Response of the Council for Work and Health (CWH) to the Department of Health (DH)

Long-term conditions (LTC) Outcome Strategy

The Council for Work & Health (CWH) brings together the professional bodies which represent these groups to provide an authoritative and representative 'single voice' on work, health and wellbeing issues. It also provides an opportunity for co-ordinated and integrated working on all issues which impact on health and wellbeing services and facilitates information sharing to promote improvement. Further information is available from http://www.councilforworkandhealth.org.uk.

CWH was grateful to be part of the stakeholder involvement by the Department of Health (DH) and to make further comments following discussion within the Council.

General points

Much can be learned about assisting those with long-term conditions by reference to the literature on rehabilitation (assisting those with disabilities). We note that the links with the Disability Strategy have yet to be made. The comparisons will be different between those with congenital or inherited disadvantages compared with those who acquire them in adult life.

There was a consensus at the stakeholder meeting that supporting those of working age to work was of fundamental importance. The CWH wishes to emphasise the importance of work to health [1].

Specific comments on the proposed shared goals

1. **People will be supported to stay healthy and avoid developing a LTC where possible**

There is considerable evidence that good work is good for health [1], which suggests that supporting people to work is both a way of helping them to be healthy, in terms of avoiding injuries, work-related ill health or the development of a LTC, in addition to helping those with LTCs avoid developing further health problems. In addition to the health benefits of work, the workplace also has great potential as a forum for health promotion and public health interventions: health campaigns and interventions provided in workplace settings could support individuals with healthy life choices and help prevent the development of a LTC. These initiatives may be particularly important in male-dominated employment as men are less likely to seek advice of health professionals – see section 2 below. The role of employers in facilitating these processes has been outlined in further evidence to this strategy

[2]. The CWH supports review of the taxation disincentives that inhibit employers from developing appropriate health promotion strategies [2].

There are over 10 million people with a limiting LTC, impairment or disability in Great Britain [3]. Although some aspects of ill health relating to disability are clearly understood e.g. osteoporosis following immobility, there is relatively little research on the health consequences to the development of permanent impairments (using the WHO use of the term impairment [4]. There is evidence that those acquiring a disabling condition e.g. after an accident are at risk of weight gain [5], and that wheelchair users are gaining weight as evidenced by the 'increasing numbers of obese individuals needing wider or heavy duty wheelchairs' [6], some of whom may proceed to bariatric surgery [7]. Simple advice on avoiding weight gain by those with enforced inactivity due to illness, injury or disability[8] could be provided by:-

- NHS wheelchair services
- Therapy services whether NHS or private (e.g. physiotherapy)
- Primary care services
- Charitable sector through newsletters or fact sheets particularly for those with defined conditions e.g. back pain, many neurological conditions.

Whilst it is clear that wheelchair sport is taken very seriously by some e.g. paralympians, it is less clear how much advice and support is given to wheelchair users (and other physically or emotionally disadvantaged individuals) to maintain or increase their physical activities. Specially adapted outdoor exercise areas in Washington DC parks have special facilities for wheelchair dependent persons and the City of San Diego has Therapeutic Recreation Services run by the city but with volunteers giving over 20,000 hours of service annually [9]. These Services include 'inclusion of individuals with disabilities into programmes at the neighbourhood recreations centres...adapted games and activities...adapted beach wheelchair programme, water sports camps, kayaking etc [9]. Similar facilities do exist in the UK, but possibly not to the extent and scope of some American services e.g. Scottish Disability Sport [10]. Wheelchair Tai Chi may offer exercise to large numbers of wheelchair users if offered the opportunity [11].

The CWH would be happy to work with the DH to enhance current, and develop new, potential cost effective ways of using occupational health services, health promotion and other workplace health and wellbeing interventions for prevention of LTCs, ill health or disability.

2. More people will have their condition diagnosed earlier

Early diagnosis can be particularly problematic to achieve for men of working age who may be reluctant to engage with the healthcare system. The workplace offers an opportunity to reach this section of the population, and also to reach those of working age in general. Workplace health information/education campaigns, on-site health checks, health surveillance activities and worksite occupational health services allow targeted and easy-to-

access opportunities for these people to engage with healthcare professionals in a non-threatening and convenient way, facilitating early diagnosis and referral of those with a LTC.

The CWH values highly the government initiatives to educate primary care physicians in all aspects of the work-health interface and the importance of the open access help advice lines relating to occupational health issues.

The CWH recognises the important leadership role the government has as a major employer in the development of appropriate employment practices through high quality management and the maintenance of high standards of occupational health.

The CWH would be happy to work with the DH to develop new potential cost effective ways of using occupational health services for early diagnosis of common LTC.

3. **Services will be joined up and based around individuals' holistic needs**

Whilst much is known about the importance of communication between the primary and secondary care services, communication between primary care, secondary care and occupational health is often deficient [12]. Communication with employers and stakeholders within the individual's workplace is often deficient or absent.

In addition, the need for the reports of medical experts to be made available to primary care teams in personal injury litigation cases is rarely considered. A judge recently commented upon recommendations made by an expert physician on potential care which were never acted upon – presumably as the primary care team had never been made aware of the report. The DH needs to discuss this with the appropriate legal department(s).

The CWH is already developing communication between health workers and employers in relation to fit notes and would be happy to work with the DH to explore ways of improving communication and collaborative working to facilitate a speedy return to work (RTW) for those off sick.

4. **People with LTCs will be socially included, including succeeding in work and education**

There is already an agreement between the relevant professional bodies in the healthcare sector that an appropriately timed RTW should be a desired outcome of healthcare treatment. It would be good to see the LTC strategy stress this and provide impetus for the recognition of the importance of good work for health. The LTC strategy should explore and support the ways in which employers can make adjustments to work and workplace environments in order to support those with a LTC to start, stay in or return to work.

There was widespread agreement of the importance of transitional services for young people with LTCs. Using cerebral palsy as just one example, the issues around employability have recently been reviewed [13]. There are strong correlations between the level of self-care obtained by the young person and future employability [14]. Although education is important

for these individuals, their social development is also crucial, and this requires appropriate work experience as part of the development of social skills and education [13].

For those acquiring LTCs in adult life, services need to be geared up to assisting those affected to maintain optimum participation in society [4]. UK Rehabilitation services remain deficient in this respect. Thus the UK has lower employment rates than other European countries following a spinal cord injury [15]. Although rehabilitation following a stroke begins on the first day by giving appropriate advice about liaison with employers etc [16], there is a widespread view that community rehabilitation tends to conclude when the patient is safe at home, precluding the late community rehabilitation that aims to ensure, amongst many other goals, safe use of public transport or driving, ability to access community exercise programmes and a successful RTW [17]. It is understood that Prof. Keith Willett is leading on the development of rehabilitation facilities/services in England. Certain aspects of rehabilitation are already seen as priorities within NHS Scotland e.g. vocational rehabilitation [18].

Others may wish to comment on transport issues.

There is now no doubt of the very positive effects of providing powered wheelchairs – the Electric Powered Indoor/outdoor scheme has been very successful for users of all ages – but they are particularly important for children and young people [19] as they facilitate social interaction from an early age and greatly enhance personal independence – a prerequisite for the world of work – see above. The Access to Work Scheme is very successful- and provides powered wheelchairs and other essential equipment for those with (usually) physical disability – but only for those who have succeeded in getting work. Many who might benefit, of working age, do not get powered mobility to assist in looking for work as they do not fulfil the current strict criteria [20]. The lives of many carers would also benefit from powered mobility for their disabled family member [21].

There was some discussion relating to the difficulties, perceived by some, of paediatric services actually seeing their patients as young people potentially moving into the workforce. Thus some paediatricians still communicate primarily with parents rather than the young person, even in their teenage years. Most young people fulfilling the criteria for powered wheelchairs receive them prior to going to secondary school, but other means of facilitating independence for young people are not championed by paediatric services but by community occupational therapists e.g. environmental control units [22].

The comments on taxation in section 1 remain appropriate here.

The CWH is happy to work with the DH in developing potential additional ways of accommodating disadvantaged individuals in the work place and in supporting employers to make adjustments to work and workplace environments in order to support those with a LTC to start, stay in or return to work.

5. **People with LTCs will be as independent as possible and in control of their lives (up to and including the end of life)**

See section 4 above. There was discussion within the group about the needs of the substantial numbers of individuals who need considerable support to enable them to achieve even modest goals – e.g. external believers [23], or those with very low intelligence. Choice can be marvellous for some, but add confusion and extra difficulties to others who already have too many problems in their lives.

Community rehabilitation is important as it may reduce the costs of long-term social support and can link with the voluntary sector to optimise the combination of state or charitable resources. The link between community rehabilitation teams supporting those with deteriorating conditions, for example, with hospice care is a good example of this. Thus the Physical Disability Support Team in Harrow worked very closely with the local hospice to the advantage of both teams and the patient and their family.

This is another area where clinicians helping those with LTCs can learn from the rehabilitation literature – where team working facilitates the partnership arrangements needed between the individual, family and informal carers, charity, education, employment, housing and social sectors.

A key method of assessing an individual's route back into employment is by assessing the difficulties (obstacles – not barriers) associated with a RTW. Thus Table 1 (taken from evidence submitted by the Vocational Rehabilitation Association to the Sickness Absence Review [24]) shows how the biopsychosocial model can be translated into many aspects of support for disadvantaged individuals. Employment facilitates independence as well as the reverse – with independence facilitating work.

6. People with LTCs will be supported to stay as well as possible.

The CWH recognises that work can be a source of strength and happiness in lives, but also that if employees are not given adequate support during the challenging or pressured times at work, then this can predispose to mental ill health (anxiety/depression etc). The CWH will be happy to work with the DH to further delineate factors associated with employment-related mental ill health and how they can best be managed. The group will recognise that occupational health teams already work closely with the Health and Safety Executive to minimise accidents at work etc.

The CWH recognises that there are already plenty of screening tools available to detect mental ill health amongst those with LTCs e.g. Hospital Anxiety and Depression Questionnaire and many occupational health teams use psychological therapies or employ councillors/psychologists to support employees. We recognise that such services are often not available to small and medium sized companies and are happy to work with the DH in devising ways of offering such support, and health promotion, to companies with no occupational health services.

7. Where do we go from here?

The group discussion clearly expressed the view that there should be some follow-on from the initial discussions. It was noted that Dame Carol Black's cross departmental team had

been very effective between 2005-10 and that this might provide a model for cross departmental monitoring of the implementation of the strategy.

This response has been drafted by Andrew Frank, Richard Jones and Emma Donaldson-Fielder, discussed and agreed by members of the Council.

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Table 1

The flag system of obstacles in RTW (Kendall and Burton, 2009 [25]), modified by the VRA [24]

Red – severity of impairment (a)
Yellow – psychosocial obstacles (b)
Orange – those with pre-existing psychological impairments (b)
Blue – perceived obstacles in the workplace – changeable (c)
Black – unalterable obstacles – e.g. national agreements (c)
Chequered – social obstacles (c) [26]

a Biological
b Psychological
c Social

a-c Components of the 'bio-psycho-social' model of service provision