and Care Research and the Faculty of Occupational Medicine

Our thanks to the Colt Foundation for supporting the venue costs for the day

AGENDA

Time	Activity	Presenter
10:00–10:15	Welcome and meeting objectives	Professor Neil Greenberg, SOM President
10:15-10:30	"Known unknowns" – what do we already know about priorities for future research in occupational medicine?	Dr Laura Cooke, NIHR
10:30–10:40	**Group work - session 1 What are your priorities?** • Economic evaluation, cost-effectiveness studies & health services research • Occupational disease / injury/ illness • Artificial intelligence and automation • Type of employment and the changing nature/ patterns of work • Prevention and health promotion • Leadership and management • Occupational hazards to health and risk assessment • Management of long-term conditions and disabilities ???What are the key research gaps and future priorities?	Victoria Thomas and Groups
10:40–11:25	**Group work – session 2: sharing individual priorities**	VT and Groups
11:20–11:35	Break	

11:30–12:20	**Group work – session 3: initial voting** Each group member gets 2 votes for their highest priorities	VT and Groups
12:20–13:00	Lunch Break	
13:00–13:15	Sharing initial topics across all groups	Victoria Thomas Professor Greenberg
13:15–14:30	**Group work – session 4: reviewing and ranking the top topics** What do you think of the top 16 topics? Rank them 1-16 in order of priority	VT and Groups
14:30-14:50	Break	
14:40-14:55	Top 6 presented, along with ranked other priorities	Victoria Thomas Professor Greenberg
14:55–15:00	Close & thanks	Professor Greenberg Nick Pahl
15:00-16:00	Optional Researcher meeting to discuss collaboration, and any barriers and facilitators	

Appendix 2 - Priority Topics for workshop

	Domain	Sub-domain(s)	Cross cutting themes for all domains
1	Economic evaluation, cost-effectiveness studies & health services research	• cost benefit analyses of occupational health services • best practice and benchmarking	Intersectionality Equality Diversity and Inclusion Worker age/ageing workforce Neurodivergence
2	Occupational disease / injury/ illness	• work related mental ill health • stress • psychological safety • physical disease: cardiovascular, respiratory and MSK	
3	Artificial intelligence and automation	• job security • 'tech stress'	
4	Type of employment and the changing nature/ patterns of work	• flexible hours, • remote working, • zero hour contracts/gig • migrant workers • subcontractors, • growth of self-employment.	
5	Prevention and health promotion	• evaluation of effectiveness of prevention/promotion programmes • engagement, productivity, behaviour change, barriers to success	
6	Leadership and management	• sickness absence management • return to work • effectiveness of interventions to keep employees at work	
7	Occupational hazards to health and risk assessment	• psycho-social hazards, • occupational environment and exposure	
8	Management of long-term conditions and disabilities	• functional capacity evaluation • objective measures of disability assessment • attitudes towards disability in the workplace- employer and employee	

Appendix 3 - Attendees and group allocation

Group 1	**Economic evaluation, cost-effectiveness studies & health services research**
Alex Bell	ACPOHE
Ben Moss	RAND
Elaine Smith	Centre for Aging Better
Sir Anthony Newman Taylor	Colt Foundation
Professor Gary Macfarlane	Scottish Centre for Work and Health
Joan Bowen	Guy's & St Thomas' NHS
Lillie Turnbull-Jones	NIHR
S Odili	Arthritis Action

Group 2	**Occupational disease / injury/ illness**
Arash Angadji	
Asaad Nafees	Agha Khan University
Dr Belinda Steffan	University of Edinburgh
Alice Martin	University of Lancaster
Dr Caroline Norrie	King's College London
Dr Helena Nixon	FOM Academic Dean
Professor Chris Warhurst	University of Warwick
Martin Thomas	Keele University
Dan Lucy	IES

Group 3	**Artificial intelligence and automation**
Corman Ryan	
Danielle Lamb	University College London
Amanda Hinkley	FOHN
Dr Jo Feary	Imperial College
Professor Drushca Lalloo	Glasgow University
Nick Pahl	SOM
Nichola Adams	CIEHF working group

Group 4	**Type of employment and the changing nature/ patterns of work**
Hamish Shah	Chartered Managers Institute
Ian Tasker	Hazards Magazine
Angie Brooker	Multiplex
Lesley Kay	NHS England
Jamie McGovern	TUC
Jo Vallom-Smith	RCOT
Professor Jo Yarker	London Centre for Work and Health
Julie Denning	VRA

Group 5	**Prevention and health promotion**
Dr Karen Michell	IOSH
Janet O'Neil	National School of Occupational Health
Oliver Williams	Public Health Wales
Laura Cooke	NIHR
Professor Paul Cullinan	Imperial College
Claire Campbell	Health Foundation
Rose Wood	SOM

Group 6	**Leadership and management**
Louise Craig	FOM (CEO)
Sasjkia Otto	Fabian Society
Catherine Dennison	Nuffield Foundation
Lisa Newington	Imperial College London
Dr Robin Cordell	FOM (President)
Rachel Suff	CIPD
Katie Sykes	RAND
Annie Irvine	University of York

Group 7	**Occupational hazards to health and risk assessment**
Dr Sahra Tekin	SOM (Research Manager)
Professor Sharon Stevelink	King's College, London
Rebecca Canham	IOM
Professor Kevin Bampton	BOHS
Professor Neil Greenberg	SOM (President)
Dr Glykeria Skamgki	ACPOHE
Dr Nina Amedzro	DWP

Group 8	**Management of long-term conditions and disabilities**
Tash Heydon	Colt Foundation
Zofia Bajorek	IES
Duncan Spencer	IOSH
Shantel Noha	Arthritis Action
Professor Martie Van Tongeran	University of Manchester
Dr Samantha Philips	TfL
Christopher Proe	DWP
Monika Waller	

Appendix 4 - Aggregated top 18

Rank	Question
1	Improve the health of aging workforce, particularly those in physically demanding work, to extend healthy work lives
2	Young people at work - what is going on with young people's conceptualisation of meaningful work, mental health/distress, how these interact, and what employers can do
3	In the management of long-term health conditions and disabilities what multiagency collaborations are needed and what data must be collected and shared?
4	What is the return on investment for individuals, employers and society of keeping people with long term disabilities and health conditions at work. (good practice in systems design and implementation, barriers to adoption, variability across sectors)
5	What health prevention initiatives have proven long term impact (5-10 years, and how are we measuring success)?
6	Timely and affordable & increasing access to OH (esp for SMEs), and quantifying return on investment of different models of access
7	Challenges for subcontractors, sole traders etc to manage health; opportunity to test sector specific approach to protect and promote worker health
8	Exploring potential for greatest impact of AI through measurement and monitoring (measuring workforce experience, tailored interventions, standardise reporting in OH)
9	What does effective interface between health professionals, employers and workers look like (barriers, enablers)
10	Interdisciplinary OH collaboration to develop evidence based practice & cost benefit evaluation
11	Job security - sustain workforce, jobs most at risk, new roles for those replaced by AI, demographics of those at risk
12	What are the long term impacts of remote work, particularly for young people?

13	How can internal existing roles be leveraged to promote health and prevent ill health (including non health roles)?
14	Intervention effectiveness with clear pathways to outcomes with a real world emphasis (health, economics, work related)
15	Critical need to build capacity in occupational health research
16	What is good work for individuals? (prediction tools, people at risk, what support helps, how to get people to thrive at work)
17	Burnout - cynicism, exhaustion, disengagement
18	Climate change - air conditioning, heat/cooling, control of the environment, uniform, PPE

Appendix 5 - Transcriptions from groups

Group	Domain	Sub-domain(s)	Cross cutting themes for all domains
1	Economic evaluation, cost-effectiveness studies & health services research	• cost benefit analyses of occupational health services • best practice and benchmarking	Intersectionality Equality Diversity and Inclusion Worker age/ageing workforce Neurodivergence
2	Occupational disease / injury/ illness	• work related mental ill health • stress • psychological safety • physical disease: cardiovascular, respiratory and MSK	
3	Artificial intelligence and automation	• job security • 'tech stress'	
4	Type of employment and the changing nature/ patterns of work	• flexible hours, • remote working, • zero hour contracts/gig • migrant workers • subcontractors, • growth of self-employment.	
5	Prevention and health promotion	• evaluation of effectiveness of prevention/promotion programmes • engagement, productivity, behaviour change, barriers to success	
6	Leadership and management	• sickness absence management • return to work • effectiveness of interventions to keep employees at work	
7	Occupational hazards to health and risk assessment	• psycho-social hazards, • occupational environment and exposure	
8	Management of long-term conditions and disabilities	• functional capacity evaluation • objective measures of disability assessment • attitudes towards disability in the workplace- employer and employee	

1. Economic evaluation, cost-effectiveness studies & health services research

- cost benefit analyses of occupational health services
- best practice and benchmarking

Top 18 research priorities
1 Improve the health of aging workforce, particularly those in physically demanding work, to extend healthy work lives **6 Timely and affordable & increasing access to OH (esp for SMEs), and quantifying return on investment of different models of access** 15 Critical need to build capacity in occupational health research
Additional comments

• Understanding what support individuals, who are economically inactive, perceive they need to return to work
 	
• Lack of expertise and funding in undertaking cost benefit analysis
 	
  ○ SMI (ROI)
 	
  ○ Integrated approach
 	
  ○ Learn from each other
 	
  ○ Population approach to prevention
 	
  ○ Maternity leave
 	
  ○ Develop organisational practice
 	
  ○ Leadership/culture
 	
• What is best practice for OH physiotherapy?
 	
• How can we measure/undertake economic evaluation if we don't know what it looks like?
 	
• Lack of academic researchers in OH physio
 	
• Support available to those economically active/in insecure work – how to access, what works
 	
• Focus on retention of aging workforce, adjustments, support available, availability for all

- Decent work, employers who don't/cannot offer support, consider how to expand offers/access
- Lack of research and evidence on return on investment of employment support measures and initiatives for people with (fluctuating) LTCs and disabilities
- More insights on a clear and practical pathway to transition to a more prevention-focused model
- Preventative approach – what needs to be considered?
- Benefits of (?) in an integrated and general system
- ?? vs in depth expertise
- Individual needs-based – early expert holistic support
- Working groups across mental health, VR, OH, EIS, physio for best practice.

2. Occupational disease / injury/ illness

- work related mental ill health
- stress
- psychological safety
- physical disease: cardiovascular, respiratory and MSK

Top 18 research priorities
17 Burnout - cynicism, exhaustion, disengagement 18 Climate change - air conditioning, heat/cooling, control of the environment, uniform, PPE
Additional comments
• workplace violence/abuse • Cost benefit evidence of mental health initiatives • Physical effects of COVID – attacks, myocarditis, asthma, long covid, stress/anxiety • Mental health – why so many people off sick? • Evidence on psychological safety – cost/benefit & longitudinal studies e.g. implications of electronic rostering, implications of outsourcing, do outsourced staff take more sick leave? • Cognitive fatigue, sleep deprivation and shift work • Post COVID generation increased difficulties interacting with the work environment, especially the neurodiverse • Psychological safety – journey to work, availability of public transport or parking, especially when working nights • Occupational lung disease due to physical agents e.g. silica, asbestos, has not gone away • Vaccine hesitancy in health care staff • How best to support practitioners to build the business case for organisational-level interventions to support mental health in the workplace? • What interventions work best in supporting the development of organisational cultures supportive of health and wellbeing at work? • What support/systems are needed to enable young people with mental health concerns to access, stay in, and thrive at work

- How to encourage more multi-level interventions in the workplace and support organisations with robust and pragmatic evaluation?
- What impact will new/emerging technologies have on work intensification and work relation mental ill-health? How best to mitigate adverse impacts?
- What interventions are not effective in supporting managers to support workplace mental health?
- Suicide – work-related suicide definition, LM training, funding/ethics applications
- Amy Edmondson's definition/application of psychological safety or generic use?
- Workplace retention/lowering sickness absence
- Menstruation, maternity, menopause – life course influence (reciprocal) on work
- Gendered ageism
- Who is responsible? Neoliberalism
- Structural fix not individuals

3. Artificial intelligence and automation

- ‘Tech stress’
- job security

Top 18 research priorities
8 Exploring potential for greatest impact of AI through measurement and monitoring (measuring workforce experience, tailored interventions, standardise reporting in OH) 11 Job security - sustain workforce, jobs most at risk, new roles for those replaced by AI, demographics of those at risk
Additional comments

• All underpinned by data security, information governance
 	
• How to sustain the workforce as AI becomes more fully implemented to keep people working and sustain livelihoods
 	
• Which jobs are most at risk?
 	
• How do we create new jobs in place of those replaced by AI?
 	
• Demographic profiles of those at risk – those with protected characteristics
 	
• How does AI impact the jobs that remain?
 	
• Impact of AI/automation on job design/workloads and the knock-on impact on health
 	
• Use of AI for early detection and case referral
 	
• Use of AI to support bespoke work support
 	
• Loneliness and AI interaction
 	
• AI for Measurement and monitoring
 	
  ○ Workplace exposure e.g ergonomics, workplace design, psychosocial impacts (stress, locus of control), environmental exposures, air quality, temperature, lighting, noise
  ○ Tailored interventions to address these
  ○ Using AI to standardise reporting in OH/primary care
  ○ Surveillance e.g. standardised reporting of chest xrays in respiratory health surveillance & harmonising work and health datasets
 	
• Shift of occupations e.g. from areas where AI makes roles redundant

- Jobs most likely to become redundant
- Areas of the country that might have larger burdens of unemployment due to AI redundancy
- New roles available
- Use of AI for analysis of imaging as part of healthcare, reference ranges and analysis
- Machine learning – needs a large dataset and needs global impact
- Predictive analytics for tailored interventions
- Exposure – air, temp, lighting, noise
- Digital ‘twins’ to mirror and simulated behaviour, condition & environment of real-world counterpart to enhance policies and practices for MSK and MH programmes
- Ergonomics, MH and stress behaviour change, pandemic/epidemic readiness, workplace design
- Industrial revolution
- How to sustain the workforce as AI becomes more fully implemented
- What jobs will be affected and what jobs will remain?
- How do we curate new jobs in place of those lost
- Is AI an occupational hazard?
- How to harness AI to make work easier and increase productivity
- Validate user ease as an outcome measure e.g. ergonomics and posture
- Demonstrate the benefits of AI to educate and not affect job security
- Apps to support workers
- Ensure training to minimise stress
- Describe the elements that cannot replace human skills/knowledge
- AI for myth busting misconceptions about work and health, esp MSK
- AI for delivering assessment and advice for common health conditions in the workplace

4. Type of employment and the changing nature/ patterns of work

- remote working,
- zero hour contracts/gig
- migrant workers
- subcontractors,
- flexible hours,
- growth of self-employment

Top 18 research priorities
7 Challenges for subcontractors, sole traders etc to manage health; opportunity to test sector specific approach to protect and promote worker health 12 What are the long term impacts of remote work, particularly for young people?
Additional comments

• Challenge
  ○ Subcontractors/sole traders/self-employed – managing health
• Opportunity
  ○ To test a sector specific approach to practice to protect and promote worker health
  ○ Awareness
  ○ Health surveillance
  ○ Managing long term conditions
• Outcome
  ○ Individual health
  ○ Stay in work
  ○ Prolonged careers
  ○ Organisational stability
  ○ Organisational/company growth
• How can SMEs, including sole traders, access effective working from home support through all elements of the healthy working life cycle

- What are the routes to access/communicate with self-employed workers (with regard to empowering them with knowledge around wellbeing and health)? Via ‘access to work’?
- What interventions are effective in OH for self-employed workers?
- Is there a business case for remote and flexible working? For whom and in what industries?
- Contractors who are self-employed and the cost of living crisis. How can we make health be a priority for them when they are on piece work and need to earn money?
- Reflecting on the transient nature of contractors, included the self-employed and migrant workers. How can health surveillance be undertaken and managed effectively?

5. Prevention and health promotion

- evaluation of effectiveness of prevention/promotion programmes
- engagement, productivity, behaviour change, barriers to success

Top 18 research priorities
5 What health prevention initiatives have proven long term impact (5-10 years, and how are we measuring success)? 13 How can internal existing roles be leveraged to promote health and prevent ill health (including non health roles)?
Additional comments
• How are we measuring success? • How can internal existing roles be leverages to promote health and prevent ill health in the workplace? (inclusive of non health roles, safety centric roles, employee working groups, line managers, unions • Leveraging existing roles - which roles can play a part in health prevention, integration of existing roles • What health protection activities are implemented and how effective are they at achieving their objectives - short and long term impacts, regional approaches • What is working, and how do we know? • Can health promotion be made sustainable? – focus on the long term impacts of health promotion? • Would a health passport, owned by an employee, which includes mandated and voluntary health checks from start to end of employment allow health to be tracked and specific information/targeted help to improve health trajectory? • Is it possible to design and deliver a single unified workplace health promotion service that everybody could buy in to? • How can self-employed, SMEs and gig economy workers be better protected to prevent ill health and promote good health? – who is responsible, who owns the programme, how to encourage individual ownership? • What would encourage workers in different economic models to participate in health promotion? – employees, employers, vulnerable • RCTs are unpopular with business. How ‘better’ can you test the effect of a health promotion programme? • Evaluation of ‘success measures’ and efficacy of prevention programmes provided by ‘outsourced’ OH providers

- How do you measure the effect of a health promotion programme beyond worker engagement?
- What models of OH service delivery are effective in delivery, preventive and promotional services (note these functions are often not offered as are through models such as external providers)
- What does prevention in SMEs look like – employer role, NHS role, who else?
- Behavioural barriers/challenges – who will employees listen to? Different advice sources/roles, demographics
- Role of incentives – what can employers offer to incentivise people
- Incentives for employers who do look after employee health e.g. discounts on OH
- What incentives within a workplace through employee voice and engagement work?
- How do we incentivise young workers/people to prioritise and track health for longer term outcomes – OH work and facilitators/facilitation
- How can workers be better approached to engage with OH services?
- Are current engagements effective – what are the barriers and facilitators?
- Approaches to behaviour change e.g. nudges – need more in the health space?
- How do 1-2-1 interventions work when included in standard health assessments e.g. health surveillance, safety critical and referrals, OH and voluntary health screening
- How to engage small businesses with OH programmes and evaluate their efficacy WRT larger enterprises
- Baseline – in cohort e.g. young workforce, how does knowledge and understanding of the importance of workplace health (prevention/life course) vary between employed and self-employed sector? Is there a difference in awareness, perceived responsibility, taking ownership etc
- Impacts on productivity and barriers supporting welfare and ‘healthy work’ in the self-employed sector
- Who owns delivery and how do you empower workers (at all levels) to take ownership

- What role can the OSH professional contribute to the prevention and promotion of LTCs. Hypothesis is safety centric practices have effectively decreased incidents and accidents. Can they do the same for health related conditions?
- What happens where there is no OK? What do managers/employers know and how can they do it? What should they do?
- Can employee working groups looking at improving health initiatives' outputs and evaluation by assuming behaviour change lead to outcomes which can be evaluated?
- Published evaluations of organisational initiatives which have focused on prevention of key health issues e.g. diabetes, risk. What works, long term impact, good practice for organisations, what is their role?
- What effective programmes exist for prevention/promotion around workplace stress?
- How do we promote empowerment to take ownership in preventing one's own workplace stress?
- How do you effectively deliver health promotion where there is no OH service?
- Health inequalities within a locality where health interventions are provided in the workplace
- How to engage sectors with significant health issues caused by work to address underlying problems of job design

6.Leadership and management

- sickness absence management
- return to work
- effectiveness of interventions to keep employees at work

Top 18 research priorities
2 Young people at work - what is going on with young people's conceptualisation of meaningful work, mental health/distress, how these interact, and what employers can do 9 What does effective interface between health professionals, employers and workers look like (barriers, enablers)
Additional comments
• What workplace policies/strategies/interventions are effective at supporting people with health needs to remain in work/ return to the workplace/ enter the workplace • What workplace wellbeing initiatives are effective and in which settings and who benefits the most/least? • Robust evaluations of brief, light-touch interventions to help people with health conditions stay in, or return to work (involving collaborations with employers and methodology of high enough quality to enable cost-benefit analysis) • How can we best take a systems approach to supporting people in 'good' work? • Interpersonal relationships at work are pivotal to disclosure and effective support around health issues • How can positive, trustful, compassionate and constructive relationships be built in the diversity of workplaces, employment structures, and diverse (perhaps transient) workforces? • How can we support people returning to work with ongoing health challenges to prevent repeated absences – this is compounded by concurrent health challenges, health complexity especially in an aging workforce • Development of managers focused on prevention and early identification of issues • Connection between non-clinical advisors and clinicians • the role of employers/managers

- understanding what support needs are and how best to implement for a diverse workforce
- understanding what advice and guidance is available and how to action
- what does sustainable cross-sector collaborations work, health, housing, education, neighbourhood models look like?
- What are key datasets that can inform assessment of effectiveness?
- How can smaller and micro firms be supported to navigate/manage/sustain operations and productivity when staff members have fluctuating and unpredictable capacity?
- How to incentivise employers to prioritise health of their workforce?
- Cost-benefit/cost-effectiveness of return to work interventions (in the UK context) considering both work and health outcomes
- What does good look like?
- How can we share/synthesise good/effective/promising practice?
- High quality evidence synthesis on topics raised by the Mayfield review (as a first step)
- Grey literature – cohesion – further studies focused on worker retention
- Remote working – how to build trust with the manager?
- What is the optimal method/format/process of supporting return to work/fit note provision from NHS primary/secondary care?
- What works for patients, employers, health care professionals?
- What will replace fit notes?

7.Occupational hazards to health and risk assessment

- psycho-social hazards
- occupational environment and exposure

Top 18 research priorities
14 Intervention effectiveness with clear pathways to outcomes with a real world emphasis (health, economics, work related) 16 What is good work for individuals? (prediction tools, people at risk, what support helps, how to get people to thrive at work)
Additional comments
• How can the duty to inform of health risks be adjusted to meet neurodivergence in the workplace? • What are the implications for the workplace environment standards of having a more diverse (unwell) workforce? • What work conditions and factors are needed to support continuation of 'good work' amongst different populations – different health conditions/comorbidities, neurodivergence – to enable them to thrive and prevent detrimental impacts • Constructive segmentation to feed forward • Risk factor assessment to direct work with greatest likelihood of success • Can we identify who is best suited to particular roles to protect their health and help organisations be productive (including age, neurodivergence, protected characteristics and intersectionality) • How to effectively eliminate or substantially reduce psychosocial harm to protect workers' health without affecting productivity • Collection of ongoing data • Effectiveness of interventions to prevent and manage stress at work (in industry/applied setting) – NB – gold standard in academic research does not translate to practice • Identification of sector-specific occupational factors and risks which impact on the mental health of workers • Identification of risk factors in the workplace which promote better physical and mental health among older workers and mitigate risk hazards • Identification of risk factors among gig workers/those in precarious forms of employment - which interventions are most effective in this cohort?

- What interventions are most effective in supporting older workers (over 65) to remain and return to work?
- Occupational environment is changing. Most assessments are made for large organisations/culture
- Rethink assessments for SMEs, hybrid, gig economy, flexible working
- Is the law helping or not?
- Are assessments implemented – most just sit in a drawer – can they be integrated and cocreated? Feedback loops
- Assessments that provide multiple points of reassessment due to domains of aging, long term conditions, and EDI etc.
- How to transform assessments into actionable interventions
- Assessments can be frameworks including psychosocial and physical hazards – need to include people with existing conditions not just prevention
- Bottom line - longitudinal stuffies with reassessment and follow-up
- Remodernising the screening process
- How the changing occupational and organisational environment impacts on the health and occupational outcomes of workers – how does this vary by different generations, and population subgroups (gender, ethnicity, geography, disability)
- What workplace adjustments work to ensure people thrive in work if they have rare health conditions
- Evaluate prevention efforts in occupational settings to reduce sickness absence, increase retention and support wellbeing at work
- How to better collect occupational hazards in real time, and link to later life outcomes
- Make better use of untapped data (OH providers, insurance companies, admin records) – could include workplace monitoring (keyboard, voice etc)
- Mapping stress, occupation and workload/hours per week against deprivation of household to understand which occupations place deprived workers at greatest risk of work related stress
- Target regulation of occupational practice in risky occupations and support reduction of work related stress for deprived households
- Burden of ill health on employer and state

- How can we better work for insecure employment?
- Evaluation of understanding of RA and SSOW in neurodivergent workers using different training methods to inform best training methods for neurodivergent workers

8.Management of long-term conditions and disabilities

- attitudes towards disability in the workplace- employer and employee
- functional capacity evaluation
- objective measures of disability assessment

Top 18 research priorities
3 In the management of long-term health conditions and disabilities what multiagency collaborations are needed and what data must be collected and shared? **4 What is the return on investment for individuals, employers and society of keeping people with long term disabilities and health conditions at work. (good practice in systems design and implementation, barriers to adoption, variability across sectors)**
Additional comments
• Impact of job quality on disabled people's job retention • What works to support employers who do not engage? • What is causing NEET rates to increase, and how does health impact this? • Evidence for effective workplace modifications, particularly long-term evidence, longitudinal follow-up linked with employment outcome and health • Interventions in SMEs for effective occupational health provision – how to engage effectively with SMEs • Informal work and occupational health – migrant workforce, precarious work – how to create an evidence base linking work and health, focused on informal/migrant workers/carers • The role of the line manager to enable safe disclosure and signpost to support • How can we support line managers in their role – especially as they are 'squeezed'? • Knowledge of 'effective' workplace adjustments to support people with long term health conditions to stay in work – what works, fidelity, return on investment • Help for SMEs who may not have HR/OH to support staff – what can they do? Evidence of best practice? • Workplace measures to support people with LTCs and disabilities – what works, what is the ROI? • Management vs prevention of LTCs

- Assess impact of condition or ability to work (in different roles) – concept of a ‘health weighted index’ e.g. at TfL cardiovascular health has a bigger impact than MSK
- What destigmatisation techniques are most effective in changing workforce culture?
- Is the development of AI tools in the workplace improving access to work for people with disabilities?
- What is the prevalence of capacity evaluation in organisational return to work systems?
- Extension and better understanding of ‘reasonable adjustments’
- The realities of an ageing workforce – people at work with long term conditions such as arthritis
- Creating work environment in which employees are willing to disclose.