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Medical Advice on Return to Work with regard to Musculoskeletal Disorders

HSL/2006/69

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ACKNOWLEDGEMENTS

On behalf of HSE, HSL would like to thank the following delegates for their valuable contribution to the workshop.

Ms Marcella Bailey, Ms Penny Barker, Prof Kim Burton, Prof David Coggon, Ms Clare Forshaw, Mr Mike Gray, Ms Margaret Hanson, Ms Gret Higgins, Ms Ann Hodgins, Ms Nicola Hunter, Ms Kay Jackson, Mr Ray Langford, Ms Rachel Lee, Prof Chris Main, Dr Serena McCluskey, Prof Mike O'Donnell, Dr Peter Oliver, Ms Hilda Palmer, Ms Judith Pitt-Brooke, Mr Doug Russell, Dr Julian Smith, Dr Kate Sparks and Dr Keith Wiley.

Special thanks go to Prof David Coggon for acting as chair. Thanks are also extended to Ms Margaret Hanson, Ms Nicola Hunter and Dr Peter Oliver for the talks they gave at the beginning of the workshop.

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EXECUTIVE SUMMARY

Objectives

This work was carried out by the Health and Safety Laboratory's (HSL) Work Psychology Team to inform HSE's Musculoskeletal disorder (MSD) Priority Programme. The report details the findings of a literature review and workshop run on January 19th 2006, which aimed to find practical ways for employers to facilitate return to work for people with MSDs using modified work. For the purposes of the workshop this was taken to include the same work but with modified hours, more flexibility, a change of equipment or task, and different work (for example, redeployment or relocation).

Main Findings

Modified work

There was a great deal of consensus between workshop delegates. Modified work can be introduced in a variety of ways. Each case is different; and should be individually assessed and tailored to the individual. Therefore, it is difficult to provide generic advice. However, there are some common themes, which were highlighted during the workshop. Firstly, modified work is not always necessary. Many people with MSD will self-manage. They may not consult with a health care professional. They may take a few days off work, and then return without any adjustment to their usual work. However, for some, work modifications may enable an employee to return more quickly. In these cases, work modifications should be considered within 2 to 4 weeks of absence. There are numerous ways in which modifications can be introduced, such as allowing more time to do a task or working a shorter day for a limited period. Problem solving skills are necessary in order to plan work modifications to suit the individual. A return to work plan should be formulated. This needs to be tightly managed, and regularly reviewed to ensure that progress is being made. If modified work is aimed at achieving a return to the original role it should be time limited and focused on change. Using the terms transitional work arrangements may better convey the temporary nature of modified work. It also avoids the implication that the work was in some way wrong or harmful and required modification. Transitional work arrangements are all about facilitating return to work (or work retention) for the symptomatic worker. They are not about making work safe – their need does not suggest there was a problem with the work initially.

Low Back Pain

There is well-established evidence that for the majority of people with low back pain, the advice is to 'stay active'. Most people have pain originating from soft tissues, which will benefit from activity within the limits imposed by symptoms. The only exceptions to this are 'Red Flags' in which serious pathology exists. The 'stay active' message does not apply when there is more serious spinal pathology, indicated by the presence of 'Red Flags'. The 'stay active' message needs to be better communicated to GPs, employers, employees and the general public. It appears that many are still unaware of or fail to act on this information and more work should be done to ensure it is properly disseminated.

Upper Limb Disorders

It seems likely that the advice to 'stay active' should also apply to the majority of people with upper limb disorders. Acute inflammatory conditions appear to be an exception to this rule, but these are much less common. This has not yet been formally established. The evidence base on the management of upper limb disorders is incomplete, and randomised control trials are required. However, the approach is supported by anecdotal evidence from health practitioners.

Small and Medium Sized Enterprises

Smaller organisations often have more limited resources and cannot offer some of the professional help that is available to large organisations, such as Human Resource and Occupational Health Departments. However, there are still many simple steps described in HSG249 – HSE's guidance on sickness absence and return to work and INDG399 for small businesses, such as keeping in contact with the employee, which can be taken to facilitate return to work and the introduction of inexpensive work modifications. In these cases the role of the line manager is highly important. Also, the approach taken by the GP is crucial here. It is important that the GP is aware of the 'stay active' message, and has an understanding of the work undertaken by the employee. Job descriptions could be useful here. Further dissemination to employers of the appropriate messages on managing MSDs in the workplace may enable them to make confident decisions about RTW and modified work.

Large Employers

Larger employers often have access to specialised professional advice from for example, occupational health physicians and physiotherapists. This can be an invaluable means for the employee to receive accurate and relevant information to facilitate a rapid return to work. Partnership work between all those involved is important to ensure good communication. There is a need for agreement and collaboration between all. Employee involvement in this process is essential. There is an ongoing need for training for line managers in using problem solving techniques to facilitate a return to work.

Culture

In some organisations there is the pervasive notion that work is harmful or in some way 'bad for you'. This is possibly derived from the alarmist way in which some health and safety material is phrased. There is a need to frame information more positively in order to give enabling messages to people with MSD. A focus on health and safety culture, attendance culture, open communication, regular early contact from managers and a supportive atmosphere need to be encouraged.

Recommendations

Guidance on Modified work.

A protocol for modified work could be developed to enable managers and employers to introduce it efficiently. This could provide general guidance about the steps to take and suggested time frames. Because each case is individual, a manual of suggested modifications may be impractical but there are best practice messages that can be disseminated.

Education on Low Back Pain

There is a need to establish ways of disseminating information and promoting the message of MSD management to GPs, employers, employees and the general public. It would be useful to find the best way to convey information to each of the above audiences. Possibilities would be to give employees the relevant information during induction training, running awareness campaigns, and developing tools and training for GPs.

Research on Upper Limb Disorder

Further work is required to establish when the ‘stay active’ message should apply in ULD. There is a need for randomised controlled trials to confirm when rest is appropriate and when it is not. This is required for the various specific diagnoses found in ULD, such as carpal tunnel syndrome, but particularly for non-specific arm pain. There is evidence that the ‘stay active’ message is used in the management of ULD, but it has not yet been formalised.

Support and Advice for Small and Medium Sized Enterprises

Better training for line managers is needed. This should encompass problem solving techniques, communication skills, health knowledge and absence management. Other ways of disseminating information to employers could be sought. Establishing ways of enabling dialogue between GPs and employers would be useful.

Advice for Large Employers

Better coordination of the return to work plan is necessary. It should not be assumed that large employers have the correct knowledge, just because they have the resources. Training is also required for large employers. Promotion of a case management approach may be appropriate. It is important to avoid a mechanistic approach, engaging line managers in the process.

Culture

There is a need to frame messages about working with MSD and maintaining activity positively in order to change culture. An environment that fosters self-care and encourages the individual to take responsibility for his/her own health and well-being is desirable.

1 INTRODUCTION

Musculoskeletal disorders (MSD) are among the most common occupational illnesses affecting about 1 million people a year. If an employee is suffering ill health due to an MSD and they are on sick leave, it can help to speed their recovery and return to work if they are given temporary modified work. In many cases, the employee does not need to be completely symptom-free before they return and could regain full function more rapidly by carrying out modified duties at work. The employee benefits from an individualised care package, and with less absence duration, avoids the attendant risks from long term absence such as symptom chronicity, mental and physical deconditioning and job loss. The employer is likely to see improvements to staff retention, productivity and morale, and reduced sickness absence costs.

In order to identify and offer modified work, most employers will require specific examples and guidance rather than vague advice to provide ‘light duties’. HSE is therefore seeking advice from practitioners and experts on ‘what works’ in relation to MSD return to work approaches. Modified work may include changing aspects of the work to reduce the physical load and other aspects such as giving the employee more control over their work.

The workshop on 19th January 2006 concentrated on discussing and agreeing areas of consensus in relation to the role and use of temporary modified work in facilitating return to work for people with MSDs, including the timing of return to work and the type of modified work. Best practice was considered, the evidence base and pragmatic practitioner experience of what works. The aim was to produce generic descriptions of modified work that related to specific MSDs commonly seen in the workplace. HSE anticipated that a lot of current best practice in relation to MSD return to work is undertaken by larger employers and wished to consider whether such practice can be extrapolated to smaller organisations where the only source of advice might be a GP.

The tissues of the musculoskeletal system are dynamic, i.e. designed for movement. Prolonged inactivity is detrimental to recovery because of a process of deconditioning. In contrast, when stresses are applied during activity the tissues improve in strength, endurance, flexibility and coordination. Activity reverses the process of deconditioning. In the case of low back pain, a ‘stay active’ recommendation is found in evidence-based clinical guidelines and in the related Faculty of Occupational Medicine guidelines for the management of low back pain at work. The Faculty guidelines indicate that:

- Staying active and returning to ordinary activities as early as possible leads to faster recovery and fewer recurrences

- Most workers with low back pain are able to continue working or return to work within a few days or weeks; they do not need to wait until they are completely pain free

- If the employee has been off work for a few weeks, temporary provision of modified duties or lighter duties facilitates return to work and reduces time off work

The employer and employee will want to be reassured that early return to work, when the employee is not 100% recovered, will not lead to further ill health. Under health and safety law, the employer has to undertake a risk assessment to prevent people being harmed by their work activities. If there has been a significant change in an employee’s functional capacity because of illness, it may make them vulnerable to further injury or relapse. The employer will usually need to review the relevant risk assessment to ensure it remains valid for that individual to remain safely at work.

1.1 WHAT IS INCLUDED IN MODIFIED WORK?

Modifications might involve taking account of ergonomic factors, e.g. altering the height of the working surface. Some modifications may become permanent in order to reduce risk. Health and safety legislation only requires the employer to consider reasonable adjustments, taking into account what is reasonable in terms of cost and practicality. The Disability Discrimination Act, 1995 also requires ‘reasonable adjustments’ to be considered.

A list of possible adjustments to consider is given below:

1.1.1 Ergonomic

- Eliminate awkward movements
- Adjust working posture
- Reduce weight and size of load being lifted and frequency of lifting
- Modify furniture (e.g. seating), workstation
- Provide new or modified equipment, including IT

1.1.2 Work Schedule/Organisation

- Make pattern of rest breaks flexible
- Adjust management and work systems
- Reduce pace of production
- Give the employee more control over their work
- Phased return to work e.g. building up from part-time to full-time hours over a period of weeks in line with recovery
- Reallocate work within the team or provide alternative tasks
- Alter employee’s working hours/conditions to allow flexibility or travel at quieter times

1.1.3 Other Support

- Provide help with transport to and from work
- Arrange home working if realistic

Employees will readjust more easily and gain confidence working with pain or other symptoms if they feel supported at work, demands are reasonable, and tasks are appropriate. These issues are part of ‘management and work systems’ in the adjustments list given above.

1.2 PREPARING A RETURN TO WORK PLAN

When adjustments have been identified, a return to work plan can be prepared. It is very important to identify employee and organisational barriers and to discuss and agree the plan

with all concerned such as the employee, line management, union and the work team as appropriate. Organisational obstacles to returning could include pay structures, bonus systems, and the attitudes of team-mates. The plan should take into account any professional advice from a health professional or ergonomist. It is useful for the plan to include the approximate date of return, whether the aim is to return to modified or normal working, alternative hours, timescales, milestones and review points. The plan must not result in conflicting demands upon the supervisor, e.g. production targets and the employee's reduced hours. If the employee is being returned to normal working over an agreed timescale, each review will monitor functional progress and make adjustments to the plan as necessary.

2 RESULTS OF LITERATURE REVIEW ON MODIFIED WORK

Preparation for the Workshop commenced with a review of the literature. The following databases were searched dating back to 1990:

- Oshrom.
- Ebsco Host
- Psychlit
- Medline
- Chartered Institute of Management

With the following search terms:

- Return to Work
- Modified work.
- Reduced hours
- Reasonable adjustment
- Light duties
- Lower work capacity
- Work activities
- Work hardening
- Graded work exposure

This section addresses studies and articles which describe or evaluate modified work. Studies focusing on any-cause sickness absence are first described followed by LBP, and non-specified MSDs. Much of the evidence related to modified work is derived from eclectic sources, such as business, legal and academic publications. The main focus will be to discover what consensus or knowledge exists, if any, on the type of modified work which facilitates a successful early RTW for employees with MSD.

2.1 DEFINITIONS OF 'MODIFIED WORK'

Numerous definitions of modified work exist in the literature. One definition is provided by the Work-Related MSDs Guide And Tools For Modified Work (Quebec, 2005). This comprehensive guide addresses the difficulties companies have providing modified work assignments, and defines modified work as work other than a person's usual work tasks, that are assigned to an injured worker with MSD. It gives a number of concrete examples of how work can be modified, as follows:

2.1.1 Work methods

- Such as providing a tool or equipment for a task that is usually done manually.

2.1.2 Task reorganisation

- Such as removing risky tasks, rotating tasks or providing an additional worker to help.

2.1.3 Work schedule

- Such as reducing the number of hours worked per day or the number of days worked per week, or organising a progressive return to work, by increasing the number of hours or days worked per week progressively.

2.1.4 Work station

- Such as modifying the height of work surfaces.

2.1.5 Tools

- Such as providing tools that are lighter, non-vibrating or have handles suited to the angles of the hand and wrist when working.

2.1.6 Equipment.

- Such as providing adjustable chairs or carts for handling even small objects.

The interventions suggested are intended for people with MSDs and work absence of less than 90 days (temporary work disability). The approach is based on the following principles:

- Prolonged inactivity is detrimental to MSD recovery.
- The longer the absence, the less chance of RTW.
- Early rehabilitation and RTW are best done in the worker's usual setting.
- Case management should start early on.
- To help retain/RTW, physical demands should match capacities and evolve as capacity increases.
- Meaningful, valued, productive work can aid recovery.
- Modified work programmes are only effective if all involved participate and communicate effectively.
- Identifying and correcting work-related risk factors can prevent MSD.

The intervention objectives are to:

- Promote early case management

- To retain at work or RTW under optimal conditions given capacities (ie modified work should promote rehabilitation and facilitate RTW).

- Promote MSD prevention

The intervention consists of four steps:

1. Identify the injured body part.

2. Choose modified work tasks for the worker.

3. Evaluate whether tasks are appropriate.

4. Follow up and evaluate modified work assignment.

A number of tools are described that can be used to facilitate the selection of tasks that match the injured worker's physical capacities. There are 4 separate assessment worksheets for different body parts: back; neck/shoulder; elbow and wrist/hand.

The guide states that rehabilitation strategies that include a "modified work" component produce better RTW outcomes and reduced sickness absence.

It also highlights the need for all involved to participate and communicate effectively to enable modified work programmes to succeed. Worker involvement is especially important. The support of the following people is necessary for success:

- Senior management

- Human resources managers and professionals

- Occupational health and safety managers and professionals

- Supervisors

- Workers and their representatives

Support from senior management must be accompanied by concrete actions:

- Creation of a working group to develop/implement a modified work programme

- Participation in the working group by at least one manager/director with decision-making power.

2.2 GENERAL LITERATURE ON MODIFIED WORK

Krause, Dasinger and Neuhauser (1998) performed a systematic review of the scientific literature on modified work (between 1975 and 1997) and critically appraised the evidence. The authors highlighted that although many practitioners consider modified work a fundamental component of rehabilitation in RTW, there is sparse knowledge on the actual structure and efficacy of different modified work programmes. In their review 29 higher quality studies were selected and the effectiveness and efficiency of modified work programmes evaluated. These studies encompassed not only MSDs but a wide range of injuries, both acute and chronic. Effectiveness of a modified work programme was measured in terms of RTW outcome. Other outcomes such as, improved physical functioning, quality of life, increased earning capacity,

employee satisfaction and prevention of new injuries were not considered because of funding limitations and a scarcity of available information.

The authors distinguished between different types of modified work, which might include any of the following:

2.2.1 Light duty

- Any temporary/permanent activity less than full duty, which enables a disabled worker to perform a job according to conditions prescribed by a health care provider. This is paid and done in a competitive work environment. It may involve adaptation of the worker's pre-injury job, or an entirely different job at the same or a different company. It may be a job that exists already, or it may have been specially created for the disabled worker. Other terms used synonymously with light duty are: alternate duty, alternative duty, lighter duty, limited duty, modified duty and restricted duty.

2.2.2 Graded work exposure

- A form of light duty in which the hours are gradually increased until the worker is ready for full or regular duty. (also known as therapeutic return to work).

2.2.3 Work trial

- Work continuance is at the employer's/worker's discretion. Can be unpaid (with the worker receiving usual compensation/disability benefits), or paid (with the worker receiving a wage and disability benefits).

2.2.4 Supported employment

- Paid work with support from a job coach/employment specialist, particularly at worksites designed for people with handicaps (who need ongoing support and traditionally have not managed to compete successfully for employment in the open market).

2.2.5 Sheltered employment

- Paid work (at a lower rate) at a site designed to provide work as a social service to disabled individuals.

A distinction was drawn between work conditioning/hardening programmes, which are implemented in clinical settings and supervised by medics, and modified work programmes, which are worksite based and at the discretion of the employer. The settings where modified work programmes were implemented varied. Of the 29 studies reviewed, 6 programmes took place in a hospital setting, 10 were on industrial sites, 1 was in the armed services and 12 did not specify the site. Most of the studies implemented light duties. Only 4 of the studies described programmes involving job modification alone. In most studies job modification was just one component of a wider intervention including some or all of the following:

- Early reporting of injuries
- Monitoring functional capacity/medical condition at regular intervals
- Vocational rehabilitation (assessment, counselling and/or training)

- Psychological assessment and/or counselling
- Pain management instruction
- Physical back/posture education
- Collaboration between employer and doctor/programme staff
- Physical therapy
- Occupational therapy

The main goal of most of the studies was not to evaluate modified work itself, but rather to evaluate a range of programmes. Most studies did not separately assess the effectiveness of modified work programmes.

Krause et al noted that the level of detail varied from one study to another, but some studies failed to specify basic information about the modified work programme. The main goal of all the programmes was RTW or reduction of injury-related costs. Other goals included raising employee morale, maintaining work ethics and reducing the number of injuries. Other problems with the studies included difficulties over the definition of RTW. Some studies treated it as a continuous variable and measured it in terms of number of days until the date of return to work, whereas, others treated it as a categorical variable and measured it as a simple ‘yes’ or ‘no’. Only 3 (out of 29) studies used a control group and less than half of them applied statistical tests. The different priorities of the various stakeholders involved were not discussed in any of the studies. None of the studies reported the cost effectiveness of their programmes, and only 3 studies addressed the employees’ perceptions of the modified work programmes.

Krause et al concluded that modified work programmes facilitated RTW for temporarily and permanently disabled workers. In studies rated as high in methodological quality, the **RTW rate doubled** when employees had access to modified work following a disabling injury, compared with employees who did not. The number of working days lost per disabling injury also halved when employers instigated modified work programmes. However, it was unclear which components of modified work programmes were most effective. The authors suggested that it may differ according to the type and cause of the injury.

In a Canadian occupational safety magazine, Theberge (2002) reported on a number of successful implementations of modified work programmes. A hotel in Calgary, Canada was cited as a good example of an organisation using modified work and enjoying high levels of staff retention. Other examples were given, including a U.S. construction group who inform their staff about modified work programmes from day one, and regard caring for their staff as essential both for the employees and for the success of the business. The following types of modified work were described:

- Modifying an existing job – the job is changed to remove the parts the employee is currently unable to perform (i.e. heavy lifting or repetitive movements).
- Providing transitional work – an employee performs regular duties for less time.
- Providing a training opportunity – the injured employee is sent for job training to enhance skills, increasing his/her value to the company.

In each case employers must ensure that any modified work is safe and controlled in accordance with physicians' guidelines.

In a review of best practice in disability management and RTW, Harris and Lee (2002) highlighted the need for employer-sponsored modified duty options to facilitate RTW. Those less likely to offer modified work were smaller employers, organisations with restrictive policies and employers with highly specialised job requirements. Other barriers to modified work programmes included job duties requiring:

- Significant physical modifications
- Ergonomic adjustments
- Qualifications
- Unstable/negative work environments

The authors emphasised the importance of examining each injured worker's situation carefully to decide the best approach to RTW.

Eakin, MacEachen and Clarke (2003) studied the effects of a Canadian 'early safe return to work' (ESRTW) policy in small workplaces. This qualitative study provided an insight into the experience of the workers, as well as the employers, in smaller organisations. This contrasts with many studies which have focused on the managers' or doctors' perspectives, and have been performed in large organisations.

ESRTW emphasised workplace self-reliance and return to work before complete recovery via 'modified work'. The authors found that both employers and employees in small businesses encountered numerous problems with modified work following injury. In addition, ESRTW could disrupt workplace norms and patterns of social interaction. The different perspectives and experiences of the employee and employer were presented. For instance, although most employers cared about their workers, they were primarily concerned with the survival of their business. They perceived ESRTW as sometimes disruptive of their relationship with employees. Some co-workers, for example, may perceive injured workers as being favoured with cushy jobs, i.e. modified or alternative work. Also, in some industries employers may find it difficult to provide satisfactory modified work arrangements. The case of the construction industry was cited, where worksites are constantly changing or belong to the customer, so often it is hard to provide places for the injured worker to sit and rest or crews may be mixed in with workers of other employers, or the worker has to be alone on the job. From the employee perspective, many workers accepted modified work for fear of reprisals, sometimes even if the work assigned was meaningless. The difficult and degrading situation of having 'nothing to do' in a modified job was made apparent by the following example: a trucker was assigned the job of operating the button to open the gate, an action that visitors could have performed themselves. Injured workers reported on resentment from fellow workers due to being perceived as receiving special treatment or increasing colleagues' workload (through assisted work duties).

Due to all these problems the authors concluded that ESRTW was more suited to large organisations as they have the necessary resources and conditions to manage the approach effectively.

Focusing on larger organisations, Catanese (2001) described how to go about a RTW programme and emphasised the importance of considering job modification before injured employees return to their former jobs. The author argued that it was necessary to establish how

each person's job could be modified to facilitate a quick and safe return. This might involve temporary part-time work schedules, or having regular employees work with a returning employee to perform tasks.

Two studies from North America addressed the physician perspective in RTW. Elswick (2002) found that physicians in the USA were generally willing to help in the RTW process, with 97% of the doctors surveyed saying that RTW was "good medicine", and 95% saying they would be willing to release a patient to transitional work if asked by the employer. However, employers rarely contact the treating doctors (80% said they were contacted rarely/never). Elswick suggested that employers contact treating physicians. However, she added a few words of warning. It is important that the employee has given consent to this, and that private issues, such as the diagnosis, are avoided. Instead the employer should focus on things the employee can do, i.e. issues of function.

In Canada, Schweigert, McNeil and Doupe (2004) investigated doctors' views of the barriers patients face when returning to work following ill health or injury. The main barrier identified was lack of accommodated work. Doctors felt their role was not clear, they lacked training in occupational health and either had too little knowledge of specific work issues, or felt overwhelmed with too much or inappropriate information at times. They also felt the need for more information related to jobs or modified work opportunities. Other barriers included lack of communication between interested parties, the dislike employees had for their jobs and lack of clinical practice guidelines.

Bernacki, Guidera, Schaefer and Tsai (2000) described a facilitated early RTW programme in an urban medical centre in the USA. This study also produced evidence that RTW programmes are more efficient if a third party who is trained in ergonomics and job accommodation is involved. The ergonomist can help both the employee and supervisor to make appropriate job accommodation decisions. Although this study was not aimed specifically at workers with MSDs, it did offer plenty of detail on the components of the programme, which were as follows:

- The process is managed by a team and includes a co-ordinator, the insurance company, the employee, the manager and a safety representative. The safety representative works with the supervisor to modify tasks/work sites and to arrange alternative work assignments.

- A task/job analysis is conducted, which identifies physical job demands and alternative work assignments.

- Alternative work assignments are developed. These allow employees to work within their current capabilities.

- Hazards identified in the task are identified and eliminated.

- Employees, supervisors, medical personnel and human resource professionals are continuously educated about the return to work process and its benefits.

Bernacki et al found that supervisors had difficulty making job accommodation decisions without the help of a trained ergonomist. The supervisors were either unwilling to modify the job, or afraid that alternative assignments may exceed the restrictions prescribed by the physician. The study suggested that conducting a job analysis would be a useful approach, and could be used for future planning of modified work. Theoretically this could be done before an injury has occurred. Both the supervisor and the occupational physician could then use this information.

Other authors have also highlighted the usefulness of job analysis for determining modified work. Three examples are described below.

In an Employee Benefits News magazine article Carroll (2000) discussed the importance of a strong RTW culture in reducing absenteeism costs. The author suggested that the provision of transitional work programs was one strategy that employers could use to promote a return-to-work culture. Companies are urged to discard policies which dictate that employees must be 100% fit before RTW. Instead they should:

"Be creative in designing temporary assignments that suit employees' physical abilities to get them back to the workplace. 'Light duty' or modified work assignments can be a solid first step in helping employees feel connected to the workplace. Studies show that more than 90% of employees who go back to work part-time eventually return full-time".

Carroll also suggested including job requirements in position descriptions:

"Design job descriptions for employees that spell out their duties as well as the specific physical requirements, e.g., how much lifting, bending or standing is entailed in performing the job. Then there is clarity about what opportunities may exist to modify the work environment or job duties to create a return-to- work path for the employee"

In an article focusing on employee law, McDonald (2001) supported the provision of light duties for injured workers, but warned that policies for alternative duty need to treat all employees equally. The author presented an example of an organisation which changed its policy when it discovered that employees had received disparate treatment in the provision of modified work. Following this change, a job description was given to the employee's doctor, who could then more accurately judge whether or not the employee was able to perform his/her job.

A third example highlighting the importance of providing job details was an article discussing how good RTW plans can reduce costs. Shafer (2005) provided general advice for employers on RTW plans, recommending a number of actions including producing a document for doctors who treat employees. This should include a job description of both the original job and a number of modified duties, plus a statement about the purpose and importance of the RTW programme. Doctors should be familiar with the documentation used by the company to identify restrictions relevant to a modified job. This is sometimes known as the 'job modification form'.

In a US Occupational Health and Safety publication, Hinton and Miller (1997) described some of the difficulties encountered when implementing light duties and ways employers can overcome them.

When a worker is injured, many people are involved in their recovery. This may include safety managers, human resource personnel, company nurses, supervisors, doctors, therapists and the worker. The importance of clear communication between these players was emphasised. Usually a doctor will write a statement to the company recommending 'light duties'. Confusion arises over the term 'light duties', which is often taken to mean limits in lifting. It can refer to restrictions for equipment usage, time of tasks, frequency of movements and concentration of work. Therefore, the authors suggested, the term 'modified duty' was preferable. Also, specific details of what can and can't be done would be more helpful. Doctors are not always aware of the nature of the company, its procedures and its policy regarding RTW. They use medical terminology, which may not be widely understood, or may be vague, and not identify the source of pain.

Hinton and Miller recommended the use of standard forms/checklists to implement/consider the following 9 steps.

Modified duty orders should include:

1. Basic administrative information, including the names of the employee, the company, the treating doctor, and the diagnosis and date of injury.

2. Details relating to time, such as, the total number of working hours the employee can work/day.

3. Lifting restrictions, such as, maximum single lift.

4. Activities and body movements to avoid.

5. Equipment restrictions.

6. Environmental restrictions.

7. Posture restrictions.

8. Braces, supports and safety devices. (*NB: This advice is contrary to current recommendations e.g. Waddell and Burton (2000))*

9. On-site Health Care, such as occupational nurses, chiropractors, therapists and trainers.

The authors also recommended purchasing a small medical dictionary for quick reference, and developing a network of healthcare providers who have strong backgrounds in ergonomics.

Franche and colleagues (2005) performed a systematic review of the effectiveness of workplace-based RTW interventions. In the 10 studies they reviewed they found strong evidence that the offer of work accommodation reduced work disability duration, but there was insufficient evidence that this was sustained. They found weaker evidence for the impact of work accommodation offers on quality of life outcomes for the injured worker involved. The authors emphasised the risk of premature return to work, arguing that some workers who return to work too early are at a higher risk of relapse. The occurrence of a re-injury may generate fear amongst other injured workers about to return to work, as well as create resistance to future RTW for the worker concerned.

From this, Franche et al posed the following questions:

"How healthy can workers be expected to feel when they return to work after an injury or illness?

"What is an acceptable level of pain or symptoms for RTW?"

These questions need to be addressed in future research in RTW and considered by employers and employees in the workplace.

In a further study, Franche, Baril, Shaw, Nicholas and Loisel (2005) contrasted the different priorities and perspectives of the various stakeholders involved in RTW programmes (not specific to MSDs). While some friction seemed inevitable, the authors suggested that collaborative problem solving in pursuit of a common goal might be useful. Franche et al noted that unions have highlighted the positive effect of modified work on recovery when the work is valued and productive (echoing the findings of Eakin et al (2003) described above). However,

they cited a number of possible obstacles to implementing RTW programmes. These included job allocation being linked to seniority, poor relationships between the employer and union representatives, fear of re-injury because the workplace is seen as unsafe and the view that the workers have not healed sufficiently.

The authors emphasised the importance of the supervisor's role in RTW interventions. The supervisor is able to provide modified work as well as interpret policy and access other resources. However, some supervisors are hostile to RTW interventions, therefore training may be necessary. A number of actions were recommended in order to engage supervisors in disability prevention:

1. Give supervisors a vested interest in improving RTW outcomes by including disability management practices in performance evaluations, and increasing departmental accountability for disability costs. This may give supervisors the motivation to support RTW programmes.

2. Senior management should support supervisors in promoting worker safety and well-being, even when it affects production.

3. Supervisors must have the first aid skills necessary to judge the seriousness of workers health problems, and provide workplace accommodations based on ergonomic principles and health care provider's guidance.

The authors also recommended the appointment of a case manager. This has a number of advantages including:

- Enabling communication between stakeholders

- Ensuring RTW protocols are performed correctly.

The case manager may be from any one of the stakeholder groups. However, a RTW insurance case manager may be able to strike a balance between the employer's focus on productivity, and the health care provider's focus on protecting the patient. A number of steps are necessary to engage and empower case managers:

1. Case managers must have enough power to recommend work restrictions and accommodations in consultation with health care providers.

2. Case managers must have enough time and resources to see the workplace, involve the employer and employee in collaborative problem solving and facilitate individualised accommodations.

Recent evidence suggests that more work accommodations are provided if case managers are trained in problem solving and work accommodation planning.

Providing stakeholders with tools to select modified tasks, and improve communication between the workplace and treating doctors, could also enhance RTW interventions. Planning modified work is often a source of tension between stakeholders due to:

- Role confusion

- Lack of knowledge

- Fear of doing harm due to lack of knowledge

Tools have been shown to aid communication and help instigate modified work. For example, one study used a guide to running a RTW programme and workshops for workplaces. Another study used a publication and checklist for insurance case managers in a structured protocol. RTW interventions may be enhanced if the following processes are formalised:

- Information campaigns about the programme.
- Evaluation of workers' functional capacities.
- Regular contact with workers absent from work.
- Worker orientated follow-up.
- Programme evaluation.

Finally, the authors acknowledged some of the limitations of RTW intervention research. Little is known of the impact on outcomes of specific components of work accommodation (i.e. ergonomic, schedule and work organisation). Many findings cannot necessarily be generalised. Small organisations are seldom studied. Many studies concentrated on MSDs as opposed to other health conditions. Outcomes often reflected the perspectives of employers and insurers, rather than workers.

2.3 LITERATURE ON LOW BACK PAIN AND MODIFIED WORK

Matheson and Brophy et al. (1995, 1997) conducted a case study of a model of health care delivery in California, involving an immediate intervention following occupational back injury to aid RTW. This included a modified work component. The RTW programme was provided by an organisation which had agreements with local companies to provide managed care for industrial injuries, using a clinical case manager from the point of entry into the system until the employee returned to work. The clinical case manager enabled communication between the injured employee, the employer, the payer and the providers. The authors found that a structured early RTW immediately after a soft tissue injury was a viable strategy. They reported that the RTW rate was more rapid and complete than that found in other studies of RTW following occupational back injury.

Rapid RTW was facilitated by the use of a diagnostic triage team, comprising a physician case manager (or a family practitioner or orthopedic surgeon) with a specialism in physical medicine and rehabilitation, a physical therapist trained in industrial rehabilitation, orthopaedic manual therapy and soft-tissue assessment and treatment, and thirdly, the clinical case manager, a nurse trained in the use of the organisation’s protocols, with an emphasis on maintaining good communication between involved parties. In the programme, soft tissue injuries were identified and treated immediately. Rest was avoided by assigning transitional light duty work if there were no medical contraindications. Treatment was delivered during work hours. The premise of the model was that medical care should focus on return to work from the initial contact. Everything possible was done to maintain the injured person in the worker role and avoid the patient role. Initially employers were reluctant to provide transitional light duty work. However, attitudes and behaviour changed when the method was seen to be effective. Light work was made widely available as long as the worker had been medically cleared to safely handle the demands of the light duties. The study assumed that all participants required immediate attention (contrary to the US insurance system’s tradition of a ‘wait and see’ period of 3-7 days).

Similar to Eakin et al (2003 – described earlier), Spencer, Yates and Butterfield (1999) addressed small companies, focusing on LBP. These authors compared absenteeism in large versus small companies. They found that employees in small companies were absent for longer than those in large organisations. They suggested this was because small companies have limited opportunities for modified work tasks and fail to recognise the importance of early RTW programmes. By contrast, larger companies are more proactive in the management of absenteeism and RTW issues.

Anema and colleagues (2003) noted the dearth of information on the structure and content of work adjustments applied in disability management programmes. They described, in detail, an ergonomic approach to RTW for people with LBP who had been sick listed for 2-6 weeks. The approach was unusual in that it was aimed at providing solutions post injury. Most ergonomic measures aim at primary prevention whereby strategies are implemented before an injury occurs. The approach involved using problem solving and worker participation in 3 different sectors in the Netherlands. The 3 sectors were: health care, manufacturing and the service industry. The programme involved the following steps:

1. Having checked the supervisor was aware of, and consented to the programme (and its costs), the ergonomist established who was responsible for workplace adjustments, and the procedures to be followed.

2. The ergonomist conducted several interviews. The worker and supervisor were interviewed together and separately, and the worker observed at work, to gain a complete picture of the job, what it entails, and how the injury affects this. Attention was paid to factors such as work organisation and materials and equipment.

3. After this a meeting was held between the worker, supervisor and any relevant others involved to brainstorm solutions and prioritise problems.

4. A joint plan of solutions was made by the worker, supervisor and ergonomist, giving precise details of who does what, when and how. This plan was sent to the worker, supervisor and occupational physician. The ergonomist contacted the employer to arrange implementation.

5. The worker may need training/instruction to implement solutions. The ergonomist provided this and informed the supervisor how to encourage and guide the worker in his/her new work situation.

The occupational physician evaluated the situation with the employer and worker.

Most workers were satisfied with this participatory ergonomic approach, and reported a stimulating effect on RTW. According to most of the workers and ergonomists, the intervention had accelerated RTW. The main obstacles to implementing the programme were technical or organisational difficulties concerning work adjustment and functional disabilities of the worker. The key to the success of this programme may have been the use of an outside agent (the ergonomist) who was able to help both the employee and employer. The cost implications of this programme were not discussed.

Ratti and Pilling (1997) reviewed the literature on back pain in the workplace, and how it was tackled by occupational health services. They described one system for dealing with simple back pain at the Rover Group Longbridge plant. Workers were seen at a clinic within 2 weeks of absence, where the doctor assessed them and excluded serious pathology. Immediate referral to a physiotherapist was possible, and treatment could start within 24 hours. This contrasts with GP referrals to NHS units, which can take several weeks. A recommendation that the worker

changes to an alternative job not involving heavy lifting, twisting or excessive bending for a period of time may be made to management (and a review suggested). This was intended as a gradual rehabilitation to normal work. The study did not report on the effectiveness of the programme, as it had only recently been devised.

Frank, Sinclair, Hogg-Johnson, Shannon, Bombardier, Beaton and Cole (1998) reported on intervention studies from 1993 to 1997 for the management of acute LBP. They found substantial evidence which suggested that employers who promptly offer appropriately modified duties could reduce time lost per episode of back pain by at least 30%.

The authors discussed the appropriate phase of absence in which to implement intervention, and concluded that many workers with soft tissue injuries and good prognoses were being seen too early and for too long. They noted that physicians became concerned about a patient's failure to recover from back pain about 3 to 4 weeks after onset. Paradoxically, guidance issued by the US Agency for Health Care Policy Research (AHCPR, 1994, cited by authors) suggested that people with LBP, who have been absent from work for more than a month or so, are more treatable than unselected patients seen earlier, in terms of demonstrated treatment benefits, even though their prognosis is worse.

The authors also noted that successful interventions in the sub-acute stage involved the workplace in the management process. This would ideally include workplace visits by rehabilitation professionals, to assess the job, and where appropriate, to negotiate worker-specific job modification.

Frank et al described 3 main potentially preventable factors which contribute to the onset of chronic disability from LBP. In the acute phase (up to 4 weeks after onset), clinical iatrogenesis or an inappropriate workplace response may contribute. In the sub-acute phase (approximately 4-12 weeks after onset) mind and body processes may lead to chronic pain syndrome. They suggested that clinical iatrogenesis may be solved by the provision of guidelines-based care by primary providers. An inappropriate workplace response may be overcome by workplace interventions focused on prompt accommodation, e.g. modification of work duties. The authors suggested that a supportive workplace response needs to start when the injury is first reported, and intensive work-related case management may offer solutions to problems in the sub-acute phase.

Finally, Frank et al emphasised the importance of engaging all stakeholders in active collaboration in order to successfully control the cause of disability. They argued that a piecemeal approach based at only one stakeholder site, or addressing only one phase of disability will not work.

Staal and colleagues (2003) compared guidelines, produced in 6 different countries, on the management of LBP in an occupational health setting. The countries were Canada, Australia, USA, New Zealand, Netherlands and UK. They found that the guidelines all agreed on advice that LBP is self-limiting, and that remaining at work or an early return on modified duties (if necessary) should be encouraged and supported. They also noted a lack of systematic approaches for workplace adaptations.

2.4 LITERATURE ON NON - SPECIFIED MUSCULOSKELETAL DISORDERS AND RETURN TO WORK INTERVENTIONS WITH MODIFIED WORK

Crook, Moldofsky and Shannon (1998) conducted a longitudinal study of 148 workers who had not returned to work within 3 months of a musculoskeletal injury. Although this work focused on the chronic phase, in support of the findings of Krause et al, the authors found that the RTW

rate doubled when employers provided a modified job. They therefore argued that access to modified work was important in the prevention of continued disability.

The findings of Crook et al, and Krause et al suggest that the provision of modified work is an important component in any successful RTW programme.

Van Duijn and colleagues (2004) identified a number of barriers to the implementation of modified work, to facilitate early RTW of workers absent with MSDs. Modified work was defined as gradually increasing the physical demands at work until the worker is ready for full duty in his regular job. They surveyed occupational health physicians and human resource managers, who detailed the following barriers:

- Lack of knowledge on modified work
- Negative attitudes of employees
- Lack of possibilities to change the work task
- Lack of possibilities to change the organisation of the work
- Mismatch between the education of the worker and the specific requirements of modified work

The size and nature of companies participating in the study varied. These included companies in the health sector, building industry, roofing and security. Some employed over 100 people whereas others had less than 20 workers. Implementation of modified work was determined by a number of factors such as the size of the company, the number of jobs and the diversity of tasks within a job. For example, physical workload was easily reduced for nurses, who could assist with drug administration or meals, whereas, the job of a roofer offered little scope for tasks with a low physical workload. Occupational physicians met with more barriers related to the absence of a clear RTW procedure.

Less than 5% of companies reported having difficulty adapting the working hours of the employee. Therefore this might be an alternative solution, when task modification is not possible. The authors suggested that participatory ergonomics might bridge the knowledge gap between occupational health physicians and workers. (Participatory ergonomics involves the planning and controlling of aspects of work by the worker themselves, the process usually guided by an ergonomics ‘team’ including employees, managers, ergonomists, health and safety personnel and research experts (Wilson and Haines, 1997)).

Indeed, Van Duijn et al argued that involvement of the worker in the decision-making process may facilitate acceptance of the redesigned job.

They concluded that maximum effort from all parties concerned was necessary for successful rehabilitation, because of the sheer number of difficulties arising from attempts to implement modified work. Clear procedures and mutual understanding of all concerned may improve the process.

In a further study, Van Duijn, Lotters and Burdorf (2005) surveyed 164 employees with MSD, and sick listed for 2-6 weeks, to determine individual and work related factors associated with performing modified work. They found those in jobs with a high physical workload were less often assigned modified work by the occupational doctor. Employees were less likely to perform modified work when their regular work was characterised by frequent lifting and their

relationship with colleagues was less than good. They also found that modified work, as the only advice given by an occupational health physician did not influence the total duration of sick leave, nor improve employee health during sick leave. This is contrary to the findings of other studies, which have included modified work in their RTW programmes, and seen a reduction in length of sick leave. The authors suggested the lack of any effect in the study could be explained by the fact that the recommendation for early RTW given by the occupational physician was most often the only advice and was not part of a multidisciplinary programme. They argued that modified work, as part of a broader rehabilitation programme, was effective.

A further reason offered for their findings was the possibility that modified work delayed the return to full duties. Having modified duties may imply an accepted *status quo* for both the employee and employer and as a consequence, result in less pressure to return to the original job. The authors argued that provision of modified work should therefore be for a clearly limited period. Waddell and Burton (2000) also suggested this. However, Waddell and Burton (2000) were also cautious about the provision of modified work. They suggested that it could act as a barrier to return to normal work because the employee may perceive their work as harmful. Further, if no modified work is available this can delay RTW, as the employee would then be deemed unfit to return.

Van Duijn et al (2005) also found that starting modified work after 7 weeks was associated with longer sick leave. A sub-group of their sample had a delayed start to modified work and were absent for a longer period. The authors suggested that the expectations of the occupational physician may have influenced these findings. A physician may assume that a worker absent for a prolonged period may have serious health problems, and hence be more careful with advising a RTW. The perception of the occupational physician involved in any RTW case is therefore an issue to consider.

A public health document published in Quebec (Prevention en pratique medicale, 2003) outlined specific advice for doctors with regard to modified work and MSD. It stated:

"The regular work environment is the best place for early rehabilitation, as long as the individual's work is productive and perceived as valued".

The document suggested that doctors should assess the physical demands of proposed modified work and not assume it is appropriate, because employers and human resource managers often know little about MSDs and ergonomics. This can be done by carefully questioning the worker or sometimes the employer. The importance of considering the intensity, duration and frequency of effort is also emphasised. In complicated cases where the worker has difficulty answering questions or tasks are poorly described or unspecified, it recommends contacting the employer. It may be necessary to seek other professional opinions, such as those of occupational therapists, ergonomists and occupational health physicians. Finally, the document urged doctors to indicate work restrictions instead of prescribing non-specific 'light duties', when they return patients to work who are unable to perform all their usual functions.

Davis, Badii and Yassi (2004) reported on a programme developed to reduce the incidence of MSD and decrease associated time loss, at a large urban hospital in Canada. The programme included modified work, although specific details on the nature of the modifications were not included. Employees who participated in the programme were offered a range of on-site services including physiotherapy and work environment assessment with modification and purchase of new equipment as necessary.

The programme was not particularly successful in reducing MSD occurrence and associated time loss. Although there was no reduction in MSD incidence, the programme appeared to be effective in returning injured employees to work more promptly once time-loss had occurred,

for some hospital staff (nurses and health science professionals). However, the programme had little effect for other workers, namely, facility support staff. The authors argued that for these employees, only 36% participated in the programme, thereby perhaps explaining the lack of any effect. They also suggested that the weak results overall may be due to the fact that although 92% of the programme participants received physiotherapy, only 26% received workplace modifications. The authors argued that time lost may have been reduced further if more participants had received work environment changes or work practice modifications.

Brooker et al (2001) noted that most published material on modified work only describes successful programmes. They attempted to address this by providing a 'snapshot view of actual practice'. They surveyed 1833 workers (with soft tissue injuries of the back, upper limb and lower limb) in Ontario in sectors including manufacturing, trade and construction. Only a third of workers reported having been offered arrangements to help them RTW in the first year. Similar to Krause et al (1997) light duty was the most common type of modified work, followed by flexible work schedules and reduced hours. Changes in work layout or equipment were minimal. The study did not investigate the employer's perspective. In contrast with the studies of Eakin et al (2003) and Spencer et al (1999) the authors also found no relationship between company size and proportion of employers who offered modified work. The survey findings indicated that a small minority of workers experienced greater pain than expected on RTW. The authors suggested that worker and workplace assessment both before and after RTW may ensure that injured employees are not returned to work too early or to situations that may reactivate their condition.

Loisel, Buchbinder, Hazard, Keller, Scheel, van Tulder and Webster (2005) conducted a literature review on work disability prevention for MSDs and barriers to evidence implementation. They found that some interventions, including advice to return to modified work and graded activity programmes, were effective in reducing work absenteeism. They also highlighted evidence that modified work is effective because links with the workplace are maintained, rather than because it provides physical protection.

The authors noted that interventions aimed at work disability prevention are often complex, multifaceted and delivered by stakeholders from a number of organisations. This means it is often difficult to replicate them in other settings. Also, the best way to deliver strategies to reduce work disability has not yet been revealed. RTW recommendations are often imprecise. This may also be of relevance when devising general advice on modified work programmes. The authors also cited two examples of RTW programmes with a modified work element. However, one programme had no effect on absence rates and the other was not cost-effective.

However, Franche, Baril, Shaw et al (2005) acknowledged some of the limitations of RTW intervention research. Little is known of the impact on outcomes of specific components of work accommodation (i.e. ergonomic, schedule and work organisation). Many findings cannot necessarily be generalised. Small organisations are seldom studied. Many studies concentrate on MSDs as opposed to other health conditions. Outcomes often reflect the perspectives of employers and insurers, rather than workers.

3 THE WORKSHOP

3.1 WORKSHOP OUTLINE.

A group of twenty health professionals and academics were invited to attend a workshop on 19th January 2006 to discuss musculoskeletal disorder (MSD) and return to work (RTW) issues with particular emphasis on modified work. For the purposes of the workshop this was taken to include the same work but with modified hours, more flexibility, a change of equipment or task, and different work (for example, redeployment or relocation). Delegates from a variety of professional backgrounds attended, including occupational medicine, physiotherapy, occupational therapy, occupational health nursing, ergonomics, health research and unions. A full list of delegates and their pen pictures are listed in the appendices. The workshop involved an introduction to the aims of the day, followed by three position statements, made by practitioners from three different areas of expertise (ergonomics, physiotherapy and occupational medicine), of their experiences of MSD and RTW in relation to modified work. Their statements are summarised below. The delegates then divided into two groups to discuss and answer the questions listed in the appendices. There follows a summary of the discussions which took place in each of the breakout groups. The groupings for the breakout groups can also be found in the appendices. The groups reunited for a plenary session in which findings were shared. The chairman then gave a summary of the key points and future direction.

3.2 INTRODUCTION BY THE CHAIRMAN.

David Coggon set the tone for the day, explaining that the focus was on persuading and supporting employers. HSE was looking for examples that are practical and applicable to an employer's situation. The examples must be evidence based - that is, be shown to work and practical to implement. Also it is important to consider the obstacles that may exist, and examples need to accommodate various approaches to individual case management.

3.3 SUMMARY OF POSITION STATEMENTS.

There follows a summary of the talks given by three different practitioners of their experiences of musculoskeletal disorder (MSD) and return to work.

3.3.1 Ergonomist's Perspective

Margaret Hanson is a consultant ergonomist who works for Hu-Tech, and offers ergonomic advice to a wide range of organisations. Much of her work is focused on helping people with MSDs stay in work or RTW, or on working with organisations that have a high MSD risk. This typically involves computer workstation assessments, or car assessments, for those whose work involves a lot of driving and who are experiencing discomfort.

Hu-Tech has an ongoing relationship with a financial organisation. Margaret gave a number of specific examples of work adaptations made for their employees, following ergonomic assessments.

- Financial consultants, such as mortgage advisers, conduct interviews in customers' homes and one was made 'branch based' following problems experienced by having to drive for long periods.

- One individual had difficulties with using a laptop on home visits (lack of suitable furniture to position the equipment, as well as manual handling issues with transporting

the laptop), so was advised to complete forms as hard copies, thus excluding the need for the laptop. They could be subsequently transcribed at a better workstation set up.

- One employee was relocated to reduce the amount of driving done to get to work.
- Repositioning of the screen at a workstation used when discussing an issue with the customer. There is anecdotal evidence that the new arrangement was an improvement for the employee with MSD problem and also better for other staff using the workstation.

Some problems encountered with adapting work include: difficulties giving people different jobs and managers being surprised and unprepared for the time required for an individual to return to work fully (eg 6 weeks).

Other examples of adaptations include:

- Removal of one component of the job.
- Task re-allocation to another employee, if the workforce is large enough to permit this, eg heavy lifting - in a bank the task of carrying coins can be done by another colleague.
- Changed type of chair.
- Raised seat height to alleviate pressure and associated discomfort in the forearm
- Provision of short keyboards.
- Provision of an alternative mouse.
- Provision of voice activated software.
- Training in touch-typing to improve posture.
- Using keyboard shortcuts and templates to reduce keying.
- Car seating altered to provide better support.

However, all the above measures can only be effective if the employee is willing to try them. If there are other factors, such as, the employee dislikes their job; the measures will have limited success or not be successful.

Following questions, Margaret provided additional information:

- The costs of Hu-Tech's services are met by the organisation that approaches them.
- Assessment includes scrutiny for yellow flags, but this could possibly be done better (See section 3.3.2 for an explanation of the Flag system).
- One problem in evaluating success is that Hu-Tech does not always learn of the impact of their measures, because they work as consultants. Therefore, they do not always know if they were acceptable to the employee, although they have an on-going relationship with some organisations and are able to evaluate the impact of

recommendations. Also cost-benefit evidence is usually not available as it is not collected by organisations.

- Hu-Tech's remit is defined by the organisation that recruits their services, for example if the organisation requests an assessment for an individual with an MSD, there is little scope to investigate the broader organisational issues which may affect the whole workforce.

- Timing delays in work modifications can hinder rapid return to work. Some changes can take months, for example, installing an alternative counter in a bank can take typically 9 months following the request to alter and specialist chair delivery from some seating suppliers takes 6 weeks.

3.3.2 Physiotherapist's Perspective:

Nicola Hunter is a chartered physiotherapist who has set up RehabWorks Limited. This provides occupational health physiotherapy and multidisciplinary functional restoration programmes for people with long-term absence due to MSD. Nicola provides a service for people with both acute and chronic problems, working in sectors such as, utility services, NHS, supermarket depots and Royal Mail.

The aim of her work is to get people back to their normal duties. For this to happen physiotherapists with the appropriate knowledge and training are required. Physiotherapists should have knowledge of red, blue, yellow and black flags. [1] They should also have knowledge of the work in question. For this they need to make worksite visits in order to fully appreciate the nature of the employee's work, their shifts, hours and how the place operates generally.

One problem is the lack of understanding of how to use modified work. For example, one employer had 40 employees on restricted duties from a workforce of 180. This meant that production could not be maintained.

It is important to have a suitable person in the company who can and will make decisions. There is not a universal shared belief that keeping people in work is the healthy option. Some professionals believe that some work is too difficult for the person to return to.

Nicola recommended the following:

- Use of the Back Book, which helps people to self-manage their back problems. This can build confidence and provide reassurance.

- Screen for any specific medical conditions, give simple good advice at an early stage and avoid offering unnecessary treatment.

- A good understanding of psychosocial factors.

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[1] *Factors influencing long-term disability and work loss have been classified according to a 'Flags Model'(Auty, 2004). Yellow flags are psychosocial risk factors, such as beliefs and emotional responses. These have been shown in the scientific literature to predict chronicity. Blue flags are features of the work or social environment that have been shown to increase the rate of symptoms, illness or work loss. For example, high demand/low control and poor social support from colleagues. Black flags are national/ organisational policies or procedures that can impede rehabilitation. Red flags are conditions indicative of serious medical pathology, such as, rheumatoid arthritis and carcinoma. These have been described in guidelines published by the Faculty of Occupational Medicine (Carter and Birrell, 2000).*

- Support from external professionals such as GPs and consultants.

- Identify non-returners and refer them to a functional restoration programme as soon as they are identified.

- Set the expectation that the employee will return to work in a stated number of weeks.

- Examine the type of task undertaken.

- Long-term light duties are not appropriate.

Nicola gave two examples of work case histories.

The first one, a transport assistant for an ambulance trust, with an 8 week history of neck pain with pins and needles in his left upper arm, was given a 6 week functional restoration programme which included a graduated RTW plan and exercises. By week 6 he had returned to full duties, his neck was fully mobile and his strength was improving.

In the second example, a supermarket depot operative had a 5-year history of recurrent low back pain. She had been working ‘light’ duties for almost 2 years following a 12-week absence for back pain. During this time she had 5 courses of physiotherapy comprising massage and mobilisations, heat treatment and core stability exercises.

A 12-week programme was set up which included stepped increases in certain work tasks, and a graded exercise plan was prescribed. The operative complained to Human Resource (HR) of becoming worse following physiotherapy and requested a return to previous physiotherapy treatments. Therefore, a meeting of all parties involved was held. HR explained that long-term light duties were no longer possible, and that previous physiotherapy had been unsuccessful. The operative agreed to participate in on-site physiotherapy following some discussion. By week 9 she was exercising 3 times/week in work time and was essentially on normal duties.

Nicola emphasised the importance of gradually increasing the demands during a functional restoration programme.

During a short discussion session, the following points emerged:

- In Nicola’s experience, return to work was successful in 88% of cases at two-year follow-up.

- Rehabilitation should be voluntary (rather than compulsory, as seen in Australia and New Zealand). However, if an employee does not wish to participate, reasons for this should be sought.

- Reasonable adjustments are not necessarily appropriate where full recovery is possible. For example, the supermarket operative (above) was not functionally disabled. They are more appropriate to people with permanent disability.

3.3.3 Occupational Physician’s Perspective:

Peter Oliver is an occupational physician who is currently working for Flintshire County Council and undertaking consultancy for Toyota Motor Manufacturing and Iceland Foods PLC. As an occupational physician Peter sees people from a variety of occupations such as, teachers, social workers, home carers and refuse collectors. He made a distinction between phased,

restricted and modified duties. Phased usually start at 50% and then the days are lengthened, however there is no evidence base to support this.

Flintshire County Council re-launched their sickness absence policy in the last 12 months, and the biggest obstacle, in Peter's view, is encouraging early and open communication between all parties involved.

Successful return to work requires the confidence of both the individual and their manager and should be process managed. The length of time on restricted duties (e.g. 6 weeks) may be viewed as a long time to a manager, but seen as only a short time to a physician. Phased rehabilitation is used in many areas such as social work.

Peter explained that he had no cost-benefit analysis but presented the following two examples of cases he had seen.

The first one involved a nursery nurse, with a 5-year history of back problems following a road traffic accident. There was no litigation, and pain management and physiotherapy had been tried. The nursery nurse had self-referred to the Occupational Health Department on the advice of her orthopaedic surgeon. The nursery nurse worked with children aged 1 to 3, and had particular difficulty dealing with the age 3 group because they were more mobile. She had one yellow flag; a problem with anaphylaxis to modelling clay, a few years previously. However, she was keen to get back to work. She had some restriction of movement.

A workplace visit was arranged including a meeting between the occupational health nurse, the health and safety manager, the line manager and the employee. A number of simple modifications were agreed, which included ergonomic changes to reduce bending, such as adapting the toilet routine for the children and using a more appropriate chair. Also, a phased return was planned over 4 weeks, starting with 50% of the routine and gradually increasing to 100% by increasing the length of each working day. This plan was successful. When reviewed at 3 months, the nursery nurse was working normal duties happily.

The second example involved a peripatetic worker with a history of neck and shoulder pain. The work involved assessing children with special needs in numerous different schools, and involved a lot of driving and a lot of carrying of equipment. Often the rooms allocated for her to do her work were not designed for the purpose, therefore the ergonomics were challenging. A risk assessment meeting was held between the employee and her manager in which a number of measures were agreed to improve the nature of the work and reduce the problems encountered. These were subsequently implemented with a good outcome.

Peter emphasised the importance of good, open communication. However, he added that he would like to have access to physiotherapy, as delayed access to this is a source of frustration to him in his work.

Following questions, Peter added the following information. Returning to work mid-week, rather than on a Monday could be used, so the employee starts back with a shorter week, however, Peter's preference is to start with a short day, and gradually increase the length of the working day. This way the employee establishes the habit of attending 5 days/week. Assessment tends to be based on the patient's level of function, rather than focusing on what they can't do.

The need to examine and challenge unhelpful beliefs was emphasised by Nicola Hunter. Mike O'Donnell emphasised the importance of training and tools to identify yellow flags early, in order to avoid unnecessary referrals to other professionals.

4 RESULTS FROM DISCUSSION GROUP 1- UPPER LIMB DISORDER

4.1 QUESTION 1. DELEGATES' EXPERIENCE OF OFFERING MODIFIED WORK, AND SPECIFIC EXAMPLES.

A general discussion identified problems and barriers to modified work, as well as practical solutions. A summary is given of the main points followed by a more in depth description of the issue.

4.1.1 Problems and Barriers:

4.1.1.1 *The Diagnosis.*

- Provides an explanation and reassurance.
- Helps establish trust.
- Confuses employees when numerous different ones are given.
- Can delay return to work if an employee is awaiting investigations before he/she is prepared to return.

The importance of establishing a diagnosis was discussed. This has both advantages and disadvantages. Nursing staff in the Occupational Health Department at Toyota use a problem solving approach, rather than seeking a specific diagnosis. However, categorisation of the problem can be useful as it provides an explanation to workers and employers.

" The reason we find it important to try and categorise it is because often we are asking people to work through pain or work with pain and we need to be able to give them a sensible explanation and their manager about what they are doing and why they are doing it. And as a consequence why it is alright for them to be doing some work that might actually be a bit uncomfortable. And so that we can also give them realistic timescales over which this might change – the pain that they are experiencing."

Also, diagnosis can provide reassurance to individuals who are seeking answers.

"…a lot of people like to identify a particular cause of that problem."

"…But I think it does help for them if you can say: 'yes, this is what you have got, and this is what will help you best".

Therefore, knowing the diagnosis can reassure patients that they are receiving the right treatment and care for their problem. It gives validation. It also provides a rational argument as to why they should partake of treatment regimes, which are not necessarily pleasant. This may help the patient to trust the therapist. Trust was highlighted as important. Workers need to be able to trust health care givers. This does not always occur in practice. GPs do not always understand the nature of their problem or the nature of their work.

"…but they have to trust the person…and with their own GPs a lot of people don't have that and quite rightly…because they don't know what is going on and they don't know the nature of their work."

However, a search for diagnosis can cause problems. The confusion caused to workers by being given numerous diagnoses by different professionals was raised.

"I think one of the biggest problems for individuals is getting different information from different medical personnel."

"I have had people who have had 13 different diagnoses, and absolutely none of them made any difference at all in terms of their treatment and help, keeping them in work, getting better in any way at all."

Another disadvantage of trying to establish a diagnosis is that it can delay return to work. Employees often remain off sick whilst awaiting medical investigations.

"How many times have we found the factor that has prevented them from going back is: 'Oh, I can't come back because I am waiting for the MRI scan.' ' I am waiting for this, I am waiting for that.' I am actually trying to get you back in the workplace."

"The MRI scan is the biggest obstacle for getting people back to work. People say;' I am waiting for the scan', and you say; 'right, okay, so what is that going to do for you?'"

4.1.1.2 *Erroneous Advice and Treatment*

- Incorrect messages from some professionals, such as the prescription of rest can mislead employees.

General Practitioners giving erroneous advice, such as prescribing rest, can be counter-productive. Workers can be left uncertain of the best action to take because they are told to rest by their family doctor, and told to remain active by the occupational physiotherapist. Physiotherapists try to pre-empt this by ensuring rapid referral to them, before the worker is misled with the wrong advice.

"We simply ask for early reporting with the businesses so that we stop them going to the GP."

4.1.1.3 *Culture*

- Emphasis on the need for specialised equipment can generate the notion that work is harmful.
- These ideas can pervade an entire organisation or nation.

The discussion turned to modifying the ways tasks are done by changing equipment such as seating. One of the problems arising from an emphasis on the importance of using specialised/individualised equipment is that it creates the impression that the work is harmful to health and this becomes a pervasive belief held throughout an organisation or society.

"*My main concern about that is that it just creates a culture. A different keyboard may create problems as well as making it easier for people to get back to work."*

Two examples were given of instances where problems appeared to have a cultural origin. In the 1980's in Australia, there was an outbreak of arm pain that was not paralleled in other countries using the same technology. And in the UK, employees at one company where there had been a lot of emphasis on potential risks from use of computers, appeared to have more problems than those working for other companies using the same technology.

Conflicting views were expressed here, as others have found that people do not always link their pain to the activities they regularly perform on a computer.

However, as yet the causes of ULD are poorly understood. There is some epidemiological evidence suggesting that any link between ULD and computer use is weak, but there is also epidemiological evidence that increased keyboard use increases ULD symptoms. This has yet to be firmly established.

"With upper limb disorders often linked with pain, the causation is probably…we don't know much about it, that is the trouble."

4.1.1.4 *Financial Incentives*

- Employers can be reluctant to consider work modifications if they are not paying the salary.
- Some employees are financially better off if they remain on sick leave.

Another problem arises through financial arrangements. Employers can be reluctant to help workers RTW on modified duties because they are not paying their salary while they are off sick. Some employers are more willing to make work modifications if they are paying them while they are on sick leave as they may return on reduced pay if they cannot return to work full time. Likewise, workers may be better off financially if they remain on sick leave. This is also obstructive to RTW efforts.

"If they are not being paid by the employer, …then the employer only wants them back if they are actually fully fit. And there may actually be financial disincentives to the employee to come back as well."

4.1.2 Practical Solutions:

Graduated return/Reduced working hours

- Rebuild confidence.
- Help the employee to feel supported
- Involve a mid-week return or working shorter days than usual and gradually increasing their length.

Where a worker has been absent on sick leave, a graduated return, in terms of the number of hours worked, was thought to be of particular importance when an employee has a ULD. This is beneficial both physically and psychologically, as it helps recondition muscles and increases confidence. Often the person has beliefs that they can no longer do their job.

"I think if you are talking about soft tissue injuries, then getting people back to using that particular part of the body in the way that they have previously is going to take some time."

"You do sometimes have to just build up that individual's confidence about: 'yes, you can still do this job, and yes, let's get you back'."

A number of ways to arrange RTW were suggested. One possibility was to return on a Thursday, so that the employee has two days to work followed by two days off at the weekend.

Another way, preferred by some occupational physicians, is for the worker to return to work on shorter days, but attend everyday in order to establish a routine of daily attendance.

"*My preference is to get somebody into work every day because it is about work pattern and work schedule.*"

This is a gentle way back into the routine and is intended to ease the employee back into work. It is a way of making the worker feel supported.

"There is a symbolic element to that. Being supported, being nice, …… we are also trying to get on board the people around that individual too."

Support was seen as highly important for people with ULDs, and not always available.

"So you need a lot of support through that. And people don't get that."

4.1.2.1 *Self-care versus early referral*

- Some employees may not need professional help.
- Early referral is sometimes used to prevent employees from being misled by the wrong advice.

It was questioned whether people with ULDs are 'over managed', and whether they would in fact recover anyway without all the input from physiotherapists and other professionals, given a similar time period. Early referral is encouraged to prevent workers from going to their GPs and being signed off sick for a number of weeks. There is a need to send a clear message to both employers and employees that in most instances it is not harmful to work with a ULD.

"If we can somehow get the message over to those who were advising people with upper limb pain that in most instances it will not be harmful..."

4.1.2.2 *Examples:*

Toyota

The system at Toyota was described. Protocols have been formulated which list work restrictions for musculoskeletal problems affecting different body parts, such as the back, upper limbs, lower limbs, hands and wrists. A set procedure is in place, which starts when an employee raises a concern about an MSD with the group leader. The group leader works with the employee to try to resolve the problem. If it has not been solved within 5 days, the worker is referred to the Occupational Health Department (OHD). The worker is then assessed and restrictions are put in place as appropriate. The protocol is used to guide OHD staff on which processes the worker may comfortably perform. The worker is reassessed 48 hours later. If there is no improvement following the implementation of work restrictions, the employee is referred to the on site physiotherapist. If improvement is seen after this, the restrictions are kept in place for a further 2 or 3 days. The aim of the procedure is to prevent further damage and enable a rapid recovery while keeping the worker productive.

"But the ultimate aim is to get them back working as they were without the restriction."

Other measures used to facilitate this aim include the availability of an on site doctor 3 days per week, plus BUPA membership which ensures rapid referral to consultant specialists. Workers are also trained in up to 8 different processes to ensure a range of duties can be performed. This

means that even if work restrictions are in place, the worker is usually able to perform some processes. The necessity of restricting activities to prevent further damage was questioned in the light of evidence on backs, which now suggests that restricting activity exacerbates the problem. It was postulated that the same might be true of ULDs. The experience at Toyota is that some ULDs mean the worker is temporarily unable to perform their usual tasks.

"…sometimes the nature of the injury means that they can't do the process that they would normally do."

4.2 QUESTION 2. THE APPROPRIATE TIME TO CONSIDER WORK MODIFICATIONS.

- Ideally within 2 weeks
- No later than 4 weeks
- Some health professionals are not informed until after 4 weeks.

The overall consensus was that work modifications should be considered within 2 weeks of an employee going on sick leave, and the earlier the better. However, there was a gap between the ideal situation and what actually happens in reality. After 2 weeks the employee will already have visited their GP for a sick note. After 4 weeks it is too late, and some managers are contemplating dismissal. Occupational physicians are unlikely to hear of the problem sooner than a month after onset.

"A bad set up is going to take several days before somebody is seen."

"Logistically I think if you are a strong OH service on site, then that is fine. …In a local government situation I am probably not going to know very much within a month …"

4.3 QUESTION 3. THE IMPORTANCE OF LINE MANAGER AND HUMAN RESOURCE (HR) INVOLVEMENT, AND THE RETURN TO WORK PLAN.

The Line Manager plays a highly important role and can offer:

- Support
- Contact
- Job knowledge
- A link to investigate aspects of the job the employee finds difficult**.**

HR should be involved:

- When available.

The Return to Work Plan is important and should:

- Be coordinated by a case manager
- Involve the cooperation of all interested parties.

4.3.1.1 *The Line Manager*

The line manager was thought to have a very important role, and is often the first point of contact for an employee with a ULD. The line manager has an important supportive role and can take many steps including asking the employee what parts of the job are difficult to perform. The line manager should also have detailed knowledge of what the employee's job involves, and therefore should be in an ideal position to help.

4.3.1.2 *The HR Department*

If there is an HR department they should be involved. If there is no HR department there is still a lot that can be done.

4.3.1.3 *The Return to Work Plan*

A RTW plan is important, and a case manager to coordinate this can be useful. The case manager may be from the OH, or HR department or could be a manager, but ideally would not be the line manager. However, it was emphasised that although appointing a case manager is a good idea, the cooperation of all those involved is important. Also, the employee should be aware of their responsibility.

"…but I think for me the challenge is to make line managers and individuals realise that the responsibility lies with them."

4.4 QUESTION 4. MODIFICATIONS FOR SPECIFIC UPPER LIMB DISORDERS (ULDS) AND NON-SPECIFIC FOREARM PAIN.

The following points were raised:

- The advice is the same for most ULDs regardless of diagnosis – 'stay active'.
- Acute inflammatory conditions require rest but these are rare.
- The message to 'stay active' needs to be communicated more widely.
- The evidence base on appropriate advice for managing ULDs is incomplete.
- Simple indicators of underlying pathology (akin to the back pain Red Flags) are not well developed in ULD.

Often the advice is the same regardless of the nature of the diagnosis. In the case of the majority of disorders activity should be maintained. A discussion followed to distinguish which disorders required rest. Acute inflammatory conditions require rest but these are rare.

"But I think with upper limb conditions, very often…we don't actually restrict them very much except those that have true acute inflammatory conditions. The only example really is a tenosynovitis. That is the only really true inflammatory condition. Otherwise, tendon pain, which we get a lot of…. The classic one is ……we work in areas where there is quite a lot of forceful, heavy work and we have battled long and hard to change culture, change the attitudes towards resting with all these."

The misconception that rest is the appropriate course of action remains a problem. There is still a need to spread the message that activity aids recovery.

"Tennis elbow",

"This is probably one group of people that we battle most to get or keep at work with pain when other medical advisors are trying to keep them off work and resting, and so what we do is, we have an education process for managers and we obviously we try and educate the patient. We don't do hands on physiotherapy so we try to de-medicalise it, we try to explain to them the timescale over which tendons are likely to heal, we try to give them information about the evidence that …tendons need work to make them better."

However, the evidence base on ULDs is incomplete. With many conditions, such as carpal tunnel syndrome, it has not yet been established whether it is better to rest that body part or remain active. There is a need for randomised control trials on this.

"There is carpal tunnel syndrome which is not as simple as everybody thinks it is... And again there is an issue about whether they do better to maintain activity or whether they benefit from rest. I don't think we know at the moment."

…."*But most of the patients that we see have non specific arm pain of some sort or another. The expectation is that they are going to behave like non specific back pain and that they would do better if you tell them to, to keep active, but I don't think we have randomised control trial evidence like we do for backs, that they do better, and that is a desperate need. That is a real area of uncertainty where it would help to have a trial not least because one of the obstacles of telling people to do that is their employers are worried about getting sued."*

The existence of 'Red Flags' in ULD, as seen in back problems, is unlikely but this has not formally been established.

4.5 QUESTION 5. THE NEED FOR MODIFIED WORK TO BE MEANINGFUL.

The consensus was that modified work should be:

- Meaningful to prevent negative psychological sequelae
- Easy enough for the employee to perform.

There was unanimous agreement that work should be meaningful because otherwise it would have a negative psychological impact. It was thought that redeployment occurs in only a minority of cases. However, care should be taken to avoid redeploying a person into a job that is too difficult for them to perform. An example was given of a problem with fire fighters who want to return to front line duty as this has more status in the macho culture. As a consequence they are often reluctant to return to light duties such as a desk job, and would rather be signed off sick. This has been overcome to some extent by assigning the fire fighters to fire prevention work.

"Fire fighters notoriously don't like to come back to it unless they are front line - that is the macho element... They are getting round that now in that a lot more guys are going out on fire prevention activities, visiting people's homes, fitting smoke alarms..."

4.6 QUESTION 6. THE DURATION OF MODIFIED WORK, PROGRESS REVIEW AND RISK ASSESSMENT REVIEW.

Work restrictions should be:

- Time limited

- Gradually increased
- Tailored to the individual
- Reviewed by the case manager

An example of a 'ramp up' was given:

- Week 1 – 25% of usual workload
- Week 2 – 50% of usual workload
- Week 3 – 75% of usual workload
- Week 4 –100% of usual workload

The length of time that work restrictions are kept in place was discussed. In principle activity is gradually increased over a fixed period. This varies according to the condition and each individual's progress. At Toyota, activity is usually increased over a period of 2 to 4 weeks. Work restrictions are rarely in place for longer than 8 weeks. The standard ramp up is 4 weeks. In week 1, the employee performs 25% of their normal activities. This increases to 50% in week 2 and 75% in week 3. By week 4, 100% of usual duties are performed.

It was felt that the person appointed to coordinate the RTW plan should perform the review; this could be the case manager. It was seen as important to make the distinction that some work modifications are permanent, for example, equipment whereas some are temporary, such as work organisation.

"So I think we need to acknowledge that some of the modifications are going to be permanent but the work organisational issue is probably going to be transitory, and should be transitory."

4.7 QUESTION 7 SPECIFIC BARRIERS TO RETURN TO WORK WITH MSD.

There are numerous obstacles to RTW with MSD. Some of these are individual and some are organisational. These include:

- Inappropriate diagnosis
- Poor advice
- Slow access to professionals, such as physiotherapists
- Loss of confidence
- Beliefs (yellow flags)
- Lack of knowledge
- Lack of support.

The ranking of these varies from one circumstance to another.

4.8 QUESTION 8. THE USEFULNESS OF THE BIOPSYCHOSOCIAL APPROACH.

The model can be helpful when it is well understood. Problems may arise when:

- Unhelpful judgements are made.
- Practitioners lack the skills to handle psychological issues.
- People become labelled as difficult.
- Practitioners do not understand the factors that mediate pain.

It is important to:

- Recognise that all health issues comprise both physical and psychological elements
- Acknowledge the problem as genuine.
- Convey the right information.

The biopsychosocial model was thought to be useful when it is properly understood. However, it can be misused, and unhelpful, judgemental inferences are sometimes made. It was questioned whether Occupational Health professionals have the necessary therapeutic skills to handle the psychological elements of the problem.

"if it is handled not so well it can come across as your saying to that person it is all in your mind."

"in that sense it is quite skilled in getting those messages across without sort of putting them off completely"

"I think the biggest problem is because a lot of these problems have been not necessarily managed in a way to help people get better or back to work. They get labelled difficult."

Therefore, it is important to acknowledge the problem as genuine. It is unhelpful and a waste of time to argue about symptoms. No health issue was thought to be all physical or all psychological. Practitioners need to understand the factors that mediate pain. The importance of conveying the right message and accurate information was also emphasised.

"People want to actually know that, and be reassured that they are not going to do themselves any harm."

"We have got the back book. We need an upper limb disorder book."

4.9 QUESTIONS 9 AND 10 WERE NOT DISCUSSED BECAUSE OF TIME LIMITATIONS.

4.10 QUESTION 11 ADVICE AND SUPPORT FOR SMALLER ORGANISATIONS.

Smaller organisations lack the resources of larger companies, such as, an Occupational Health or Human Resource Department. In these circumstances the line manager's role is crucial. If well informed and interpersonally skilled the line manager can:

- Provide a detailed understanding of the workplace
- Dispel myths
- Allay fears
- Provide support

Other resources of potential use to smaller organisations include:

- Workplace Health Connect
- The Back Book
- Working Backs Scotland

Although it was acknowledged that small companies do not have the luxury of an Occupational Health Department or a Human Resources Department, it was thought that there are still many actions that can be helpful. In small businesses the role of the line manager is crucial. Many simple modifications can be made which could be viewed as practical common sense. Line managers are well placed because they have an understanding of the workplace. One problem for smaller companies is that they often lack the resources to attend workplace seminars and conferences, which could be a source of up to date information. However, armed with the right information, line managers have huge potential to dispel myths and allay people's fears about returning to work. They are also in a strong position to provide the employee with the support they need to return, provided they possess the necessary interpersonal skills.

HSE has a scheme to assist small and medium size enterprises (SMEs) known as Workplace Health Connect. This is being piloted in 5 regions, and consists of a 3-tier service. The first tier consists of a telephone advice line, a website and outreach events to provide free advice and information. The second tier consists of a free problem solving service available upon an employer's request. This includes specific advice on risk assessment, 'best practice', RTW and signposting to specialist support. The final tier is not free and comprises approved specialist support from professionals such as physiotherapists, ergonomists, occupational health physicians and occupational health nurses.

The Back Book was cited as a useful resource, however, it needs to be more widely circulated. It has been available for a long time, and problems persist with some practitioners being uninformed and giving erroneous advice. The Working Backs Campaign in Scotland also promoted the 'Stay Active!' message and provided a free advice line on back pain.

4.11 SUMMARY OF ULD GROUP

The specific diagnosis in upper limb disorder is probably not critical to fitness for work activities unless there is an inflammatory condition. The workplace management is the same for all other conditions, and consists of maintaining activities. The evidence base on this is limited at present; however, the consensus of the group was that activity should be maintained. The message promoted in the Back Book should also be used for people with ULDs. A similar book written for people with ULDs is needed. More work is needed to establish a full evidence base on ULDs.

Work modifications may involve performing the same job in a different way, with adjusted equipment or new equipment. It may involve doing the same task but with altered hours. This

can be done in a number of different ways, such as, returning to work midweek, to ensure the employee works two days, then has two days off. Alternatively, (or as well) a worker could return to work on reduced hours per day to establish a routine of daily attendance. The number of hours worked per day could be increased gradually until the usual hours of attendance are reached. This gradual approach can have psychological and physical benefits. Another type of work modification may involve omitting a task, or avoiding a particular tool. Finally, the last option would be to perform a different job. It is important to recognise that some modifications are permanent, such as a new keyboard, whereas some are only temporary, such as a gradual increase in number of hours worked. This increase should be phased in over a number of weeks rather than months. The plan should be individually tailored and should be reviewed, to check that symptoms are not increasing and the problem is not becoming worse.

The problem of GPs inappropriately prescribing rest and signing people off sick was raised. More needs to be done to effectively communicate to medical personnel that experiencing pain does not necessarily mean an individual cannot work. However, the evidence base on ULD is incomplete. There is a need to clarify the circumstances in which rest is advised. It seems likely that rest is appropriate in only a minority of cases. These involve acute inflammatory conditions (tenosynovitis). However, this has not yet been confirmed, and more research is needed.

A return to work plan, with consideration of job modifications, should be formulated within 2 weeks of an employee going on sick leave. If it is done 4 weeks after the absence commenced, it is likely that problems will ensue. It was recognised that timing can be disrupted by limited resources. The supervisor/line manager is essential to the RTW process. The Human Resource Department should be involved if the company has one. However, small companies are unlikely to have this facility. Different individuals will assume the role of coordinator according to the resources available. In the case of large organisations, the Occupational Health Department or the Human Resources Department can assume the role. In smaller organisations the line manager may act as coordinator. The importance of full and active participation by the employee was also emphasised.

Meaningful work should be offered to people when returning to work to avoid negative psychological effects. Attempts should be made to avoid over demanding work. The duration of modified work will vary according to the individual, however it should span a short number of weeks and not last for months. The exact number of weeks will vary according to the progress made. The coordinator should review this.

There are numerous obstacles to RTW with MSD. Some of these are individual and some are organisational. These include inappropriate diagnosis, poor advice, slow access to professionals such as physiotherapists, loss of confidence, beliefs (yellow flags), lack of knowledge and lack of support. The ranking of these varies from one circumstance to another.

The biopsychosocial model can be a useful tool. It is important to recognise symptoms as genuine to avoid stigmatising the individual and causing alienation, which will be unhelpful to the RTW process. People with ULD need to feel that they are being taken seriously. This will help establish trust, which is necessary for them to accept the advice to stay active.

5 SUMMARY OF GROUP 2 DISCUSSION: LOW BACK PAIN.

5.1 QUESTION 1. DELEGATES' EXPERIENCE OF OFFERING MODIFIED WORK, AND SPECIFIC EXAMPLES.

The discussion generated an extensive list of problems and solutions in offering modified work. Several examples were given.

5.1.1 Problems:

- Resentment (uneven distribution of heavy work)
- Job design can limit the options for modified work
- Fear of Litigation
- Terminology
- Each case is individual, therefore generic advice can be hard to formulate.

5.1.1.1 *Resentment*

Offering modified work to some employees may give rise to resentment on the part of the remaining workers. A small group of people may be left to undertake all the heavy work.

"There seems to be more and more job rotation type of things coming in and what happens is that someone with a problem comes back and then they are doing all the lighter things, and the other people actually haven't got as much opportunity to have those things……….I have come across a number of situations where this has become something of a problem and that causes resentment between people, it actually makes it more difficult for someone to come back working for you."

However, it was noted that some modifications lead to benefits for all employees. For example long manhole keys were provided for one employee, and subsequently for all staff.

"…you change them to lifting in a much better position at knee height it has got to be a good ergonomic change that should be applied across the board not just for those with back pain."

Therefore, some solutions help everyone. For example, awareness of good manual handling techniques was increased across the entire work force, following the experience of one employee. Another example given involved a production line, which was working twice as fast as another, but was also incurring more injuries. Ergonomic assessment of the job led to improvements for everyone, not just those who were injured.

5.1.1.2 *Job Design*

Another problem highlighted was that some jobs have extremely narrow job descriptions. This leaves very little scope to introduce modifications to the job. An example was given of a supermarket chain, which has a system whereby van delivery drivers work 12-hour shifts.

"…van delivery drivers all work 12 hour shifts and they do a hell of a lot of deliveries and that is the way the system works. There isn't any slack in there at all."

"But I think the problems is... they haven't got that control and flexibility, they are there and they have got to do whatever is thrown at them."

This problem is circumvented in the ambulance service by sending out the employee as an extra, so that another worker can undertake any tasks the returning employee feels unable to perform.

"And we send them out ....a third man and building up their lifting capabilities so that as they become able, they can test themselves on tasks. And alongside that we have got the rehabilitation programme building their competence and building their capability, and that works very well".

However, it was acknowledged that small companies may have insufficient resources to fund this type of measure.

5.1.1.3 *Fear of Litigation*

Many employers do not wish to consider offering modified work because they believe encouraging employees to return before they are fully fit, could lead to legal proceedings and compensation claims.

"The biggest barrier for most companies is the fear that if they have somebody back before they are a hundred percent fit, they are going to re-injure, they are going to have another claim on their hands. And they need to know that it is okay to negotiate and to get the person back in."

5.1.1.4 *Terminology*

It was suggested that transitional work arrangements would be a better way of describing work modifications because it conveys the temporary nature of the arrangements. It also avoids the implication that the work was in some way wrong or harmful and required modification. Transitional work arrangements are all about facilitating return to work (or work retention) for the symptomatic worker. They are not about making work safe – their need does not suggest there was a problem with the work initially.

"I think transitional work arrangements are better. It is a facilitated thing. .... It is moving from one place to another, it is there for a purpose, it is not saying the work was clearly wrong in the first place and must have damaged you therefore we have to modify it,..."

5.1.1.5 *Each case is individual*

Attempts to provide generic guidance on modified work can be difficult because each case is different and entirely individual. Therefore it should be assessed according to the specific details and circumstances of the individual.

"you can't really tell employers what they can do to get people back to work because cases are so individual"

Instead it was suggested that a system of assessment could be formulated and training recommended on appropriate communication skills to conduct the process.

"...what you can do is you can have a system for employers in assessing cases..."

"...I think much simpler is how do you communicate with people, how you negotiate..."

5.1.2 Solutions:

- Partnership working
- Positive approach
- Ensure SMEs have access to professionals
- Consider the context
- Further disseminate HSE information and improve HSE contact with Employers
- Job descriptions
- Allow more time to do the job (Royal Mail example)
- More focus on work during treatment (especially medical profession)
- Ensure modified work is time limited and focused on change.
- RTW plan should set increments for change.

5.1.2.1 *Partnership Working*

For work restrictions to be successful, it is important that all those involved take an active interest and accept responsibility for their implementation and review. This is especially important in the case of line managers.

"That is why we work to our timetable. The manager has the timetable. The person is signed up and needs to give it to the manager in person, to be their responsibility. And each time they see the physio,… the physio reviews it and then another little note goes back to the line manager confirming it ……if you don't tightly manage it, it is very easy for it to drift."

Therefore, the line manager has a significant role in monitoring the return to work plan. He/she is responsible for driving it forward and checking it is on schedule. There may be a number of people involved but the line manager has overall responsibility, and liaison with all is important. Problems can arise when there is disagreement between the parties involved. For example, a manager may agree to a return to work plan, but the line manager disagrees with it and does not comply with it.

5.1.2.2 *Positive Approach*

The importance of taking a positive approach when considering work modifications was also discussed. Putting the emphasis on employees' capabilities rather than their limitations was thought to be more helpful and effective.

"'*What can you think about in your job that we can change to enable you to get back to work?' -which is quite different from:' what can't you do?' Switch it to a can do approach …"*

5.1.2.3 *Ensure SMEs have access to professionals*

It was noted that larger organisations often have the advantage of greater resources and therefore can access specialist professionals, such as occupational health physicians and physiotherapists, more easily and quickly. One physiotherapist remarked:

"…it is so much better if we are on site. And if we are not on site it is so much harder. We have very strong links with the occupational health team and we regularly liaise."

By contrast small and medium sized enterprises (SMEs) usually do not have an occupational health or human resource department. They need access to professionals. This can be limited by cost.

"I think you can't just put the responsibility down to occupational health. Yes the large organisations will have access, but you need to be giving guidance to the smaller industries…."

It was thought that the role of the line manager was especially important in the case of SMEs.

"..but you need to be giving guidance to the smaller industries, to managers to say: 'ring that person up', and get them to engage with the individuals and keeping the individuals ….keeping people in work is a crucial thing"

However, specialised professionals were not thought to be necessary in every case. Some instances will not require their involvement.

"It is interesting talking about the use of professionals. Again they may not be available to small employers, and the other issue is that of the use of professionals getting in the way of what actually is often very common sense."

It was also noted that the individual is often a good judge of what will facilitate return to work. He/she can often make practical suggestions. This underlines the importance of negotiation and contact.

5.1.2.4 *Consider the Context*

The importance of looking at the context in which the employee works when considering return to work issues was emphasised. As mentioned above, each case is highly individual. The circumstances vary enormously from one instance to another. When modified work is introduced, it impacts on the employee's colleagues and managers. Also, modified work does not have one discrete definition. It can take many forms.

"We have already heard about how businesses can virtually collapse if there are too many people in modified work. There are other effects on colleagues and managers. So the implication of prescribing modified work, if you will, is a risky business sometimes, unless it is very crudely agreed policies. The other thing is that modified work is all sorts of different things …"

5.1.2.5 *Further disseminate HSE information and improve HSE contact with Employers*

It was also highlighted that there is considerable scope to further disseminate the information HSE has already accrued on return to work issues such as HSG249 – HSE's guidance on sickness absence and return to work (HSE,2004). It was suggested that it contains helpful advice but that many employers would not read it.

"The book contains an enormous amount of good sense … … because the average employer, even the HR department or occupational health department aren't going to read it, and the small employers just are not going to go anywhere near it."

"So there is a lot more for HSE to do."

Therefore, the idea of work and return to work could be better promoted. There is also a need to ensure that all those involved in return to work issues are equipped with the right information.

It is vital to give a consistent message. The confusion caused to employees when they receive conflicting advice from different professionals was discussed.

"…a GP might say stay at home, the physio might give a different view - and the poor person sitting in the middle in complete confusion, doesn't know which way to go."

This further illustrates the importance of ensuring the right information is conveyed to the right people. To facilitate this, it was thought that HSE could improve its links with employers.

"So one rule for HSE is to start communicating about these issues such as what we collectively consider professionals should be adopting as good practice."

5.1.2.6 *Job Descriptions*

The formulation of job descriptions was thought to be a useful way of facilitating the implementation of job modifications. It would then be relatively quick and easy to see where adjustments could be made.

"One of the things that perhaps we are missing, and I think it might be quite easy to do, and that is a simple description, not ergonomically, but in terms of opportunities for shifting and influencing…dependent on colleagues as part of a team, there is a simple way of describing these things other than a detailed ergonomic analysis because one could then begin to talk about clustering jobs"

5.1.2.7 *Allow more time to do the job (Royal Mail example)*

Another way of offering modified work was suggested. This involved allowing longer to perform the usual duties. Royal Mail has used this approach.

"I wonder if actually giving people just a little bit more time to do their job is one way of modifying it."

"Within Royal Mail one of the things ….I would say somebody could go back to their duty but they still have ongoing problems, they are going to be slower so …expect normal delivery time would be 2 hours, you can expect them to take 3 hours and if the managers are aware of that, you can accommodate that.

And the individuals aren't coming back worrying saying 'I am not up to speed'. That is the only duty, because it is a small rural delivery office or small office, we say to managers they are going to take longer, the individual knows they have got that permission and that takes the pressure off them as well".

However, it was acknowledged that the narrowness of some job descriptions did not allow for this, such as, the supermarket delivery work described earlier.

5.1.2.8 *More focus on work during treatment*

It was also felt that some health care professionals could be more mindful of the work the individual does, during the treatment process. There should be a greater focus on work throughout treatment.

"But if you are an occupational physician or if you are a physio… … it is important for people to think about work all the time and think of the impact on people's behaviour. I think that is terribly important."

5.1.2.9 *Ensure modified work is time limited and focused on change*

There was general agreement that any period of modified work should be time limited and focused on change. However, difficulty can arise when setting specific time periods. Therefore, defining it in terms of progress and setting incremental targets, which are specific to the individual, could overcome this.

"What they did was they worked out the person's function, they worked out where they needed to get to, and they worked out 10% increments and 10 time slots they were encouraged to reach that target, and they could be different from one person to another person."

5.1.2.10 *RTW plan should set increments for change*

Another suggestion to ease the return to work process was to use a goal setting approach in the RTW plan, which comprises gradually increasing demands.

"We have the programme that set the increment and then we have the work that runs alongside and if at any point they stop making progress we get to a point where you have to confront the issue and sometimes it is a genuine disability issue and they need more medical help."

5.2 QUESTION 2.THE APPROPRIATE TIME TO CONSIDER WORK MODIFICATIONS.

A number of points were raised:

- Early contact
- Triage system
- Line manager referral within 2 weeks of absence
- The need to communicate with GPs
- Employers need more health knowledge and GPs need more job knowledge

5.2.1 Early contact.

It is impossible to define a standard time when job modifications should be considered because a variety of possible scenarios exist and each case is individual. For example, the employee might have an isolated 'one off' injury, or he/she might have a recurrent problem. However, early contact with the employee was thought to be highly important.

" ..but you need to be giving guidance… … to managers to say: 'ring that person up', and get them to engage with the individuals and keeping the individuals ….keeping people in work is a crucial thing"

This should also involve getting the correct advice to the worker at the earliest opportunity. For example, the Back Book was seen as a vital resource, which should be conveyed to workers with back pain as soon as possible.

"If you have got back pain, get it to them straight away. Give them some good advice, clear advice straight away..."

It was suggested that GP surgeries are the ideal place for copies of the Back Book to be placed, allowing easy and immediate access to accurate and up to date information. However, it was also highlighted that a proportion of employees with back pain will not visit the GP at all.

"...lots of people of course don't go to see their GP, they have a few days off work, they can talk to their line manager and they do get back to work and there has not been any health interface at all.

Early provision of modified work for employees could be seen as a positive step taken by employers, if the employee decides to make a case via the Disability Discrimination Act (DDA). This could provide an incentive to employers.

5.2.2 Triage system

A triage system of telephone advice could be used such as that used in Working Backs Scotland and Royal Mail. Occupational health nurses or physiotherapists can offer advice and fast-track referral to physiotherapy if necessary.

"One easy answer of a way to get advice is by telephone as well. One large organisation is now going to telephone assessments so you can do a lot. You can glean a lot of information over the telephone and give some sound advice on what the person has given...without having to organise a face to face appointment which is time consuming"

This also has the advantage of providing professional advice, which can be more reassuring to some individuals who are anxious about their condition, and believe it might be serious. It was acknowledged that some of the professionals involved in the return to work process lack the confidence and expertise to make a decision about the severity of an employee's condition, and need the advice of experts such as health professionals.

"The risk for a personnel person is they are going to say: 'I don't know whether this back pain is... or whether it is one where I really ought to get them off to the surgery.' And they wouldn't have the confidence that someone like a physio would have."

5.2.3 Line manager referral within 2 weeks of absence

An example of a system was described whereby line managers refer employees to the occupational health department after an employee has been absent for 2 weeks. This would trigger an occupational health assessment performed by telephone. This way employees were assessed, and those who required physiotherapy were fast-tracked to the service.

"...a telephone assessment would be taken through an assessment process, with the occupational health authority, they fast track physiotherapy".

However, questions were raised regarding GP involvement, and how the GP was included in the process.

"How does that sort of system interface with the GP? I was just thinking about, from an employers perspective, an employer will find it difficult to give health advice it is not what they do, it is not their job, and by employer I mean manager, line manager or whatever it might be, it

is not their job. Most people if they are concerned about their back pain for instance, will wander off to see their GP…"

5.2.3.1 *The need to communicate with GPs*

A mechanism is required to ensure that GPs are kept informed about the availability of /when their patients are working modified duties. The need to work in partnership, with all interested parties kept informed of progress and developments was reiterated.

"So the link there is between the employer and the GP for getting some sort of information about the health of the person and what they can do and when they can expect them back...."

The need for better liaison between employers and GPs was highlighted by another problem. Instances have been noted where GPs are misled about the work their patients perform.

"we have had the issue where postmen go into a GP surgery and will say I am a postman they fail to tell the GP that he doesn't walk the streets as….he stands in a nice warm mechanised office just sorting letters. So individuals can use that as well. So it is keeping the GP informed. A lot a GPs in good faith will say you are not fit to do that job but they don't realise that modifications can be made. GPs need to get on board.

5.2.3.2 *Employers need more health knowledge and GPs need more job knowledge.*

The overall consensus was that employers need more health knowledge. This will enable them to make informed decisions, and give employees encouragement to return to work without fear of causing harm. At the same time GPs need more job knowledge to enable them to make better decisions about sickness certification, and help their patients return to work.

5.3 QUESTION 3. THE IMPORTANCE OF LINE MANAGER AND HUMAN RESOURCE (HR) INVOLVEMENT, AND THE RETURN TO WORK PLAN

Discussion centred on the following issues:

- Role of line manager is crucial
- More training required for line managers
- HR role in preventing black flags
- Return to work plans are invaluable
- Stepped care and Trigger points
- Culture

5.3.1.1 *Role of line manager is crucial – more training required*

The role of the line manager was seen as pivotal. Line managers need more training, especially when they first take on any kind of management responsibility. This needs to cover a number of

areas including communication skills, problem solving techniques and absence management/return to work issues. A specific example of training was described:

"In our organisation we have sickness absence training for managers. HR does the sort of introduction on the policy etc, and then myself and the occupational health nurses look at how we assess and how we can return people to work. That tends to be generalised rather than specific to MSDs, but we are in a position to readily address some of the misconceptions that managers have about the whole process. And since we have been doing that it has made, I think, a very significant impact on …much less resistance for those people who have actually been on the training.

Training in problem solving techniques could equip line managers with the skills to work up an individual approach to modifications. The line manager needs good communications skills in order to gain an understanding of the problems the employee faces. The process should start with the line manager asking: "What can we do to help you come back?"

It was recognised that smaller companies might not have sufficient resources to allow for expensive training packages. However, in these cases there are still steps, which can be taken, such as making contact, conveying that the employee is valued and missed, and giving encouragement to return.

"The line manager …………….I am really sorry you are …really missing you …guidelines. When do you go to see your GP to make sure you are OK? Tell him that we would love to have you back and we are willing to have you in just for a cup of tea if necessary. Then the GP allows them to go and talk to the workplace about getting back, it is that sort of approach that you want. You are not discouraging …"

5.3.1.2 *HR role in preventing black flags*

The Human Resource Department can play an important role in preventing black flags (features related to organisational policy). An instance was related where a black flag undermined an early intervention approach.

"We came up with a massive black flag which completely wrecked the whole approach to an early intervention, which was a psycho social intervention and it was essential. Identification of the absentee occurred too late for our intervention to work, and it is just such a simple issue that, a nightmare"

Therefore, HR needs to ensure that absentees are identified early on to facilitate the return to work process. However, challenges exist regarding the safeguarding of personal information.

5.3.1.3 *Return to work plans are invaluable*

Return to work (RTW) plans can be an efficient way to ensure that all parties involved are aware of the situation and willing to participate. It provides a way of communicating, and gaining commitment. It also facilitates co-ordination of the process.

"It is a way of coordinating and communicating as well - the return to work plan. It outlines..having to talk to you, 'do you agree? We expect you to be able to return but we will review progress in 2 weeks or a month".

It was suggested that involving the GP in the RTW plan might circumvent some of the problems encountered by diverging professional opinions. As discussed, the confusion caused to some

employees, when their GP gives advice that is contradictory to that of the physiotherapist, might be averted.

RTW plans will vary according to the individual circumstances of the employee.

"There is going to be different types of work plan, return to work plans. I mean there is heavy duty RehabWorks stuff which is absolutely brilliant but it is utterly and completely inappropriate. The majority of people who go absent, they are not coming to you."

It was also highlighted that many employees will not require modified work at all.

"if you are going to introduce some sort of transitional work arrangement …it is not always going to be required…"

5.3.1.4 *Stepped care and trigger points*

A stepped care approach was suggested in which the employee is given the help they need and no more. The approach is flexible, but requires strong communication to be in place. The employee gets more help from a person who has more competence when the employee becomes stuck, or when agreement can't be reached. The approach avoids unnecessary complication. Atos Origin use trigger points in an approach similar to this.

"In the clinical literature, for early interventions, people have talked a lot about step care approaches. And it is almost like we are beginning to talk about. I don't know whether it is …..minor function but some way of general advice and moving up to second level advice, and you could attach increasing the requirements for competency as you get further down this line. There is a strong sense in the first couple of weeks you are taking …..on it that it should be the general educational approach and reassurance in maintaining contacts and if you start medlling more than that, maybe you are producing a …generic problem"

Many modifications can be simple to negotiate and accommodate.

"The point about these things is that a lot of things can be negotiated without difficulty and without action causing any problems to anybody"

5.3.1.5 *Culture*

A change in culture was highlighted as necessary. The notion that work is risky and unhealthy or harmful needs to be challenged. The need to simplify matters and de-medicalise the issues was stated.

"The fact is that simple things can often be done which don't need, which aren't going to cost the employer very much and which aren't going to significantly impact anybody, so why bother going to all the trouble of asking occupational health professionals or some intermediary, why not just do it and so employers need to make that judgement first of all. ' Is this difficult?' 'Is this easy?' 'Can I go along with this?'"

There was general agreement that there is more scope for public education about back pain.

5.4 QUESTION 4. MODIFICATIONS FOR NON-SPECIFIC LOW BACK PAIN.

The following ideas for modifications were suggested:

- Gradually increasing shift length

- Gradual increase in work load
- Expert reviews/monitoring
- Job coaching
- Repetition of training programmes, such as, manual handling

The Disability Discrimination Act (DDA) gives examples.

5.4.1.1 *DDA examples*

The Disability Discrimination Act (DDA) lists examples of modified work.

"If you read the DDA and one of the things is that it actually lists the types of modification which are prescribed. It is actually quite a helpful list. It is change or modifying the duties, assigning some duties to other people, modifying the working hours, modifying the type of work done, it has got a whole list in the Disability Discrimination Act which is quite a useful starting point from where to go"

However, some caution was suggested, as case studies can limit people's thinking. There is a need for each case to be considered individually.

"…but I think if you have got to get the ideas in place because people can be so restricted by just examples".

5.5 QUESTION 5. THE NEED FOR MODIFIED WORK TO BE MEANINGFUL.

There was unanimous agreement that modified work should be meaningful.

5.6 QUESTION 6. THE DURATION OF MODIFIED WORK, PROGRESS REVIEW AND RISK ASSESSMENT REVIEW.

The main points discussed were:

- When to stop transitional work
- The importance of setting expectations at the outset
- Regular reviews should take place and mutual agreement is required

5.6.1.1 *When to stop transitional work*

It was agreed that in some instances there comes a point when modified work should be reconsidered if no further progress is being made. An exact time frame for this is difficult to stipulate. However, it was suggested that if progress has reached a plateau, transitional work should be stopped.

5.6.1.2 *The importance of setting expectations at the outset*

It is important to set expectations at the outset, with some flexibility as time progresses. Extensions can be agreed according to the progress made. There was general consensus that goal setting is helpful.

"…negotiation at the beginning. 'We have agreed that we are going to give you …modified work or transition work load, we are going to try this for the next three weeks in order to get you back to full work. That is our goal. How does that sound to you? About three weeks or whatever. Lets do that and then you …'…and at the end of that agreed period you have got to review and hopefully they are back to full work"

5.6.1.3 *Regular reviews should take place and mutual agreement is required.*

Hence regular review is essential to monitor progress and ensure all parties agree to changes and extensions. A partnership approach should be adopted. However, in many cases it does not need to be a medical professional that monitors progress.

5.7 QUESTIONS 7 AND 10 WERE ANSWERED UNDER QUESTION 1.

5.8 QUESTIONS 8, 9 AND 11 WERE NOT COVERED.

5.9 SUMMARY OF LBP GROUP.

Offering modified work is not necessary in all cases. However, early advice is crucial. This need not always involve the Occupational Health Department (OHD). A system of triage by telephone may be useful. This involves telephone assessments by health professionals. Advice is given and fast track physiotherapist referral is possible. This enables return to work in a matter of days. Line managers can refer employees to this service. The Back Book should be more widely disseminated. There is a need for education of both practitioners and workers. Employers need health knowledge; GPs need job knowledge. A partnership approach should be adopted. An employee can often judge his/her own capabilities. A GP can ask questions about difficult aspects of the job.

The context in which an employee works is highly significant. Attitudes of managers and colleagues can have a far-reaching impact. The organisational culture is also important, as this can influence RTW. The nature of an employee's role is a factor, which may determine the degree of flexibility to provide work modifications.

Job descriptions should be used more widely. These can be particularly helpful to GPs, who may have no knowledge of the work undertaken, or the nature of the organisation in which the patient works. Job descriptions can also be a useful starting point from which to plan work modifications.

Modified work should be time limited with an emphasis on change. This could be better communicated by referring to them as transitional work arrangements. The importance of effective communication between all parties involved was emphasised. Transitional work arrangements are all about facilitating return to work (or work retention) for the symptomatic worker. They are not about making work safe – their need does not suggest there was a problem with the work initially.

There is a need for line manager training to enhance interviewing skills, knowledge and problem solving techniques. RTW plans provide a viable way of coordinating the RTW process, and ensure commitment. However, they need to be well managed and reviewed.

A number of barriers exist which impede RTW with MSD. The notion that an employee must be a hundred percent fit before he/she can return to his/her job often presents a problem. Health professionals giving conflicting or erroneous advice can be disruptive. They need to follow best practice advice. A lack of knowledge of 'soft skills' from management or HR can also be unhelpful. Job design, which lacks flexibility, can impede the RTW process. Some jobs offer

more scope for job accommodations than others. Other obstacles to the RTW process include fear of claims, perceptions of cost and poor communication.

Lists of potential modifications for specific disorders are potentially of little help, as each modification is specific to the individual and the job performed. This would also be a replication of reasonable adjustments described in the Disability Discrimination Act (DDA). Case studies may be helpful to illustrate the sort of measures possible. Training line managers in problem solving techniques was thought to be highly important. The key to success is using appropriate communication skills, but the so-called ‘soft-skills’ are sometimes lacking. ‘Stepped care’ may be used, which involves giving what is needed and no more. The line manager could initiate this by asking: “What can we do to help you come back?”

The duration of modified work should be negotiated at the outset. Flexibility is important and the plan should be reviewed regularly. Any extension to the duration of work modifications should be formally agreed, with an emphasis on mutual partnership.

6 FINAL SUMMARY OF WORKSHOP BY CHAIRMAN

The Chairman stated that an interesting and useful discussion had taken place and many relevant issues had arisen. He highlighted a number of important points.

There is a need to convey information to employers, GPs and the community at large.

Partnership is important. The employee must be engaged. This process should start before the onset of illness. This applies to any disorder. The employee should work with the employer to optimise the outcome.

It appears that the biopsychosocial model is accepted but there is a possible danger that the problem could be seen as "all in the mind". This is not true. Moreover, malingerers are rare. Thus, there should be a presumption that if a patient says he/she has symptoms, it will be accepted.

There are many similarities between back pain and ULD. The numerous diagnostic distinctions in ULD complicate the issue. The best approach is likely to be different for true inflammatory conditions. Therefore these should be distinguished. An expert opinion may be required to do this.

The evidence base is well established for back pain. It is better to stay active. The evidence for ULDs is limited, especially for non-specific arm pain. HSE should gather this empirical evidence. This is a future research requirement.

7 MAIN FINDINGS

7.1 CONSENSUS ON THE DESIGN AND MANAGEMENT OF MODIFIED WORK.

There was a great deal of consensus within and between the groups. Modified work can be introduced in a variety of ways. Each case is different; and should be individually assessed. It should be tailored to the individual. For this reason it is difficult to provide generic advice. However, there are some common themes, which have been highlighted during the workshop. Firstly, modified work is not always necessary. Many people with MSD will self-manage. They may not consult with a health care professional. They may take a few days off work, and then return without any adjustment to their usual work. However, for some, work modifications may enable an employee to return more quickly. In these cases, work modifications should be considered within 2 to 4 weeks of absence. There are numerous ways in which modifications can be introduced, such as allowing more time to do a task or working a shorter day for a limited period , or physical changes to the workplace and tasks. Each case should be considered individually. Problem solving skills are necessary in order to plan work modifications to suit the individual. A return to work plan should be formulated. This needs to be tightly managed, and regularly reviewed to ensure that progress is being made. If modified work is aimed at achieving a return to the original role it should be time limited and focused on change. Using the term transitional work arrangements may better convey the temporary nature of modified work.

7.2 SIMILARITIES AND DIFFERENCES BETWEEN LOW BACK PAIN AND UPPER LIMB DISORDER.

The similarities and differences between low back pain and upper limb disorder are shown in Table 1. There is well-established evidence that for the majority of people with low back pain, the advice is to ‘stay active’. Most people have pain originating from soft tissues, which will benefit from activity. The ‘stay active’ message does not apply when there is more serious pathology, indicated by the presence of ‘Red Flags’ The ‘stay active’ message needs to be better communicated to GPs, employers, employees and the general public. It appears that many are still unaware of or fail to act on this information and more work should be done to ensure it is properly disseminated.

It seems likely that the advice to ‘stay active’ should also apply to the majority of people with upper limb disorder. Acute inflammatory conditions may be an exception to this rule, but these are rare. This has not yet been formally established. The evidence base on upper limb disorder is incomplete, and more work is required. However, these conclusions are supported by anecdotal evidence from health practitioners.

Smaller organisations often have more limited resources and cannot offer some of the professional help that is available to large organisations, such as Human Resource and Occupational Health Departments. However, there are still many simple steps described in HSG249 – HSE’s guidance on managing sickness absence and return to work and INDG399 for smaller businesses, such as keeping in contact, which can be taken to facilitate return to work and the introduction of inexpensive work modifications. In these cases the role of the line manager is highly important. Also, the approach taken by the GP is crucial here. It is important that the GP is aware of the ‘stay active’ message, and has an understanding of the work undertaken by the employee. Job descriptions could be useful here. Further dissemination to employers of the appropriate messages on managing MSDs in the workplace may enable them to make confident decisions about RTW and modified work.

Larger employers often have access to specialised professional advice from for example, occupational health physicians and physiotherapists. This can be an invaluable means for the employee to receive accurate and relevant information to facilitate a rapid return to work. Partnership work between all those involved is important to ensure good communication. There is a need for agreement and collaboration between all. Case management may be appropriate for larger employers. Employee involvement in this process is essential. There is an ongoing need for training for line managers and using problem solving techniques to facilitate a return to work.

In some organisations there is the pervasive notion that work is harmful or in some way 'bad for you'. This is possibly derived from the alarmist way in which some health and safety material is phrased. There is a need to frame information more positively in order to give enabling messages to people with MSD. A focus on health and safety culture, attendance culture, open communication- regular early contact from managers - and a supportive atmosphere needs to be encouraged .

Table 1. Areas of convergence and divergence between backs and ULDs.

Applies to backs and ULD	*Applies to backs only*	*Applies to ULD only*
	The evidence base is well established.	**The evidence base is incomplete.**
Early contact from the line manager is crucial. More training is needed (interviewing, problem solving and knowledge).		
Greater education of GPs, employers and public in general is needed.	**Educational material has been published, such as the Back Book. Back book requires wider dissemination**	**ULD book is needed.**
The message to 'stay active' applies in most cases.	**The message to 'stay active' does not apply to 'Red Flags' (where there is serious medical pathology).**	**The 'stay active' message does not apply to acute inflammatory conditions. More research is required to establish whether the 'stay active' message applies to ULDs, in the same way as it does for backs.**
Managing sickness absence and RTW messages need wider distribution.		
Consistent and accurate messages around MSD management are needed to avoid confusing people.		
A RTW plan is advised, and should be formulated after 2 weeks (and definitely no later than 4). This should be tightly managed and reviewed regularly. Full and active participation by the employee is important.		
Modified work is not necessary in all cases, but early advice is crucial.		
Triage telephone advice for employees by an appropriate health care worker may facilitate early return in employees with MSD .		
Modified work should be meaningful .		
Modified work can be permanent, to reduce risk such as, introducing new/ altered equipment, or it can be temporary, such as, allowing more time to do the job.		

Applies to backs andULD	*Applies to backs only*	*Applies to ULD only*
Temporary modified work should not last more than a few weeks. The exact duration varies from one person to the next. Each case should be individually assessed and reviewed to ensure progress is being made and problems are not becoming worse.		
Transitional work arrangements may be a more useful way of describing modified work, because it conveys the temporary nature of the arrangements.		
Modified work can be introduced in a number of ways. The same job can be done a different way, such as, providing new equipment. The same job can be done with a change of hours, such as, a midweek return, or reduced hours per day. Tasks or tools can be omitted. A final option may be redeployment.		
Work context and culture is important. The attitudes of managers and colleagues can have a significant impact on the success of modified work.		
Brief job descriptions in functional terms developed through job analysis could be used more widely. These would provide GPs with the information necessary to make better decisions about RTW and sickness certification. In the absence of a job description, GPs need to ask patients what they actually do in functional terms.		
Functional job descriptions derived from job analysis may provide a starting point from which to plan work modifications.		
'Stepped care' may be useful. This involves giving what is needed and no more- avoiding over medicalisation and unnecessary use of expensive resources.		

8 RECOMMENDATIONS

8.1.1.1

- Target information better. (GPs, employers and general public)
- Wider distribution of Back book.
- Need a ULD book.
- Line manager training is needed.
- More research is required on ULD
- RTW plan is useful.
- Modified work is not required by all employees with MSD.
- The input of professionals is not required by all employees with MSD.

8.1.1.2 *Guidance on modified work*

A protocol for modified work could be developed to enable managers and employers to introduce it efficiently. This could provide general guidance about the steps to take and suggested time frames. Because each case is individual, a manual of suggested modifications may be impractical but there are best practice messages that can be disseminated.

8.1.1.3 *Education on Low Back Pain*

There is a need to establish ways of disseminating information and promoting the message of MSD management to GPs, employers, employees and the general public. It would be useful to find the best way to convey information to each of the above audiences. Possibilities would be to give employees the relevant information during induction training, running awareness campaigns, developing tools and training for GPs.

8.1.1.4 *Research on Upper Limb Disorder.*

Further work is required to establish whether and when the ‘stay active’ message applies in ULD. There is a need for randomised controlled trials to confirm when rest is appropriate and when it is not. This is required for the various specific diagnoses found in ULD, such as tenosynovitis and carpal tunnel syndrome, and also to non-specific arm pain. There is evidence that the ‘stay active’ message is useful in the management of many ULD, but it has not yet been formalised.

8.1.1.5 *Support and Advice for Small and Medium Sized Enterprise.*

Better training for line managers is needed. This should encompass problem solving techniques, communication skills, health knowledge and absence management. Other ways of disseminating information to employers could be sought. Establishing ways of enabling dialogue between GPs and employers would be useful.

8.1.1.6 *Advice for Large Employers*

Better coordination of the return to work plan is necessary. It should not be assumed that large employers have the correct knowledge, just because they have the resources. Training is also required for large employers. Promotion of a case management approach may be appropriate. It is important to avoid a mechanistic approach, and to engage line managers in the process.

8.1.1.7 *Culture*

There is a need to frame messages about working with MSD and maintaining activity positively in order to change culture. An environment that fosters self-care and encourages the individual to take responsibility for his/her own health and well-being is desirable.

9 APPENDICES

9.1 DELEGATE LIST

Name	Organisation
Ms Marcella Bailey	Atos Origin
Ms Penny Barker	Health & Safety Executive
Prof Kim Burton	Spinal Research Unit, Huddersfield University
Prof David Coggon	MRC Epidemiology Resource Centre, University of Southampton
Ms Clare Forshaw	Health & Safety Executive
Mr Mike Gray	Health & Safety Executive
Ms Margaret Hanson	Hu-Tech Ergonomics
Ms Gret Higgins	Health & Safety Laboratory
Ms Ann Hodgins	OHC Department, Toyota Motor Manufacturing
Ms Nicola Hunter	Bury Physio / RehabWorks Ltd
Ms Kay Jackson	Health & Safety Laboratory
Mr Ray Langford	Whiston Hospital, St Helens & Knowsley NHS Trust
Ms Rachel Lee	Health & Safety Laboratory
Prof Chris Main	Calderbank Research Unit, University of Manchester
Dr Serena McCluskey	Centre for Public Health Research, Salford University.
Prof Mike O'Donnell	Unumprovident
Dr Peter Oliver	Flintshire County Council
Ms Hilda Palmer	Greater Manchester Hazards Centre
Ms Judith Pitt-Brooke	East Midlands Physiotherapy Clinic
Mr Doug Russell	USDAW
Dr Julian Smith	
Dr Kate Sparks	
Dr Keith Wiley	Health & Safety Executive

9.2 DELEGATE PEN PICTURES

Ms Marcella Bailey is an Occupational Health Nurse who works for Atos Origin, an International Occupational Health provider. In this role she has worked with the Royal Mail Service tackling MSDs.

Ms Penny Barker a Biomedical Scientist in HSE's Corporate Medical Unit and works with the Musculoskeletal Disorders Programme on return to work issues and the evidence base for occupational upper limb disorders and back pain.

Prof Kim Burton is Director of Spinal Research at Huddersfield University, which specialises in the biomechanical and psychosocial aspects of occupational low back pain. Kim is an Ergonomist with a clinical background, and has contributed to the development of guidelines for the management of back pain in primary care and occupational health.

Prof David Coggon is Professor of Occupational and Environmental Medicine at the MRC Epidemiology Resource Centre at Southampton University. Two of his main research interests are the relation of work to MSDs, and the translation of research into policy. He chairs the Government's Depleted Uranium Oversight Board, and from 2000 to 2005 he was Chairman of the Advisory Committee on Pesticides. In the past he has been a member of the Industrial Injuries Advisory Council.

Mrs Clare Forshaw works in the biomedical section of HSE's Corporate Medical Group, and has responsibility for providing biomedical advice on exposure to physical agents and musculoskeletal problems. Recent work has involved developing case studies on cost benefit and reviewing the evidence base on return to work with MSDs.

Mr Mike Gray is an Ergonomist Specialist who leads the Health and Safety executive's ergonomics team within the Field Operations Directorate. He has over 25 years experience of applying ergonomics to occupational health and safety problems. He is the Chairman of the British Standards Committee on Anthropometry and Biomechanics. He has also helped to develop European standards on ergonomics design principles and workplace design.

Ms **Margaret Hanson** is an Ergonomist And Principal Consultant with Hu-Tech Ergonomics where she offers advice on ergonomic issues to a wide range of organisations. She has undertaken research concerning ergonomics for government and industrial bodies including HSE, and is currently developing guidance on MSD rehabilitation for HSE.

Ms **Gret Higgins** is a Chartered Occupational Psychologist within the Work Psychology team at the Health and Safety Laboratory (HSL). Gret has worked in Applied Psychology for 15 years, including 12 years at Jobcentre Plus providing occupational assessment and counselling to disabled people and their employers. Gret joined HSL in February 2005 to manage the Workability Research Program, a research program that includes return to work, disability and sickness absence. She also works with HSE's Public Services program to examine the causes and patterns of sickness absence in the public sector.

Ms **Ann Hodgins** is an occupational health nurse specialist who has worked at the ohc department at Toyota for the past 18 months. She is involved in assessing and treating msd concerns on initial presentation, and also advising on work restrictions. Ann has also conducted work in formulating an advised restriction list for common MSD concerns.

Ms Nicola Hunter is a Chartered Physiotherapist and Chartered Member of the Institute of Occupational Safety and Health. She set up Bury Physio, a private physiotherapy clinic in 1987, and RehabWorks Limited in 1997. RehabWorks Limited provides occupational health physiotherapy and multidisciplinary functional restoration programmes for people with long-term absence due to MSD.

Mr **Ray Langford** is an occupational therapist at Whiston Hospital, St Helens And Knowsley NHS trust. He runs a return to work programme for staff employed by the trust who have been on long-term sick leave.

Ms Rachel Lee is a member of the Work Psychology team at the Health and Safety Laboratory (HSL) in Buxton. Since joining in March 2005, she has been involved in the Health Models Review Workshop. This involved a stakeholder workshop, which reviewed the risk assessment approach and its applicability to complex health issues such as MSDs and stress. Prior to joining HSL Rachel worked as a general and psychiatric nurse.

Dr Serena McCluskey (nee Bartys) is a Research Fellow at the Centre for Public Health Research based at Salford University. She has conducted research into organisational obstacles to recovery from Musculoskeletal Disorders (MSDs) and psychosocial influences on absence due to MSD.

Prof Mike O'Donnell is Chief Medical Officer at UnumProvident and an accredited specialist in occupational medicine. Prior to taking up his current post he was responsible for all medical advice to the National Health Service Pensions Agency and advised a number of other Government bodies and commercial organisations. His previous experience is in the nuclear, petrochemical and oil industries both in the UK and Middle East.

Dr Peter Oliver is an Occupational Physician with experience both in the private and public sector. He is currently working for Flintshire County Council and undertaking consultancy for Toyota Motor Manufacturing and Iceland Foods PLC.

Ms Hilda Palmer is the co-ordinator of the Greater Manchester Hazards Centre, and also runs a support group for people with repetitive strain injuries (RSI). She is a spokesperson for the Hazards Campaign, a network of resource centres and campaigns on health and safety at work.

Ms Judith Pitt-Brooke is a physiotherapist and was co-partner in establishing East Midlands Physiotherapy Clinic. She has a special interest in the management of painful MSDs and a desire to promote the use of the latest evidence in clinical physiotherapy practice.

Mr Doug Russell has been Health and Safety Officer at the Union of Shop, Distributive and Allied Workers (Usdaw) since 1986. He represents the union on several tripartite health and safety forums in the UK, and in Europe. He is also a member of HSE's Stress, MSD and Return to Work Project Board.

Dr Julian Smith is an Occupational Physician, has worked in various industries and HSE for four years. He is now involved with the Policy and Biomedical teams within HSE, dealing with rehabilitation and sickness absence issues.

Dr Kate Sparks is a Chartered Health Psychologist and joined the Work Psychology Section at the Health and Safety Laboratory in September 2005. She has several years of research and consultancy experience in organisational and health psychology, including workplace stress, bullying, working time and how these factors impact on employee well-being and performance.

Dr Keith Wiley is head of a unit in HSE's Policy Group, and responsible for developing policy on managing sickness absence and return to work following ill health or injury. Prior to this he coordinated HSE's health research programme.

9.3 QUESTIONS FOR DISCUSSION.

1 In general, have you found that offering modified work, such as a temporary reduction in hours, is a practical means to help employees back into work?

Note: The Back Book states (for an acute attack of low back pain) "stay active and at work, modify your activities…you may need some help from your workmates…simple changes can make your job easier…talk to your boss." And "either stay at work or return to work as soon as possible. If necessary ask if you can get lighter duties for a week or two." Can we elaborate on "lighter duties" with some examples?

Aim to share specific examples of modified work. Expand to cover advantages, what works, problems and barriers.

2. At what point after an employee goes on sick leave would you recommend assessing whether work modifications might be appropriate? Please frame the answer in terms of the time period and/or degree of function and/or level of symptoms used in making this judgement.

3. How crucial is the involvement of the supervisor/line manager to the process? Does HR have a role to play? How important is a return to work plan and who coordinates the plan?

4. What modifications should be considered for specific upper limb disorders and non-specific forearm pain (Group 1) or non-specific low back pain (Group 2)?

5. Does return to work need to involve offering meaningful work that meets a minimum standard (in terms of content, challenge etc)?

6. Is there consensus on time limits for modified work after return to work i.e. duration of the modified work? When should resumption to the original work be gradual and when is it unnecessary? Who carries out reviews to monitor progress and make any changes to the plan? How useful is a review of the risk assessment for the task?

7. Describe and rank specific barriers to return to work with MSD. (Omit if this has been covered adequately in Q1)

Managerial concern?

Lack of training/skills of managers?

Fear of civil litigation?

GP resistance?

TU resistance?

Colleagues' resistance?

Poor safety culture?

Poor communication?

The individual?

The nature of the tasks?

The type of MSD?

8. Do you, as practitioners, find the biopsychosocial model and approach useful when compared to the medical or other models? If so, how does it work in reality? Do you give information, encourage activity, self-care, identify barriers (e.g. yellow flags) and tailor interventions accordingly? (Are other models or approaches in use?)

9. How are ergonomists, physiotherapists and occupational therapists used?

Advice?

Modified work identification?

Treatment?

10. Do job descriptions help or should the employee be asked to describe actual tasks in functional terms as part of the process of agreeing modifications?

11. What particular advice and support can be offered to smaller organisations where specialist advice is absent and the only medical input for the individual is from a GP?

9.4 GROUPINGS FOR BREAKOUT GROUPS.

	GROUP 1 Upper Limb Disorder	GROUP 2 Low Back Pain
ROOM	Syndicate Room 204	Beijing Suite
FACILITATORS	Dr Julian Smith Assisted by Ms Rachel Lee	Ms Penny Barker Assisted by Ms Kay Jackson
DELEGATES	Ms Clare Forshaw Ms Margaret Hanson Ms Ann Hodgins Dr Serena McCluskey Dr Peter Oliver Ms Hilda Palmer Ms Judith Pitt-Brooke Dr Kate Sparks Dr Keith Wiley	Ms Marcella Bailey Prof Kim Burton Prof David Coggon Mr Mike Gray Ms Gret Higgins Ms Nicola Hunter Mr Ray Langford Prof Chris Main Prof Mike O'Donnell Mr Doug Russell

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