Summary Report

Work-related Musculoskeletal Disorders, a tri-sector exploration

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Revealing Reality

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1. Background and objectives

Work-related musculoskeletal disorders (WRMSDs) are widespread and have a significant impact on individuals, employers and the wider economy. In 2016/17, 8.9 million working days were lost due to WRMSDs, with 507,000 workers suffering from new or on-going WRMSDs and an estimated £2bn cost to the UK economy.

High rates of WRMSD-related sick leave put pressure on employers and businesses, hitting their bottom lines and potentially leading to understaffing, reduced productivity and lower staff morale. Directly affected workers not only suffer pain but also consequences that can be felt across their working, home and social lives.

The construction, healthcare and transportation and storage industries were selected as the focus of this research because they have significantly higher rates of WRMSDs compared with the average rate for all industry.[1] Qualitative research was commissioned to:

- Explore what employers and workers knew about WRMSDs and regulation.
- Explore employers' attitudes and perceptions of WRMSDs, their approaches to prevention and management and what was limiting engagement with health and safety issues.
- Explore the journeys of workers and how they have managed health challenges in relation to WRMSDs.
- Uncover the needs of 'both sides' to highlight barriers and opportunities regarding future intervention, communication and campaign strategies.
- Understand current workplace practice and inspire improvements in WRMSD prevention and management.

Sector similarities

As this report will detail, there are differences in the ways that these three sectors operate, their priorities, their cultures and their working practices; however, they also have some significant characteristics in common:

- Complex supply chains
- Widespread use of agency or temporary workers
- Operations across multiple sites
- Off-site and 'out of sight' workers
- Challenging contractual pressures and/ or performance targets

Workers in all three sectors often carry out repetitive and/or strenuous activities, placing them at a higher risk of MSDs.

[1] Work-related Musculoskeletal Disorders (WRMSDs) Statistics in Great Britain 2017

2. Research methodology

The research was divided into stages, with the learning from each phase feeding into the next. The project consisted of the following phases:

2.1 Secondary research

At the beginning of the project, 12 academics and industry leaders were interviewed. Their expertise informed the fieldwork and the rest of the project.

2.2 Employer and worker depth interviews

Qualitative fieldwork was conducted with 30 employers (10 per sector) and 45 workers (15 per sector). The sample covered employers and workers from a range of company sizes, on a variety of types of contract and in different roles.

Employer interviews were conducted over the telephone while worker interviews were split between face-to-face and telephone interviews.

2.3 Observational site visits and worker diaries

Site visits and worker diaries provided additional context for the interviews, enabling a richer understanding of what was happening on the ground.

- 9 site visits across the UK – 3 per sector
- 15 week-long worker diaries – 5 per sector

Throughout the project day-to-day working was observed, allowing comparison between people’s claimed and actual behaviours. Workers were shadowed and shifts joined to experience the physical environments and observe the availability and use of equipment. Intercept interviews were conducted with ‘harder to reach’ workers.

3. Caveats

3.1 Use of the terms musculoskeletal disorder and MSD

This report reflects employers’ and workers’ understanding of MSDs and interventions to prevent and manage them. In describing the findings, the term “MSD” is used as employers and workers used it themselves.

3.2 Report findings

The findings in this report reflect evidence gathered in three sectors: construction, healthcare and transport and storage. They cannot be generalised to workers or employers outside the scope of this research.

4. Main findings

4.1 Language and understanding

The terms “musculoskeletal disorder” and “MSD” were not consistently understood or applied by either employers or workers.

Some respondents barely used the term MSDs; when they did, or when asked about it, they understood it to mean a variety of different things. Some associated MSDs with just one or two specific physical problems, others with a wide-ranging but ill-defined set of physical issues, including some or all of the following:

- general injuries
- ‘fitness for work’
- obesity
- vehicle accidents
- manual handling
- vibration
- repetitive strain injury
- sedentary working
- awkward work, confined spaces and lifting

Language describing MSDs was often used interchangeably with broader ‘health and safety’ terminology**.** Employers and workers often pointed to general health and safety materials when asked what information was available about MSDs.

MSDs tended to be thought of by employers and workers in all three sectors as injuries, often specifically as the result of an accident, rather than conditions that develop gradually.

Employers found it difficult to determine the root cause of an MSD and whether it was work-related or relevant to the worker’s job**.** Many believed that while MSDs could be caused by the job or daily tasks such as bending, awkward positions or lifting, they also believed they were also due to natural ageing and lifestyle choices.

Employers said that back pain was the MSD they encountered most often, but many did not have detailed data to back this up.

4.2 Attitudes

MSD-related injuries were thought of as events that 'happen', and which often require immediate action. These were addressed in line with pre-existing workplace health and safety policies. This meant that accidents and incidents were much more likely to be reported, recorded and focussed on, rather than cases with a more gradual or cumulative onset.

Across all three sectors workers were aware that repetitive, strenuous or sedentary roles were the primary causes of MSDs. The risks associated with these roles were often compounded by challenging contractual pressures or other targets as well as different workplace cultures, e.g. a 'macho' attitude in construction and the 'patient-first' mentality of nurses in healthcare. In addition, corner-cutting and not using the correct equipment was common practice across all sectors, further increasing the risk to worker health.

In all three sectors, employers and workers had fatalistic attitudes towards MSDs and believed they had little control over their occurrence. They tended to feel either that MSDs 'won't happen to them' or, conversely, that they were an inevitable consequence of their role.

Both employers and workers saw MSDs as a shared responsibility. This had led to a stalemate, with neither employers nor workers displaying an appetite to increase or improve interventions. There was a general confidence among employers that they were doing everything that could be done via the preventative and managerial approaches to MSDs they were already taking. Workers echoed and were confident in their employers' approaches to MSDs. They felt it was their responsibility to follow the training and guidance provided by their employer.

4.3 Competing priorities

Employers and workers across all three sectors generally perceived MSDs to be of relatively low importance compared with other work-related health and safety issues. These tended to differ by sector. Examples included:

- Construction - site safety and respiratory issues.
- Transport and Storage - vehicle safety, accidents and slips, trips and falls.
- Healthcare - workers putting patient safety and care before their own health and well-being. Employers tending to prioritise workers' mental health, including stress and physical problems such as obesity and sedentary working. Repetitive Strain Injuries (RSIs) were sometimes given attention, but were not always classified as an MSD.

Motivation to prioritise the issue of MSDs was limited by other factors, not directly related to health and safety in the workplace. Examples included:

- Construction - the perceived replaceability of sub-contracted workers, limiting the importance of staff retention.

- Transport and Storage - the need to achieve time-driven delivery targets, meaning good practice was not always followed on the “shop floor”.
- Health – maintaining the balance between meeting stretching targets and performance indicators, amidst financial and budgetary challenges.

Employers across all sectors cited various “push” factors that influenced their attitudes and actions to address the issue of MSDs. These included:

- Legal requirements e.g. regulation
- Media coverage and company reputation
- Severe injury or death
- Company and workforce size e.g. unions influencing employers’ approaches and practices
- Worker feedback
- Political, cultural and societal factors
- Managerial empathy

The importance that employers placed on MSDs at strategic and operational levels directly affected the degree to which workers saw them as a priority, and vice versa. Multiple employers talked of a direct ‘trickle-down’ relationship between:

- Those who set MSD policy (employers, HSE)
- Those tasked with implementing policy (health and safety leads)
- Those who must follow the policy (workers)
- When employers did not attach importance to MSDs, their workers were unlikely to either.

4.4 MSD interventions

Employer interventions more often focused on the prevention of musculoskeletal injuries rather than the management of existing health conditions. Specific interventions sometimes differed by sector but manual handling training, posters, the provision of lifting / moving equipment and use of temporary workers were common across all sectors.

Preventative MSD interventions	Interventions to manage MSDs
• Risk assessments (all sectors) • Manual handling training (all sectors) • Posters / communications around the workplace (all sectors) • PPE equipment (construction and transport & storage) • Toolbox talks (construction) • Provision of equipment to aid lifting and moving • Automation (transport & storage) • Fast track physiotherapy (healthcare)	• Agency workers to cover MSD sickness absence (healthcare and transport & storage) • Agency workers to assist injured workers (transport and storage) • Job rotation to lighter duties (transport & storage) • Time off work (all sectors) • HR / occupational health, outsourced sickness absence management (healthcare) • Fast track physiotherapy (healthcare)

Table 1 - preventative and managerial MSD interventions

4.4.1 Equipment

Although available across all three sectors, equipment (e.g. for lifting or moving patients, materials, merchandise, etc.) was more readily available in construction and transport and storage, but workers often felt it hindered productivity and prolonged the task. In the healthcare sector, equipment availability varied significantly by hospital trust, department and ward.

4.4.2 Communications

For some employers, communications – usually posters – were the primary form of intervention cited to prevent MSDs. The places that posters were displayed (e.g. away from where work actually took place or in managers' offices) and their poor upkeep often gave the impression their content was of low importance.

The tone, messages and content of posters about MSDs or health and safety were often confusing, abstract, or seen as ineffective. The tone of communications ranged from legalistic and wordy to patronising, obvious and childish. Some posters had an authoritative or militant message that workers found disengaging.

4.4.3 Manual handling training

Training content was widely felt to be uninspiring and lacking relevance to workers' actual jobs or duties, for example manual handling training showing nurses how to lift boxes instead of patients. In addition, training facilities were often viewed as boring and sterile environments that brought back negative memories of school for workers. This deterred participation, attention, retention and implementation of information from these sessions.

The physical space and layout of these rooms did not promote physical activity – attendees were often sat down 'watching' rather than 'doing' and the content of training sessions had often been seen multiple times by individual workers. Out-dated technology further undermined perceptions of the importance and quality of training.

Training generally showed best-case scenarios, which rarely reflected the context, environment or equipment that workers experienced in reality.

4.4.4 Innovation

Employers' approach to MSD policy in the workplace tended to be reactive as opposed to pro-active. Health and safety policy was often only reviewed when an incident occurred, for example after a severe injury or death in the workplace, or when employers were told to do so, for example ahead of a visit by an HSE representative.

Overall, employers appeared to lack ideas about how they might improve their approach to dealing with the challenge of MSDs. There was some evidence that employers were attempting to improve existing interventions, like posters and

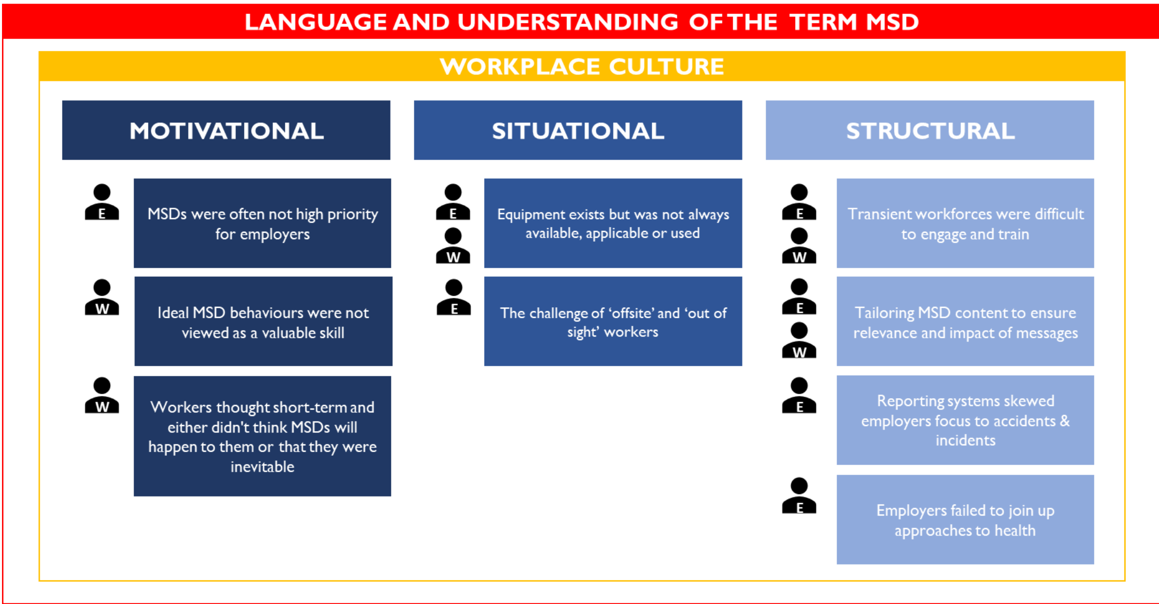
training. However, these were often only incremental improvements or minor updates that would be unlikely to significantly change outcomes.

Similarly, workers did not have high expectations of what their employers would be able to do and they accepted the status quo.

Interventions were largely focused on addressing physical risks. Neither employers nor workers demonstrated an awareness of the potential risks from the social or psychological factors. Factors such as stress, isolation, job dissatisfaction or perceived low social status have the potential to contribute to the risk and severity of MSDs, and limit the effectiveness of measures to prevent or manage them.

5. Barriers

Taking all of the research findings into consideration, nine cross-sector barriers were identified to improving approaches to MSD prevention and management.



All sectors lacked innovation, which had caused a plateau in effective interventions and a stalemate over whose responsibility it was to bring about improvements.

Behaviour change models can facilitate consideration of multiple, alternative ways in which MSDs could be better tackled. Assessing employers' current MSD interventions using a behaviour change framework showed there were many areas in each sector offering opportunities for improvement.

6. Opportunities

The research suggests a number of opportunities to improve the support provided to employers and workers, which HSE could explore in partnership with industry and other key stakeholders:

- Collaborating with industry to raise the profile and priority of MSDs, with solutions tailored or targeted to meet the needs of each sector.
- Raising awareness of the link between MSDs and other associated - but “higher priority” - occupational health conditions, for example stress.
- Reviewing the language around MSDs, to ensure greater clarity and understanding between HSE, business, workers and other stakeholders.
- Improving the relevance and quality of training and communications, and reinforcing the importance of messages through other means e.g. role modelling.
- Exploring how to reward the development and application of MSD prevention and management skills by workers – not just attendance at training.
- Considering how to encourage or coerce workers to use the correct equipment, when it has been provided, for example through the use of behaviour change techniques.
- Further consideration of the role of psychological and social factors in relation to MSDs, and how they can be effectively addressed.