

Health and Safety Commission Paper		HSC/03/67	
Meeting Date:	14 October 2003	Open Gov. Status:	Open
Type of Paper:	Above the line	Paper File Ref:	137/HD/1009/2002
Exemptions:	None		

HEALTH AND SAFETY COMMISSION

MUSCULOSKELETAL DISORDERS PRIORITY PROGRAMME

A Paper by Elizabeth Gyngell

**Advisor(s): Malcolm Darvill and David Lewis
Cleared by Sandra Caldwell on 25 September 2003**

Issue

1. A report on progress with the Musculoskeletal Disorder (MSD) Priority Programme (PP) and to suggest ways forward for the necessary gear change to become world class.

Timing

2. The paper will be presented at the Commission meeting on 14 October.

Recommendation

3. HSC are asked to:
 - a) note the progress of the PP and some of its considerable successes (see paragraphs 5 to 15);
 - b) give a view on the future work proposed to achieve world leadership in the prevention and management of MSD (see paragraphs 17 to 26).

Background

4. MSD are the most common type of work-related illhealth in Great Britain. They have been a priority for HSE since 1990 and the advent of Securing Health Together and the adoption of PSA targets has raised that priority. Because they are so common MSD have attracted a great deal of research and the evidence on which the programme's messages are based is sound. The MSD PP started work in April 2001 and the HSC received a report on its plans and current work in June 2001. The PP is very much a cross-HSE programme and depends heavily on all Directorates and Divisions working together on projects and promoting the same messages. It cuts across the FOD Sector PPs, where there is a high risk of MSD. It also meshes with the work of other teams in the Better Working Environment Division and OGD, in particular DWP and DoH, on rehabilitation and the provision of occupational health support. The programme recognised from the outset the importance and benefits of partnership working. The HSC Occupational Health Advisory Committee (OHAC) set up a working group on MSD to advise the MSD PP. Professional bodies, unions and trade associations and other stakeholders have been kept informed of the programme through presentations to their conferences and consultation exercises. More information about the background, evidence base and planning arrangements of the MSD PP can be found at **annex A**. Minutes of the HSC's previous discussion on the PP can found at **annex B**.

Assessment of progress to date

5. This paper's assessment of the work of MSD PP is in two parts: the first is about whether we are going to meet the PSA health targets; and the second is about what more we need to do to be world class. Before those sections, there is a brief description of the current work and initiatives, because an assessment of our progress depends on how good that work is. Detailed information on the programme can be found in annexes on the five strands of the programme (see **annexes C, D, E, F, G**) and work in HSE Sectors (see **annex H**). The following two paragraphs draw attention to some of the successful, and less successful, aspects of the current programme.

6. In the positive column are:

- the new FOD Topic Inspection programme (see **annex C**) that has resulted in a significant rise in compliance activity, including a 29% rise in improvement notices between 2001-02 and 2002-03;
- the Manual Handling Assessment Chart (MAC) we developed to support inspectors in giving advice (see **annex C**);
- the work of the Corrugated Packaging Association. The CPA now has a national rolling programme of awards for good practice, road shows, interventions to promote behavioural change in workers and a management action plan for use throughout the industry (see **annex D**);
- some sectors, particular some of the non-PP ones, have added excellent value to the MSD PP. We would encourage more activity in those non-priority sectors that have the potential and track record of making a difference, provided the industry has a high-risk of MSD (see **annex H**);
- the MSD website has conveyed the key messages of the MSD PP in a way that is informative, useful and suitable for any audience: between November and July it received an average, 46,000 requests for MSD related pages per month (see **annex G**); and
- Working Backs Scotland is a public health campaign that was developed with the support of the MSD programme team and preliminary evidence from the project has shown a significant change in beliefs amongst the general public and GPs (see **annex I**).

7. In the negative column:

- the skills strand has been one of the most problematic of the programme. There is a national shortage of ergonomists and in the long-term this may have a detrimental affect on the ability of the programme to deliver (see **annex F**);
- the MSD PP Management Team has tried to use programme management techniques based on those of the Office of Government Commerce. However, we have had to adapt our paperwork to various changing Ministerial needs and most recently to DWP's delivery

requirements. These changes have been disruptive and resource intensive;

- HSE’s own planning and reporting procedures have mitigated against achieving an integrated programme plan.

Current new initiatives

8. There are three new projects being developed this year that are designed increase the impact of the programme in the next planning year:

- a new project to encourage greater use of lifting aids, (see **annex J**);
- Active Case Management, Rehabilitation and Job Retention. This will look at ways of encouraging employers to manage employees who suffer from MSD, assist them back into work, and help them take on staff with chronic MSD (see **annex K**); and
- HSE is one of the partners in the NHS National Backpain Collaborative, a group of government departments sponsoring a pilot research project, for convenience called Working Backs England, to look at the effectiveness of different media campaigns in altering beliefs about back pain in England. This is based on Working Backs Scotland and, if it is as successful, it will make a significant contribution towards the PSA health targets, (see **annex L**).

9. Has HSC other proposals for new work?
--

Will the MSD PP meet its targets?

10. The assessment of progress towards meeting the PSA Health targets is difficult because the statistical information we have is not perfect and the surrogate indicators we have need improvement. It is uncomfortable not being able to give a clear “yes” or “no” to this question, but it is simply too early to say what progress has been made against the 2001-02 baseline. The present view of HSE’s statisticians is that MSD show no discernable

trend since the start of the programme. This is not hopeful, but much of the data on which it is based relates to 2001-02. **Annex A** gives more information on evaluation.

11. The MSD PP addresses two of HSE's three PSA targets. If successful it will contribute 42% of the asked for reduction in work-related ill health and 31% of the asked for reduction in working days lost due to ill health. These are large percentages and clearly if the MSD PP falls short of expectations it could have a serious impact on HSE's ability to meet its PSA health targets. Conversely, if more needs to be done to meet the targets, MSD are the key area in which to put more effort and resources.

12. Without objective measures a view has to be taken based on what has already happened and the successes and failures already experienced. On the plus side is the knowledge that the messages and interventions promoted by the programme are based on sound evidence. In addition, the topic inspection programme is signalling to employers the importance of compliance and there are clear regulations and guidance for them to follow. Finally, the Stress PP is coming on stream and this should help reduce the considerable psychosocial risks associated with MSD.

13. The negative side has two aspects. One is to do with planning and process. It has taken some time to get HSE to pull together and we are still not entirely there, particularly in the planning and adoption of evidence-based policies. We also need to be more effective in co-ordinating the information we have about MSD and intervention strategies so that an integrated and targeted programme of work can be planned. HSE's adoption of strategic programme management for all its work should overcome this problem.

14. The second aspect is the shortage, mentioned earlier, of trained ergonomists. Their absence is a drag on providing help to employers and inspectors on how to deal with MSD. HSE is reviewing its likely skill needs over the next decade and we expect this will address the internal problem. Finally, something we can do nothing about, is the possibility that, as

awareness is raised about MSD, more are likely to be reported and this may distort progress towards the targets.

15. In summary, the programme has many success stories and we expect to soon overcome the two major drags on progress.

16. Against this backdrop is HSC content that the MSD PP is making satisfactory progress towards meeting the PSA health targets?

A gear change to bring us up to world class

17. The HSE “New Manifesto” sets out the decision to raise the profile of health and safety and “to achieve the position of world leadership in health as well as safety”. This second part of the assessment gives suggestions on how we might become the world leader in the prevention and management of workplace MSD. It requires us to do more in certain areas e.g. compliance and to do new things differently. We are asking for the Commission’s views on the proposals. Should the Commission and HSE decide to take them further, the OHAC MSD working group and other key stakeholders will be consulted on more detailed proposals. The OHAC working group already advises the programme, on for example, the analysis of our objective measurements.

Prevention and Case Management work

18. The evidence on which the programme is based strongly suggests that it is possible to prevent most MSD, but that prevention alone is not sufficient. In recent months some experts have challenged this assumption particularly with regard to the prevention of back pain. Their contention is that despite a reduction in physical risk factors the incidence of back pain has not fallen, which suggests to them the real “pathogens” for chronic back pain are inappropriate pain beliefs, fear avoidance behaviours and inactivity levels. Therefore, if we are to reduce sickness absence and its associated costs we must tackle these inappropriate beliefs and responses and put our effort into

the public health message and the effective case management of acute incidents. Some new projects address these issues (for example “Working Backs England”) and HSE is working on more general rehabilitation issues. However, a move towards case management is a considerable shift away from HSE’s present expertise and needs to be managed carefully.

19. Does the Commission think the dual track approach of both prevention and case management is the right approach?

20. Assuming that the Commission is content, we propose to enhance the case management aspect of the programme. The enhancement would be in accord with a key message from the MSD evidence base (see **annex A**), that those MSD that do occur must be properly managed. Again, more detailed proposals will be developed in consultation with the OHAC MSD working group and other key stakeholders. Using our experience of previous work and taking advantage of other developing HSE initiatives we will explore whether:

- resources (financial and human) could be found to run a second phase of Back in Work (see **annex N** for more on BiW);
- MSD should be a key topic in the workers’ safety advisor project; and
- MSD should be a key topic in the new priority programme Government Setting an Example.

Compliance and problem solving

21. This debate is about whether we will achieve world leadership in the prevention and management of MSD by focussing on prevention or by providing a support network of some kind. The HSC/E’s draft strategy for 2004-10 (HSC/03/136) recommends “*the development of occupational health and safety advice and support outside HSE with national coverage and active both in preventive modes and promoting rehabilitation*”. Providing problem solvers is in accord with this part of the strategy.

22. This is not to suggest compliance should be neglected. We are clear the achievement of world class status will, in part, depend on a more imaginative and forthright approach to compliance. Some suggestions for this, to be developed in consultation with key stakeholders in HSE, are to:

- carry across topic inspections to other HSE Divisions;
- further develop safety and health awareness days and carry them across from agriculture and construction to other sectors; or
- plan MSD blitzes focusing on high risk manual handling tasks.

23. But our experience and some research suggests the legal argument is not particularly compelling, that courts are unwilling to impose fines that deter and that compliance soon becomes routine. In addition, a focus on compliance alone would not address belief patterns and psychosocial issues. In Scotland there is now a network of people giving advice to SMEs both over the phone and in person (see **annex M**). As the draft strategy points out “*the evidence points to the need to develop channels of support and advice separate from enforcement, much of which need not involve HSE directly*”. HSE has past experience of working with intermediaries (see **annex D** on Continuous Improvement) and this is being built on. We are currently working with a wide range of key stakeholders to establish an occupational health and safety support system, for England, to help workers and employers identify their occupational health, safety and rehabilitative needs and access the solutions and people providing it.

24. Does HSC support our two pronged approach of compliance and of problem solving through providing access to practical advice and support through working with others?

Closer working with other HSE programmes

25. It seems natural to use synergies between different HSE work programmes to promote MSD messages and we intend to raise the profile of MSD within several of HSE’s other work streams such as:

- building on the corporate responsibility work to include MSD as a particular topic;
- closer involvement with other PP such as stress and slips and trips; and
- including rehabilitation from MSD as a specific topic in the rehabilitation work stream.

By working together, the spread, and hopefully the impact, of the MSD messages will be increased.

Worker involvement

26. Evidence shows the most successful MSD solutions are those developed in conjunction with safety representatives and workers. HSE has published research on participatory ergonomics and worker involvement is one of the 6 key elements needed for a successful MSD intervention. Unions have been involved in several of the projects particularly those in the Continuous Improvement strand, for example:

- the CPA's programme was developed in partnership with Graphical Media and Paper Union (GMPU)
- the guidance for cleaners on MSD and the research behind it was produced and commissioned in partnership with Unison; and
- the TGWU helped review the provision of manual handling training in agriculture and research the scope for a reduction in pack sizes of packaged goods.

However, much more could be done in this area and this is one that will be expanded as the programme moves forward.

Consultation

27. This paper is based on a wide consultation with the programme partners in HSE.

Presentation

28. No current presentational issues – should important changes be made to the programme the need for publicity should be considered. The programme already takes account of devolution issues and we are working closely with the developed administrations to achieve the best possible gearing.

Costs and Benefits

29. There are costs and benefits associated with major changes to the programme, but until these are determined the analysis cannot be done.

Financial Assessment

30. The present financial requirements of the MSD PP are factored into HSC/E's budget and planning round.

Environmental considerations

31. None.

Background information on the MSD PP

MSD in the workplace

The figures from the self-reported work-related (SWI) survey in 2000-2001 showed that an estimated 1.1 million people were suffering from a work-related MSD, with an estimated 240,000 new cases a year; there was a loss of 12.3 million working days a year, at a cost to the economy of £5.7 billion (1995 prices). MSD are found in all industrial and business sectors and HSE and Local Authority inspectors expect to find them in most of the workplaces they visit. MSD have been a priority for HSE since the 1991 Health Risk Reviews. The research and policy work done during the last decade provided a sound base on which to develop an evidence-based PP. The experience of planning and running *Good Health is Good Business* also played a part in future thinking.

Evidence base to HSE's MSD strategy

The key features of the strategy are that it is:

- evidence based;
- takes the SH2 wide view of occupational health; and therefore
- promotes a holistic approach to better management of acute WRMSD.

This was necessary because evidence, for example from New Zealand, that reliance on prevention alone, HSE's traditional approach, is not sufficient.

However there was also clear evidence that MSD can be drastically reduced by effective ergonomic interventions, which incorporate all of the following elements:

- senior management commitment;
- worker involvement;
- risk assessment;
- appropriate control measures;
- instruction and training; and
- proper management of cases that do occur.

It was also clear, again from evidence, that psychosocial as well physical risk factors need to be addressed and that it was possible and necessary to change the way people deal with MSD. The latter, for example is being addressed by the Working Backs Scotland initiative, which is now getting over the message to people with backache that they should: stay active; try simple pain relief and seek advice if necessary.

One example where the strategy and the evidence behind has fed into policy development is HSE's new guidance on upper limb disorders in the workplace. This is again evidence based, using ergonomic principles to

promote an active management approach for tackling ULD's and encouraging employee involvement in assessing risks and developing control measures.

Promoting this guidance is a significant element in HSC's MSD PP – which is trying to broadcast the following key messages:

- MSD is a challenge in all workplaces, (not just in a few high risk sectors);
- you can prevent MSD/minimise the effects – and it is cost effective;
- but you cannot prevent all MSD so appropriate management i.e. early reporting of symptoms, correct diagnosis, proper treatment and suitable rehabilitation, is essential.

Planning and monitoring the MSD PP

The MSD PP was developed at the same time as Securing Health Together (SH2), so it followed the approach of using the five tools, Compliance, Continuous Improvement, Knowledge, Skills and Support. It is evidence-based and its strategy and messages are well supported by academic study and empirical experience. Detailed programme planning was initiated by HSC in October 2000 and the programme formally started work in April 2001. At its meeting on 5 June 2001, HSC received an extensive presentation on the evidence-based strategy that underpinned the PP and its planned work. A debating point at that meeting was the relative merits of compliance and continuous improvement. The minutes of the June 2001 meeting are reproduced at **annex B**.

The MSD PP is very much a cross-HSE programme and depends heavily on all Directorates and Divisions working together on projects and putting forward the same messages. Internally, the programme's first steering group was the Inter-divisional Steering Group on Musculoskeletal Disorders (ISGMD) established to inform the MSD Health Risk Review programme. This has been reformed to become the MSD PP Management Group and has on it representatives from all of HSE's D/Ds and LA enforcers and is chaired by the Programme Manager. The MSD PP Support Team assists her, using the Programme Management techniques advocated by the Office of Government Commerce and HSE. The programme is now part of the HSE Strategic Programme, "Safety and Health Priority Hazards".

The programme recognised from the outset the importance and benefits of partnership working. Externally, OHAC set up a working group on MSD to advise the MSD PP. Professional bodies, unions and trade associations and other stakeholders have been kept informed of the programme through presentations to their conferences and consultation exercises. The organisations involved in projects with HSE include the Ergonomics Society, BackCare and the RSI Association. Perhaps the best example, however, has been Working Backs Scotland, in which HSE is one of 20 partners who have been involved in promoting the "stay active" message.

Programme evaluation

The base line against which progress towards the PSA targets will be measured is based on data collected in 2001-02 and presented in *Health and Safety Statistical Highlights 2002*. The statistical assessment was that there had been no discernable trend in MSD over the previous years. It is too early to say what progress there has been against the 2001-02 baseline.

HSE statisticians are using an integrated approach to monitor progress against the global PSA targets and this will provide information on progress on MSD. The approach will first be used, on an experimental basis, for the year 2002/03 and published in November 2003 in *Health and Safety Statistical Highlights*. For 2003/04 it will be extended to take in data from a Self-reported Work-related Illness (SWI) survey being run that year, and then for 2004/05 a wider range of data sources will be integrated, including the Workplace Health and Safety Survey (WHASS) and a GP based monitoring scheme.

Surrogate targets have been developed on which to report to the Delivery Board and Ministers. The most important of these is based on the Risk Control Indicators (RCI) generated by inspectors during MSD topic inspections. Because we only have one year of this data it, too, can give no information about trends at present. The OHAC MSD working group considered both the surrogate indicators and the RCI data and made some useful suggestions about how they might be analysed to bring out their full potential.

References:

Jones JR, et al. Self-reported work-related illness in 1995: Results from a household survey. HSE Books 1998 ISBN 0 7176 1509 X

Shieff J, Turner P, "Chronic back pain – A National Strategy", Occ. Health Review, 67, May 1997

US General Accounting Office study: [HEHS-97-163](#) August 27, 1997 Worker Protection: Private Sector Ergonomics Programs Yield Positive Results. (can be accessed - www.gao.gov)

Hemmingway H, *et al.* Sickness absence from back pain, psychosocial work characteristics and employment grade among office workers. Scand J Work Environ Health 1997; 23: 121-9

Burton A K, *et al* " Is ergonomic intervention alone sufficient to limit musculoskeletal problems in Nurses". Occ Med. 47, 25-32

Buchbinder *et al*: Population based intervention to change back pain beliefs and disability. BMJ 2001;322: 1516 – 1520

Waddell G, *et al*: Back pain, incapacity for work and social security benefits. ISBN I 85315 542 X RSM Press

Extract from HSC Minutes of 5 June 2001

Musculoskeletal Disorders

1.1 Elizabeth Gyngell introduced the topic and gave an overview of the priority programme. Commissioners had been sent background briefing on an audio tape prior to their visit to Scotland. The objectives of this review was to provide the Commission with an opportunity to review: the nature, scale and location of MSD risks; the gaps in the knowledge and plans to fill them; the action planned to deliver the RHS/SH2 targets; the threats to and opportunities of the programme and how it could help and support the programme

1.2 The Commission set out its thoughts on the issue supported by the evidence that it had gathered at its MSD-themed visit to Scotland. These included:

- i. The need to involve all workers and contractors in tackling issues and identifying solutions;
- ii. Simple solutions were available but knowledge about them needed to be disseminated;
- iii. Monitoring systems were required to show cost effectiveness;
- iv. Inspectors needed appropriate information for enforcement purposes.

1.3 Mark Boocock from the Health and Safety Laboratory described a case study on tackling MSD at a boot manufacturer in South Wales.

1.4 Other presentations were based on the five tools of Securing Health Together; compliance, continuous improvement (where Carole Bannister, RCN, talked about the HSE/DoH "Back in Work" initiative the project which she was involved with which aims to improve patient handling in nursing homes), knowledge, skills and support. These were followed by a short presentation outlining the proposed MSD priority programme communications strategy.

1.5 The following points were discussed following the presentations

- i. For the strategy to be effective there should be a clear message on action and the right structures in place to disseminate the message. Several of the "top 350" UK major companies, to whom Michael Meacher and the Chair had written in March 2001, had already signed up to the Revitalising targets. HSE should follow up with some of these companies, and with senior level management in the public sector such as the NHS, to monitor actions being taken, specifically on MSD, to achieve the targets;
- ii. Different interventions may be required for each sectoral industry;
- iii. Senior management needed to be aware of sickness records so that resources could be targeted;

- iv. Concerns about over-regulation in nursing homes might be addressed through consolidating inspections within one authority and disseminating best practice. This should be considered;
- v. Businesses needed to be aware of the effect on their costs and productivity of absences arising from MSD.

STRAND 1: COMPLIANCE

Background

The aim of the Compliance strand is that “by 2010 there will be a substantial increase in the number of duty holders complying with legislation related to MSD”. The main pieces of legislation are the Health and Safety (Manual Handling Operations) Regulations 1992 and the Health and Safety (Display Screen Equipment) Regulations 1992, supported by the Management of Health and Safety at Work Regulations 1999 and Health Safety at Work etc. Act 1974. The law is fairly clear, does not contain any serious omissions or difficulties and has proved robust when used in court. The programme does not envisage any legal changes to the specific MH and DSE regulations will be needed during its 10 year period.

Enforcement

FOD Topic Inspection Programme

FOD introduced major changes in April 2002 to meet the demands of Revitalising, Securing Health Together and the Commission’s strategic plan. The MSD topic inspection programme was part of that new way of working. 2002/3 was a successful year with pro-active MSD inspection exceeding by 23% the planned time for that work. Enforcement Notices relating to MSD increased significantly, by 25% to 366 compared to 292 the year before and were targeted at the factors which make a difference in MSD risk management.

The proactive FOD inspections recorded on IRF1 are based on the RHS MSD topic Inspection Pack which contains key information to assist inspectors applying the new intervention strategy. Some Local Authorities, primarily in Scotland and some in England and Wales, have also implemented this way of working supported by the RHS MSD topic Inspection Pack and the same evidence based risk control indicators on which to structure inspection.

Inspectors are required to focus on risk control indicators (RCIs) for each Revitalising topic. The RCIs are different for each of these topics because they are the factors which can make a difference for that topic. The MSD RCIs are evidence based capturing 5 of the elements that lead to successful management of MSD and include management commitment, worker involvement, control measures and instruction and training. Risk assessment is implicit in risk avoidance/control. Management of MSD cases is a main element which does not have an RCI but this is being promoted by inspectors at visits and in dealings with intermediaries.

HID Land Division Inspection project on manual handling

There were 20 project templates completed in 01/02 and 25 in 02/03. There were also a large number of other contacts (inspection, investigation etc.) outwith the formal project. The formal project was applied during normal preventive inspection and investigations of incidents and complaints. Initial

analysis shows that over half the companies inspected employed 51-250 employees and in 46% of the companies over half the workforce were involved in manual handling. The most common tasks seen were unloading/loading pallets and loading mixers/hoppers/reactors etc from bags; but about 26 different tasks were examined. Risk control measures have not been analysed in detail yet, but risk assessment(s) had been completed for 74% of the task(s) inspected, but only 65% of these were these considered "suitable and sufficient". Suitable control measures were in place for 63% of the processes and planned for 52% of the remainder. The MAC was generally found to be useful and relatively easy to apply. Visits relating to the project have resulted in 1 PN, 4 INs, 19 letters and 34 cases of verbal advice, other notices may follow if advice is not followed.

Guidance

Guidance can be seen as belonging to both the Compliance and Support strands. It is essential for Compliance as it explains to employers what they have to do to comply with the law: the substantial guidance, such as HSG60, may be referred to in legal cases. On the other hand, leaflets and sector specific guidance is often seen, and used, as a vehicle of support and encouragement. In this paper guidance materials are covered by compliance.

The last two years have seen projects to review and improve the main pieces of MSD guidance on DSE and manual handling. The PP identified a need for comprehensive revision of these guidance packages, for the following reasons:

- a) minor changes to both the DSE and Manual Handling Regulations were made in September 2002 by the Health and Safety (Miscellaneous Amendments) Regulations, so the guidance needed to be brought into line with the new legal requirements;
- b) this revision also gave an opportunity for a wider-ranging look at the guidance, to bring it fully up to date and take account of recent advances in knowledge and changes in technology and working practices.

First priority was given to DSE, as (b) was particularly relevant to the DSE guidance much of which had not been revised since 1992.

Work on the DSE guidance was completed earlier this year. Revised editions of the two priced booklets (L26 *Work with display screen equipment: guidance on regulations* and HSG90 *The law on VDUs: an easy guide*) were launched successfully at a conference on 28 February, International RSI Awareness Day. Also included in this February launch was a checklist for assessing DSE workstations. To complete the package, a revised edition of the short free booklet *Working with VDUs* was published on 27 June.

On manual handling, work is well underway to revise the main legal series guidance note (L23) and the SME short guide booklet "Getting to grips with manual handling". Consultation on new drafts is due to take place this October and publication is planned for spring 2004. Revision of this guidance

also ties in with development of the new assessment tool, the Manual Handling Assessment Chart (MAC), see below.

The advent of state of the art guidance on DSE and manual handling is seen as an important milestone in the PP, with potential to help get us closer to the 2010 illhealth targets. Even in the case of DSE, where risks will generally be low if good ergonomic practice is followed, HSE believes there may be considerable scope for reducing ill health and working days lost given the very large numbers of people (estimated to be over 5 million) who are DSE users. Steps are currently in hand to collect and analyse more data to clarify the extent of DSE-related ill health and the scope for improvements.

Action is also in hand to increase awareness of the DSE guidance and secure increased compliance with the Regulations through increased activity by HSE and LA inspectors. A speakers pack has been produced. A project is underway to promote the exchange of information on DSE matters between LA inspectors (and between them and HSE), and to encourage them to take more action to obtain compliance with the Regulations. Other follow-up action will be considered on manual handling after that guidance has been published in 2004.

Sector-specific guidance

When the DSE and MH regulations came into force, the HSC asked that sector specific guidance be produced for both sets of regulations, so that smaller firms would have the support of guidance tailored to their context, even if the definitive words were elsewhere; much of this is now coming up for revision.

Our understanding of MSD has moved on and the context within HSE of enforcing the law has also changed, including the work of the MSD PP. It is hoped that, instead of each piece of guidance being revised separately, a common section covering the new messages on MSD, enforcement and the priority programme can be agreed, with the sectors adding case studies and specific references as appropriate.

Manual Handling Assessment Chart (MAC)

HSE has developed a Manual Handling Assessment Chart (the MAC) which is principally designed to help health and safety inspectors assess the most common risk factors in lifting, carrying and team handling operations. The MAC is aimed at both HSE and Local Authority inspectors to help them in the enforcement of the Manual Handling Operations Regulations. It was released in November 2002.

Because employers, safety representatives, safety officers and others, may also find the MAC useful in helping to carry out manual handling risk assessments, reliability and usability studies have been undertaken to ensure its suitability for public use. The MAC was released to the public in August 2003, supported by a website containing further guidance. On the website the user can score a video based manual handling task and can compare their

scores with that of an ergonomics expert. A series of potential generic control measures are provided which may assist the user in making improvements.

The use of the MAC by both inspectors and the public is to be monitored to ensure that it proving to be both usable and reliable. The intention is to develop a similar tool for other manual handling operations such as pushing and pulling.

STRAND 2: CONTINUOUS IMPROVEMENT

Background

The Continuous Improvement strand of the MSD PP aims to promote a culture and create an environment where people can collaborate, form partnerships and work together in innovative ways to address occupational health. When the programme was established, the Management Team encouraged sectors and other Directorates and Divisions to promote initiatives, led by industry to set their own targets for MSD and undertaking work to incorporate the 6 key factors without which it's known that interventions will not be effective (see annex A).

There can be difficulties when enforcers suddenly seek to work in partnership with duty holders. However, in recent years, HSE has put resources into partnership working, for example:

- the FOD Intermediaries project¹;
- the work with SMEs while implementing the OHAC report on *Improving access to occupational health support*;
- the expanded the role of Workplace Contact Officers as a means to improve workforce involvement in health and safety in small businesses;
- the Workers Safety Advisor Pilot;
- the top 350 project, promoting corporate responsibility and accountability goals; and
- the National Account Managers Pilot Scheme as a means to strengthen top level company engagement.

The further examples below show how well some in HSE have risen to this challenge, using mainly personal contacts and a great deal of enthusiasm.

Current work

Partnerships with Industry

There have been some highly successful projects across HSE where inspectors and trade associations have worked together to encourage companies to go “beyond compliance”. Examples are:

- *Step Change* is an industry wide initiative involving all the offshore industry associations and unions aimed to make the UK oil and gas sector the safest in the world. The work is supported by a full-time

¹ *Working with local intermediaries: an evaluation of HSE's Field Operations Directorate pilot project*. The Foundation for Small and Medium Enterprise Development, University of Durham. HSE Contract Research Report 389/2001 and *Expanding HSE's ability to communicate with small firms: a targeted approach*. AEA Technology plc. HSE Contract Research Report 420/2002, both available from HSE's website.

Secretariat and has a range of ongoing initiatives including securing a reduction in manual handling incidents. RIDDOR data for offshore suggest that the total number of accidents that could be categorised as “handling/strains” is slowly falling but the number of reported incidents of situations where Manual Handling Operations Regulations would have applied remained static.

- *Corrugated Packaging Association (CPA)*: as a result of an intervention by HSE staff the CPA introduced a national rolling programme of awards for good practice, road shows, interventions to create a behavioural change in workers and a management action plan for use throughout the industry. The programme emphasises a holistic approach to the prevention and treatment of MSD.
- *The Wood Sector* has promoted, with both inspectors and the Trussed Rafter Association (TRA), the use of mechanical lifting systems to eliminate manual handling risks associated with team manual handling of wooden roof trusses. The Sector has forged good links with the TRA by participation in their newly formed Health and Safety Committee. The major producers of trusses now have rolling programmes in place to install such equipment at all their sites. We have given three presentations to TRA members around the country. Interest and enquiries from manual handling presentations at SAD events has been particularly high
- *The Polymers and Fibres Sector*: HSE staff have worked with the trade associations, PIAC, TEXIAC, RUBIAC, PABIAC and PPHLSC (the Plastics industry liaison committee) to set targets and agree action plans addressing priorities within their industries, including MSD. The new FOD topic inspection programme has been shared with Trade Associations and their members, to encourage employers to raise their standards and help them understand what it is inspectors expect from them. In addition HSE staff have written articles for the trade press on a variety of topics including rehabilitation and ergonomic advice.

Information and awareness raising

Before full-scale partnerships are set up, a substantial amount of “courting” is required. The examples below could be seen in that light – they are also examples of information dissemination and awareness raising.

- *TEXIAC MSD Working Group* has persuaded the Footwear Industry Health and Safety Committee to include ‘rehabilitation’ as a topic at its annual conference.
- *Rubber*: The Second RUBIAC Action Plan has manual handling as one of its key issues and the incidence of manual handling accidents has fallen from 902 to 716 per 100,000 – the target is 500/100,000). Workplace Contact Officers have visited 200 rubber firms in support of the action plan, promoting the use of the RUBIAC manual handling guidance.

- *Road Haulage Industry:* HSE staff have much improved their engagement in this industry and have participated in a series of industry wide safety seminars. Guidance was written to raise awareness of the priorities including MSD.

STRAND 3: KNOWLEDGE

Background

The aim of the Knowledge strand is to develop "increased collaboration to collect the necessary occupational health data and other facts using a co-ordinated and standardised approach, and to process the required knowledge". HSE has had an MSD research strategy since the Health Risk Reviews in 1991. In the late 1990s efforts (including expert workshops) were made to take a strategic look at desirable future research themes. This work led to a paper giving an overview of UK research needs, which was promoted in professional circles². HSC's new focus on delivering the illhealth targets in the MSD PP meant a re-examination of the research strategy to focus on issues most likely to help deliver the MSD PP targets.

The new research agenda

During 2002 a review was undertaken and a new agenda produced, structured around the five themes of SH2³. The change in emphasis meant the agenda was more focused on achieving specific outcomes. The important features of the are that it:

- is a framework that will remain relevant for the duration of the programme;
- has research aims associated with each of the SH2 strands;
- identifies the broad areas within which research can contribute to the aims of the MSD PP;
- is not specific to any one type of musculoskeletal problem or body region, the principles are equally relevant to disorders of the neck and upper limb, back and lower limb;
- is not based around any particular model of prevention, the agenda goes wider than job-specific risk factors and the individual;
- goes wider than HSE's own research programme; it is expected that some of the aims will be met by research led and funded by others, collaborative research will be considered; and
- is a continuously evolving document and HSE is happy to consider suggestions for improving it.

For work in 2003/04 the MSD MG research subgroup prioritised research suggestions from across HSE and came up with a "top ten" list. Because of this rigorous approach, the programme was able to win sufficient allocation (£1 million) to initiate work on all ten. One issue is that smaller operational research projects are no longer easily prioritised because they do not reach sufficient numbers of MSD sufferers, we hope to address this by ring-fencing funds.

² Morris, L.A., McCaig, R.H., Gray, M., Mackay C.J., Dickinson, C.E., Shaw, T.F. and Watson, N. (1998a). "Prevention of musculoskeletal disorders in the workplace: a strategy for UK research". In Hanson M (Ed) *Contemporary Ergonomics 1998, Proceedings of the Ergonomics Society Annual Conference*, London: Taylor and Francis.

³ Available on HSE's website at www.hse.gov.uk/msd/pdfs/researchagenda.pdf

STRAND 4: SKILLS

Background

The aim of the skills strand is to “make a substantial move towards understanding and agreeing the skills (which will not necessarily be formal qualifications) which different interested parties require”.

For many years only Loughborough University has offered a BSc in Ergonomics. Most ergonomists were trained through MScs, following completion of a relevant undergraduate course e.g. in psychology, human biology, engineering or design. The current MSc courses (recognised by the Ergonomics Society) are at Leeds, UCL, Nottingham University, Surrey University and Loughborough University; one at Birmingham has recently closed. Part of the problem is the reduced emphasis given to biological and physical aspects, Surrey is one of the few left that is strong on this side. It is also likely that there are many more entrants to the MSc courses with first degrees in psychology than human biology. These may be the reasons for a lack of qualified ergonomists with interest and experience in the ergonomics of MSD.

HSE has a long record of applying ergonomics in the prevention of MSD, and has a small number of staff dedicated to doing this. The advent of SH2 and the PP meant a need to expand resources in this area. This has proved difficult, so far, due to the state of the external market; there is a particular problem in recruiting senior staff with a flair for working in a regulatory setting. HSE is currently reviewing the future direction of its human factors work and the outcome may affect for the better the resource available to the PP. Currently the Health and Safety Laboratory (HSL) is addressing some of the needs but, as it is competing for the same small pool of talent, one organisation's gain is a loss to the other - sometimes a direct loss when staff transfer.

Internal skills needs

The situation is even more difficult in the field. Only one region, Wales and the West, has an ergonomist available to support front line staff. The Manual Handling Assessment Chart (MAC) was developed to help inspectors make ergonomic judgements about risk and to highlight which risk factors could be addressed. Advice from ergonomists is still required to support formal enforcement action. Unless field ergonomists can provide the expertise, experience, and understanding of case law it is unfair to expect inspectors to push compliance further forward than “common practice”. To alleviate this one region has used external back care advisors with expertise in giving expert evidence for civil cases, but this has been limited to the few prosecutions taken.

Each FOD region does have a Nominated Person for Ergonomics (NPE) whose role it is to act as first point of contact when inspectors require ergonomics advice. They will provide advice/assistance from their own

knowledge or pass the request to the Health and Safety Laboratory who can provide ergonomic support within the limits of their resource. There are currently 7 NPEs.

External skill needs

It would seem obvious that if HSE cannot recruit ergonomists, then employers, especially smaller ones, and trade unions will be in a similar situation and so short of the advice they need comply with the law or defend their members. But is this the case and are ergonomists precisely the sort of people they need? Perhaps less highly trained enablers or problem solvers are needed, at least initially, to provide a “quick fix” and point in the direction of more sustained and long-term advice.

Both the Skills and Support Programme Action Groups (PAG) considered the external skills market within the SH2 structure. The Skills PAG considered where to address efforts to boost OH skills and concluded the biggest impact would be improve line managers’ skills. Their premise was that better work design would be built in if line managers had a basic knowledge of prevention of work-related health disorders, including MSD. Beyond the skills of the managers themselves the Support PAG developed a model for delivery of basic support to such line managers and sign posting to specialist help, which would include ergonomists.

Both Groups recognised there were currently skills shortages. Much could be achieved to ease this by ensuring that skilled practitioners were not bogged down by providing services that could be delivered by less skilled people and by making more use of multi-disciplinary teams. In considering how to boost the numbers of the right type of people with the right skills both groups concluded that courses could be set up or syllabi changed, but that the only real way to increase the skills pool is to ensure that there was an attractive career in the discipline for either general advisors or specialists. This may be far more problematic.

Future work

The internal HSE review has been mentioned. The MSD PP is not presently engaged in actively promoting the skills base externally. In many cases to do so would be outside its remit, e.g. increasing the number of places in higher education, but there are steps that could be taken including:

- funding a one-off course on ergonomics for safety representatives so that they can then spread the message about the benefits of training;
- promoting distance learning in ergonomics; and
- encouraging others in government to address *the reasons* for the shortage in course places.

STRAND 5: SUPPORT

Background

The aim of the Support strand is to:

- identify the information, advice and other support required to help people contribute to the strategy's targets;
- set suitable frameworks and deliver this advice and support to the right people; and
- raise awareness of the existence of these frameworks and what they can deliver to those who need the support.

MSD webpages

The webpages form part of the Compliance and Support strands of the MSD PP. Their aim is to increase awareness, promote new guidance and set out the key messages of the programme and how best to deal with WRMSD. This information has been conveyed in a way that is informative, useful and suitable for any audience. The webpages are updated regularly and have recently undergone a major revision to make the language more accessible, update the research strategy pages and include a new section on risk assessment with links to the Manual Handling Assessment Chart (MAC) webpages. The MSD webpages contain:

- information on guidance relating to WRMSD;
- case studies showing office and factory scenarios where MSD might exist and advice on how to reduce the risks;
- live issues i.e. current projects we are working on;
- frequently asked questions;
- the MSD programme of work;
- useful links to other sites and organisations; and
- a feedback form for people to pass on their views of the site and to share their experiences of dealing with MSD.

Between November and July we have received on average, 46,000 requests for MSD related pages per month.

Other support work

Guidance material is covered by the Compliance pages, see **annex C**.

REVIEW OF MSD PP WORK CARRIED OUT IN THE SECTORS

At the start of the MSD PP the programme incorporated existing and planned Sector MSD work. The support team encouraged sectors to expand this work, especially that for which there was evidence it could help to achieve the RHS/SH2 targets. The team also suggested a new approach of initiating non-HSE led sector Continuous Improvement initiatives. In these the industry set their own sector targets for reducing MSD and promoted all the 6 factors that are needed to make a difference.

Some sectors have revised their MSD work in accordance with our strategy. An outstanding example of this is the work of the polymers and fibres sector now part of the new manufacturing sector with the Corrugated Packaging Association. Unfortunately others have not taken the MSD PP strategy fully into account in their planning and undertake work that the evidence suggests will not have an effective impact. We consider the main reason for this is that priority programmes are not embedded into the FOD/sector planning process.

The PP Management Team has given presentations on the MSD strategy to a number of sectors and they are well received. They are particularly successful if another speaker from the sector reinforces the message as happened at CERIAC with the quarry industry.

Mapping exercise

The PP Management Team, encouraged by the OHAC MSD working group, initiated a mapping exercise of MSD work in FOD sectors, later extended to all HSE sectors. The exercise provided useful information and was discussed in detail at the last working group meeting, where some very useful suggestions were made for linking this information to inspection data and industry specific statistics on MSD. If this could be done, it is still being explored; it would provide a useful tool for focusing programme work on those areas where it can have the most impact.

HSE review of sector work

HSE is about to complete a review of sector work to determine the “specific and unique contribution Sectors make which justifies the resources HSE is applying to this way of delivering HSC/E's business”, noting that the identification of Sectors as a separate discipline implies a need to manage interfaces both with policy and operations. The mapping exercise demonstrated that some sectors, particular some of the non-PP ones, had added excellent value to the MSD PP. Where the sectors had used their resources to initiate evidence -based work it was an excellent use of resources - and probably better than using it for routine inspections. We would particularly encourage more resources for the non-priority sectors which have the potential and track record of making a difference, provided the industry has a high risk of MSD.

WORKING BACKS SCOTLAND

Working Backs Scotland is a national educational campaign that has been running since October 2000. HSE was heavily involved in its establishment and offered considerable advice to the Health Education Board for Scotland (HEBS) who lead the partnership. It is a national partnership, involving all the health professions who treat back pain and national organizations for employers, unions and patients. Its aims are to:

- share new understanding about the management of back pain;
- make sure everyone gets consistent advice; and
- get employers, employees and health practitioners to work together.

It built on the RCGP (1999) and UK Occupational Health Guidelines (2000) and *The Back Book* and devoted its resources to presenting the main messages in a simple, user-friendly way:

- stay active;
- try simple pain relief; and
- if you need it, get advice.

The core of the campaign was commercial radio adverts – played 1,777 times on 15 stations in the first four weeks, and reaching 60% of adults. There was extensive (free) press and TV news cover and 35,000 packs were distributed to every health professional treating back pain in Scotland. Since that time there have been periodic ‘booster’ campaigns and WBS developed additional resources for family doctors, occupational health and orthopedic surgeons.

Results

WBS carried out population surveys of 1,000 adults per month for two months before the launch (as a baseline) and these have been ongoing since then. They show a high awareness of the campaign. The shift in public beliefs on how to deal with back pain, is an impressive 20% reversal from a majority in favour of rest to a majority in favour of staying active. It occurred within a month or two of the launch and has continued to improve for more than two years. There are early indications of a fall in sick certification and time off work.

LIFTING AIDS PROJECT

Background

At a planning meeting of the MSD PP Management Group, in 2002, the PP Management Team asked HSE Directorates and Divisions to consider new projects that might have an impact on the MSD targets. As a result the Health Unit, together with sector representatives, proposed a cross-sector "campaign" aimed to reduce the incidence of frequent and heavy lifting by the promotion and greater use of lifting aids.

Project plan

A working group has now been formed to develop the proposal. The project's outputs will be "products" and tools to achieve better compliance with the Manual Handling Operations Regulations, and which promote and secure the use of lifting/handling aids. These will be targeted at a range of dutyholders and stakeholders, including employers, equipment suppliers, safety representatives and employees in all sectors of employment including those inspected by Local Authorities.

The use of lifting/handling aids is a proven way of controlling MSD risks. The products will aim to change workplace practice, behaviour and culture to one where people are provided with appropriate lifting aids and use them instinctively. HSE and local authority staff and intermediaries such as hirers, trade associations and unions will be engaged in the initiative which is expected to have an impact on the MSD targets by reducing risk and the potential for injury.

The project will not provide products that specifically support other aspects of effective MSD management. It will avoid messages that conflict with them – e.g. "your back will be ruined by frequent/heavy lifting".

Current work

Embracing HSE's new ways of working, a cross directorate project group held an overnight meeting in August to develop a programme of work with a view to launch the initiative in the second half of 2004/05. The actions agreed at the meeting demonstrate both the amount of preliminary work such an initiative requires in order to make an impact, and the breadth of staff involvement across HSE. They include:

- the Human Factors Unit to summarise the evidence base on the effects of frequent and heavy lifting, which will justify the initiative;
- HSE Sectors to identify areas where frequent and heavy lifting is a problem and we can maximise impact;
- HSE Sectors to extract relevant case studies from existing sector guidance;

- Health Unit to identify possible sources of funding assistance for employers;
- Health Unit and PP Management Team to identify key messages for the project;
- Health Unit and PP Management Team to consider the planning cycle issues and how these impinge on MSD and other priority programmes, identify potential risks and necessary preventative action taken; and
- Health Unit to develop the enforcement policy and any necessary amendments to the MSD inspection pack.

It is proposed to consult key stakeholders, such as Trade Unions and Trade Associations, such as the Association of Lifting Equipment Manufactures, before proceeding to the next stage of the project.

ACTIVE CASE MANAGEMENT

Rationale and background

The primary role of the health and safety system (legislation, guidance, advice and enforcement) is the prevention of accidents or ill health arising from work activities. For musculoskeletal disorders it is recognised that work is an important, but not unique, causative factor, and that it will be difficult to prevent all work related musculoskeletal disorders. There is therefore a need to ensure that such cases as do arise are properly managed in the workplace and to limit the impact of the disorders on the individuals affected and their employers.

The clinical management of cases of occupational ill health is the responsibility of the health care system, both public and private. However, HSE is well positioned to influence the workplace case management of musculoskeletal disorders by promoting key messages to employers and employees and amongst occupational health professionals.

A **first level message** for managers and supervisors is that most musculoskeletal disorders will respond well if they are identified early and appropriate action taken. The underlying philosophy of active case management for MSD is that it is important to have systems in place to identify cases and then to ensure the correct advice is given to the individual. This philosophy was the basis of HSE's revision of its guidance on the management of upper limb disorders, HSG 60 (rev).

Current activity

In March 2003, the MSD PP Management Group created a sub-group to address the issue of active case management. That has contacted the key HSE stakeholders and begun identifying non-HSE experts to take part a working group, led by HSE. The role of the working group will be to identify the key messages in this area and how best to communicate them. A quick literature review of MSD rehabilitation has been commissioned from HSL to inform its thinking. It will also take account of the wider generic work being undertaken by HSE on occupational rehabilitation and job retention.

HSE, in consultation with DWP, is developing a protocol for a further research project to identify examples of good practice in active case management and rehabilitation of MSD. This research will concentrate on finding and describing good practice and providing case studies for working group to consider.

Finally, there is a current research project into the training needs of physicians, nurses and physiotherapists with regard to upper limb disorders. The results of these studies will help the working group to develop key messages for these professionals.

WORKING BACKS ENGLAND⁴

The NHS Modernisation Agency has established a partnership with DoH, DWP and HSE to jointly fund a research project aimed “To assess the relative effectiveness of different components of media campaigns in altering population beliefs about back pain”.

Study Design

This will be a quasi-experimental and non-randomised study which has yet to be agreed in detail. In outline, the proposal is for the populations of the Spinal Collaborative areas of South Devon, Peterborough and Oxfordshire to receive either a different component of the media campaign or act as the control area. The components of the media campaigns will be based on messages delineated in the *Back Book*, an evidence-based patient educational booklet (Burton *et al* 1999). The campaign will provide unambiguous advice directed towards staying active and exercising, not resting for prolonged periods, and remaining at work. The media interventions will be radio adverts (intensity depending on funding) and advertisements on buses, in newspapers and billboards (again the number of posters and newspapers will depend on funding).

Evaluation

The effectiveness of the media interventions will be assessed using a computer assisted telephone interview questionnaire with cross-sectional random samples of the populations in the intervention and control areas. The number of subjects required for each area will be estimated using an effect measure to determine the proportion of subjects reporting an ‘adequate’ score on the primary outcome measure, the Back Beliefs Questionnaire. A baseline of 25% will be assumed, and an increase of at least 5% will be sought. This can be detected with a power of 80% using a sample size of approximately 1200 per area. Sampling will be carried out before the media interventions, then at three and six months after the end of the campaigns. The interviews will be conducted during the same times of day at each evaluation point.

⁴ This is a provisional title

OCCUPATIONAL HEALTH SUPPORT (FROM HSC/03/74 ANNEX V)

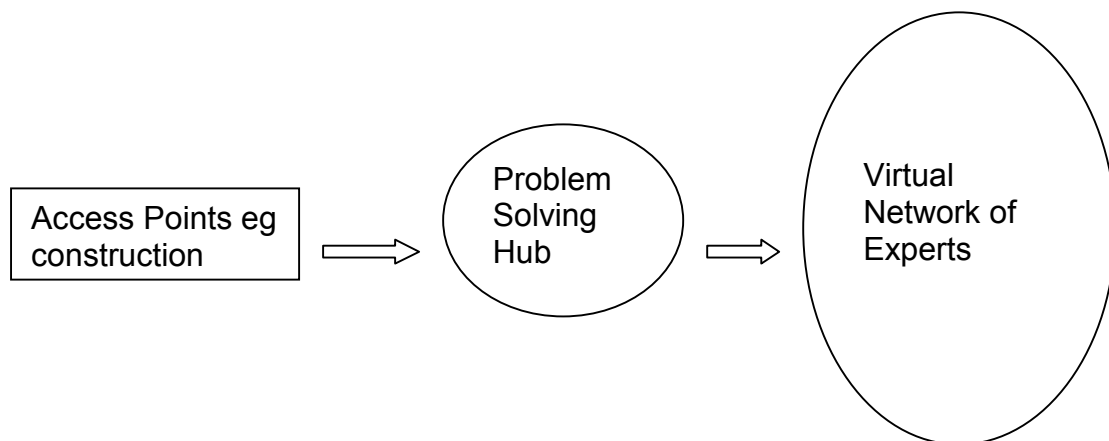
The Project Board for OHAC’s report on Improving Access to Occupational Health Support has now completed its overview on delivering the report’s recommendations. The underlying premise of the report was that no one solution would meet the occupational health support needs of everyone and flexibility would need to be the key to delivery mechanisms. Consequently, there have been a number of incremental steps towards the wider provision of OH support, for example:

An occupational health and safety telephone helpline piloted in Lanarkshire, Scotland has been upgraded to become the National Adviceline for an OH service for SMEs in Scotland, funded by the Scottish Executive.

The service aims to provide equal access for employers and workers to a national advice line, a free workplace assessment (including risk assessment), and some referrals to an OH nurse and OH physician.

The feasibility of a pilot occupational health service for the construction industry has been explored and work is now in progress to encourage the industry to set up a consortium to fund and manage a pilot occupational health support scheme.

These incremental steps have helped to develop thinking on how a national occupational health support system might operate. The model proposed by the Securing Health Together Support Programme Action Group is based on multiple access points leading to a problem solving “hub” as a free service to all workers and employers in Great Britain. The “hub” will be responsible for routing service users towards relevant expertise (see below). This is the model on which the Scottish OH support system for SMEs and the construction pilot is based.



BACK IN WORK: ENGLISH INITIATIVE TO TACKLE BACK PAIN IN THE WORKPLACE.

The Back in Work initiative, launched at HSE's Beating Back Pain conference, May 1999, is part of the joint DoH/HSE Healthy Workplace Initiative. The DoH provided £700,000 funding for innovative projects to tackle back pain in the workplace through examples of good practice.

19 pilot projects were selected for funding⁵. 330 businesses and 2,790 participants were involved.

Projects were run by local partnerships to develop examples of good practice, improve workplace health and raise its status through a holistic approach and partnership working. 12 projects involved rehabilitation, 7 through fast track referral schemes⁶. Some of the conclusions were that:

- successful rehabilitation schemes require concurrent commitment from a variety of government and non-government organisations⁷.
- Successful fast track return to work referral systems require:
 - clear and well understood entry criteria and referral pathways,
 - treatment times and places that are acceptable to the worker and employer; and
 - a return to work programme agreed between worker, employer, GP and health professionals.

All the projects produced products for future use and a number of pilots were so successful that local funding was made available for them to continue.

⁵ From 2000 expressions of interest and 339 proposals submitted

⁶ See Securing Health Together Best Practice Database Annex X for example.

⁷ The local NHS Trust, the local Primary Care Trust, employers' organisations, independent health care professionals and health and safety specialists