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MSD: Safety Reps Survey

HSL/2006/20

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EXECUTIVE SUMMARY

Objectives

The study aimed to establish the role of Safety Representatives (SRs) in the workplace in the prevention and control of work related Musculoskeletal Disorders (MSDs), and to gather information in order to plan support and training for SRs. The study had five objectives:

1. To survey SR motivations for becoming safety representatives.
2. To establish SRs level of knowledge about MSDs and their prevention and control.
3. To establish what role SRs currently play in the prevention and control of MSDs in the workplace.
4. To survey SR attitudes about the prevention and control of MSDs in workplaces, and how they could be improved.
5. To survey what role, if any, SRs have in managing sickness absence and return to work plans.

Main Findings

The decision to become a SR was generally a pro-active rather than a reactive decision. The main motivations were an interest in health and safety issues, wanting to improve health and safety standards and the combination of SR and union steward roles.

Knowledge of a SR was related to the length of time in the role. In general SRs had a good knowledge about health and safety but less knowledge about MSDs, although they could often identify major causes and problems.

Companies with the highest Health and Safety (H&S) standards, as measured using the responses from SRs, effectively made use of SRs, particularly those with more experience. SRs with the most active roles came from workplaces with high H&S standards, high quality risk assessments, and which were unobstructive to SRs having access to training. Both employers and employees were more likely to consult experienced SRs.

SRs were keen to increase their knowledge about MSDs, and to attend further training in order to plug knowledge gaps.

Generally, SRs had minor roles in return to work plans, although professional help was widely used. More experienced SRs played a larger part in return to work plans.

Recommendations

Further training that is specific to MSDs is required. The prevalence and the severity of injuries justify a stand-alone training course, which is specific to MSDs.

Training needs to be tailored to the work environment of SRs, and the main MSD causes and problems that might be encountered in their workplace. Courses should distinguish between manual handling and DSE risks.

Training should be delivered by way of one or two day face-to-face courses.

1 INTRODUCTION

The Health and Safety Executive (HSE) commissioned the first of five modules on self reported ill health in the Labour Force Survey (LFS) in 1990. HSE used the survey to gain an insight into work related illness based on individuals' perceptions. The first survey was limited to England and Wales, with a second survey in 1995 covering Great Britain (GB). The third survey, commissioned by the European Union Statistical Office (EUROSTAT), followed in 1997/98. The final 2 surveys, commissioned by HSE in winter 2001/02 and winter 2003/04, and reported in Jones *et al.* (2003) and Jones *et al.* (2005), contained more detailed information on the causes of ill health.

Jones *et al.* (2005) estimated that 2,233,000 people (5.2% of people who have ever worked) in GB were suffering from illnesses that were caused or made worse by work. Furthermore an estimated 29.8 million working days were lost in 2003/04 through illnesses that were caused or made worse by work. Jones *et al.* (2005) reported that the average number of working days lost per work related illness was approximately 22 days, although this varied substantially according to the cause of illness, and on a case by case basis.

As part of the Government's 'Revitalising Health and Safety Strategy', HSE has a commitment to improving Health and Safety (H&S) at work, and reducing the incidence of deaths, major accidents and work related ill-health. Two specific targets, measured under the Public Service Agreement (PSA) relate to work related ill health:

- **PSA 2** To reduce the number of working days lost per 100,000 workers from work related injury and ill-health by 30% by 2010, and achieve reductions of 15% by 2004.
- **PSA 3** To reduce the incidence rate of causes of work related ill-health by 20% by 2010, and achieve a reduction of 10% by 2004.

The success of HSE policy in meeting these two PSA targets will be measured by comparing future data against the benchmark figures from the base year of 2001/2002 (with data from LFS 2001/2002 used to set targets).

Musculoskeletal Disorders (MSDs), which are defined as bone, joint or muscle problems affecting the back and upper and lower limbs, are the most common cause of occupational ill-health in GB. Jones *et al.* (2005) estimated that 1,108,000 people in Great Britain (2.6% of people who have ever worked) have suffered from an MSD caused by or made worse by work. MSDs account for approximately half of all occupational ill-health and account for 11.8 million working days lost every year, second only to stress with 12.8 million working days lost. The cost to the economy of MSDs has previously been estimated as £5.7 billion a year in 1995 prices (figures reproduced from Gyngell (2003), however the origin of this estimate is unclear).

The success of HSE in achieving its PSA targets is strongly dependent upon the success of policies that are aimed at achieving a reduction in both the incidence and number of working days lost to MSDs. One of HSE's key strategies for the prevention and control of MSDs is the use of trained safety representatives (SRs) in the workplace. It was thought that increasing SRs knowledge of MSDs and how to prevent and control them would reduce the incidence and severity of the diseases, thus contributing to the HSE PSA targets.

In order to realise the potential of SRs in the prevention and control of MSDs, HSE need to identify knowledge gaps of SRs, how training and interventions might be best delivered, and the part that SRs currently play in the workplace. To this end a survey of SRs, who had recently attended a health and safety training course provided by the Trade Union Congress (TUC)

through a network of trade union studies centres based in colleges of further education, was undertaken. The aim of the survey was to assess the role of SRs in the workplace in the prevention and control of MSDs. HSE also wished to gather information in order to plan further support and training for SRs if considered appropriate.

In all the survey had five objectives:

1. To survey SR motivations for becoming safety representatives.
2. To establish SRs level of knowledge about MSDs and their prevention and control.
3. To establish what role SRs currently play in the prevention and control of MSDs in the workplace.
4. To survey SR attitudes about the prevention and control of MSDs in workplaces, and how they could be improved.
5. To survey what role, if any, SRs have in managing sickness absence and return to work plans.

This report analyses the responses to the MSD questionnaire, which is referred to in this report as MSD 2005, and focuses on the five objectives given above. Where relevant, comparisons are made with a larger health and safety representatives' survey, commissioned by the TUC in 2004 and reported in Kirby (2004). For clarity this latter survey will be referred to hereafter as TUC 2004. The TUC 2004 survey had a broader scope questioning SRs about H&S as a whole rather than focussing specifically on MSDs.

2 SUBJECTS AND METHODS

2.1 QUESTIONNAIRE SURVEY

The MSD 2005 questionnaire was delivered to SRs that attended health and safety level 1 and level 2 courses run by TUC education during the 2005 April – June term. In total, 3898 questionnaires were printed corresponding to the number of places on TUC training courses that were scheduled. However, the courses would only run if there were sufficient numbers of attendees and of the courses that did run, not all were at capacity. As a result, it is not known at present how many SRs attended the courses precisely. However, based on 2004 figures approximately 1570 SRs are likely to have attended. A total of 620 questionnaires were returned to HSL and using the estimated total number of attendees a response rate to the MSD 2005 survey of 40% was achieved.

The questionnaire contained 46 questions divided into nine sections:

- Questions about yourself.
- Why did you decide to become a safety representative?
- Your workplace health and safety regime.
- Special activity over the last year.
- Return to work and rehabilitation.
- Your role in MSD prevention/control in the workplace.
- Inspections.
- Training.
- Questions relating to the MSD web pages (URL: <http://www.hse.gov.uk/msd>) on HSE's website.

The questionnaires were completed by the SRs and returned to HSL using pre-paid envelopes. The majority of questions were categorical and required the SR to respond by selecting one or more boxes, although there were some open ended questions requiring numerical responses, and some questions asking for written explanations. Written explanations were usually required in cases where the SR answered 'yes' to a filtering question, and they were subsequently asked to elaborate on their answer. The open ended numeric answers were categorised into ordinal groups (the groups suggested by the data) prior to analysis.

2.2 STATISTICAL ANALYSIS

All statistical analysis, tables and graphs were produced using STATA version 8. Spearman's rank correlation was used to measure association between two responses, chi-squared tests and Kendall's tau-b were used to measure association between ordinal variables and chi-squared tests were used to measure association between nominal variables.

3 RESULTS

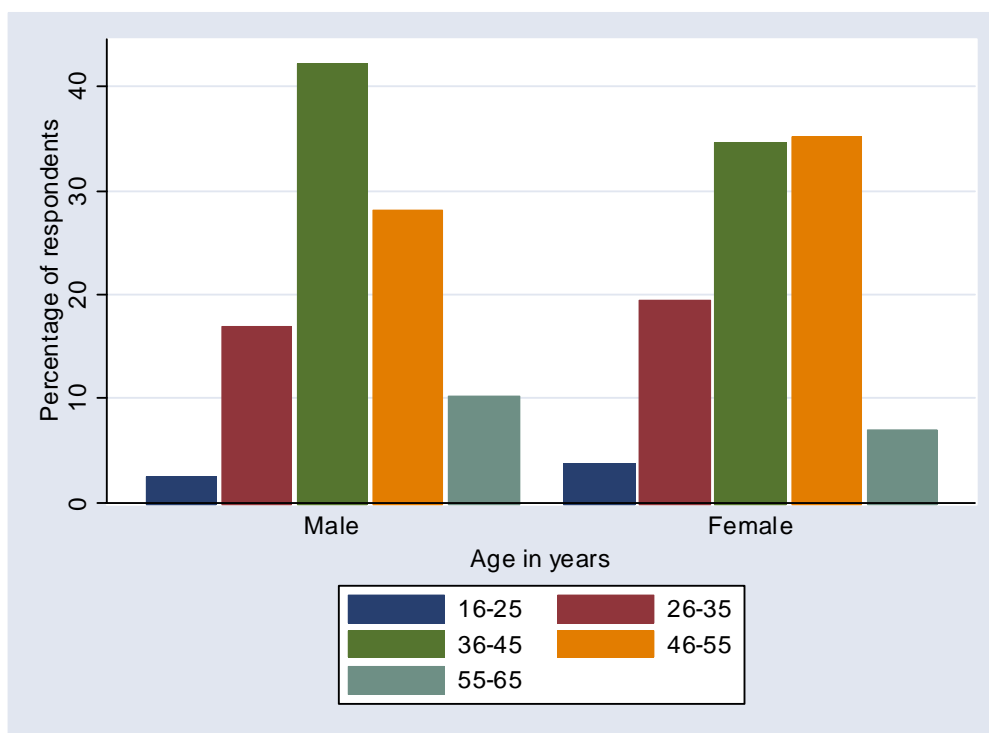
3.1 QUESTIONS ABOUT YOURSELF

3.1.1 Age and Gender

Of the responses to MSD 2005, 73% were from males and 27% from females. These percentages were almost identical to the responses from TUC 2004.

Figure 1 shows the ages and genders of the 609 safety representatives who responded to this question. Eleven SRs, ten females and one male, did not respond to the question.

Figure 1: Distribution of ages of Safety Representatives



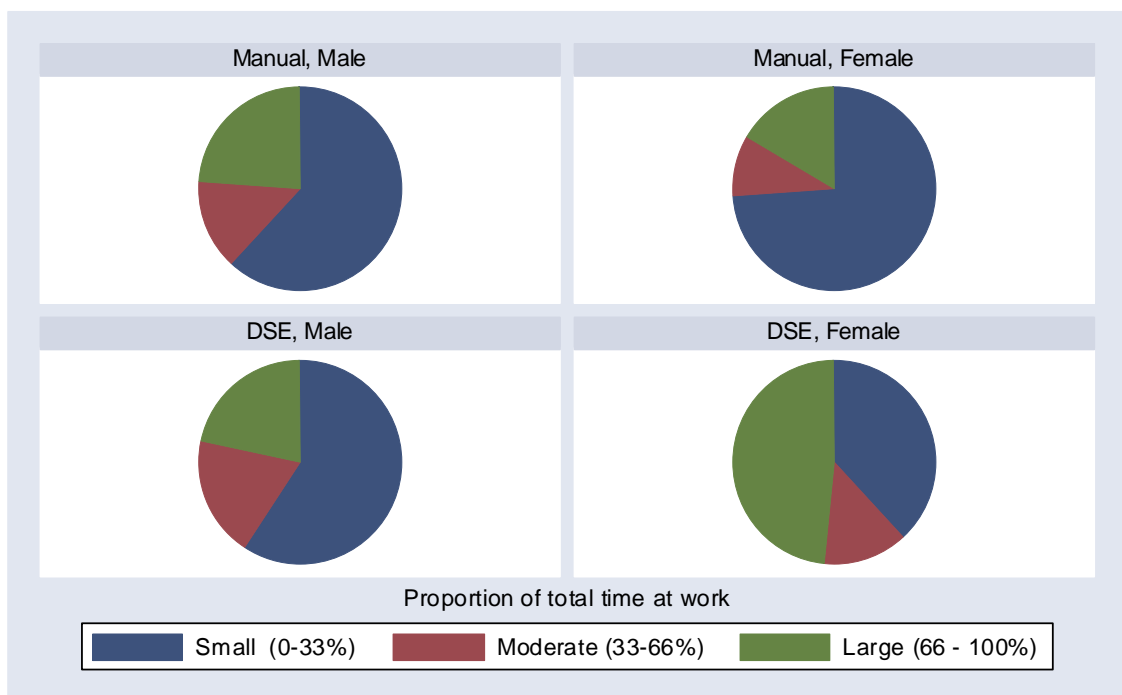
The youngest and oldest respondents were aged 19 and 63 years old, respectively. Mean ages for males and females were 43 and 42 years old, respectively and the majority of respondents were between 36 and 55 years old (approximately 70% of both males and females). The respondents to MSD 2005 were on average younger than respondents to TUC 2004. The latter survey had approximately 50% of respondents aged between 46 and 60 years old, and approximately 80% of respondents aged between 36 and 60 years old.

Further information concerning the ethnicity of SRs or their regional location within GB was not available and thus it was not possible to compare MSD 2005 with TUC 2004.

3.1.2 Type of Work

Figure 2 shows the amounts of time respondents spent on manual and DSE work by gender. The responses to the questions were open-ended and were grouped into three categories: small - less than 33% of time at work, moderate - between 33% and 66% of time at work and large - over 66% of time at work. The question was answered by different SRs in a variety of ways with some providing answers as the percentage of their working time they spent on manual and DSE tasks, whilst others answered in terms of hours per day/week/month. All answers were converted to the percentage scale, which required a subjective judgement and hence, the categories were chosen to be broad in order to minimise the possibility of error in this recoding.

Figure 2: Time spent by Safety Representatives on manual and DSE work

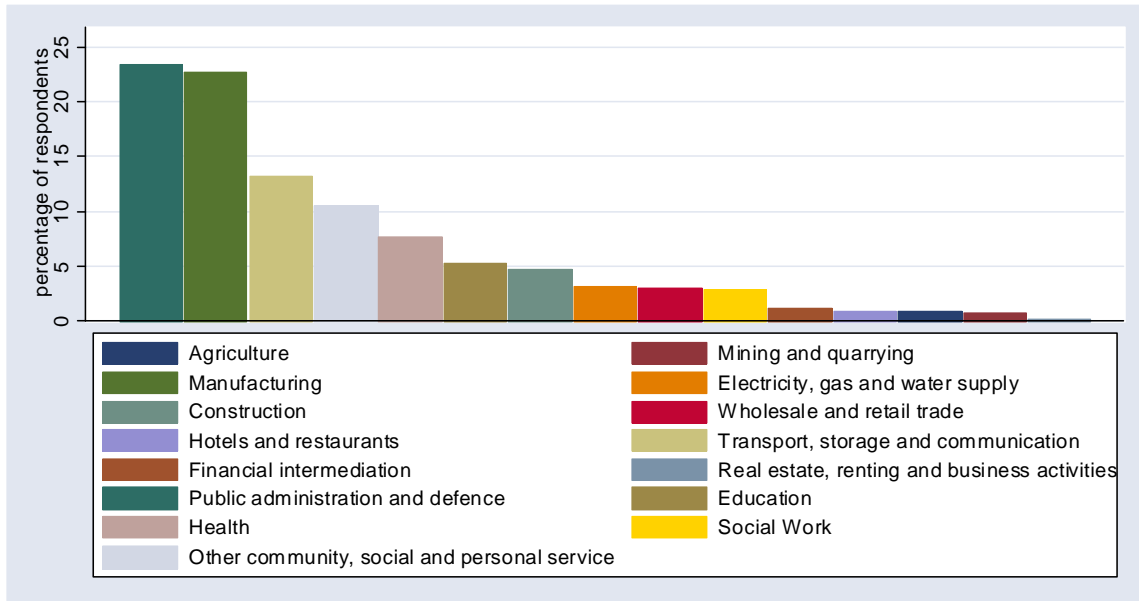


The male responses showed that similar proportions of SRs spent small, moderate and large amounts of time on manual and DSE tasks. Approximately 60% of males spent a small amount of time on DSE work, with a further 20% spending a moderate amount of time on DSE work and approximately 20% spending a large amount of time on DSE work. Likewise approximately 61% of respondents spent a small amount of time on manual work with 15% and 24% respectively spending moderate and large amounts of time on manual work. Results for females were noticeably different for amounts of time spent on manual and DSE work; approximately 75% spent a small amount of time on manual work, with approximately 12% spending moderate and large amounts of time on manual work. Approximately 50% of females spent a large amount of time on DSE work, with 12% spending a moderate amount of time and 38% a small amount of time.

3.1.3 Sector

Figure 3 shows which sectors that the responding SRs worked within. The occupations were classified by the top-level codes, sections A to O, of the Standard Industrial Classification (SIC) of economic activities ONS (2003). In some instances respondents failed to respond to this question, but appropriate SIC classifications were assigned based upon the respondents job title and description of their main job tasks.

Figure 3: Sector that SRs work within

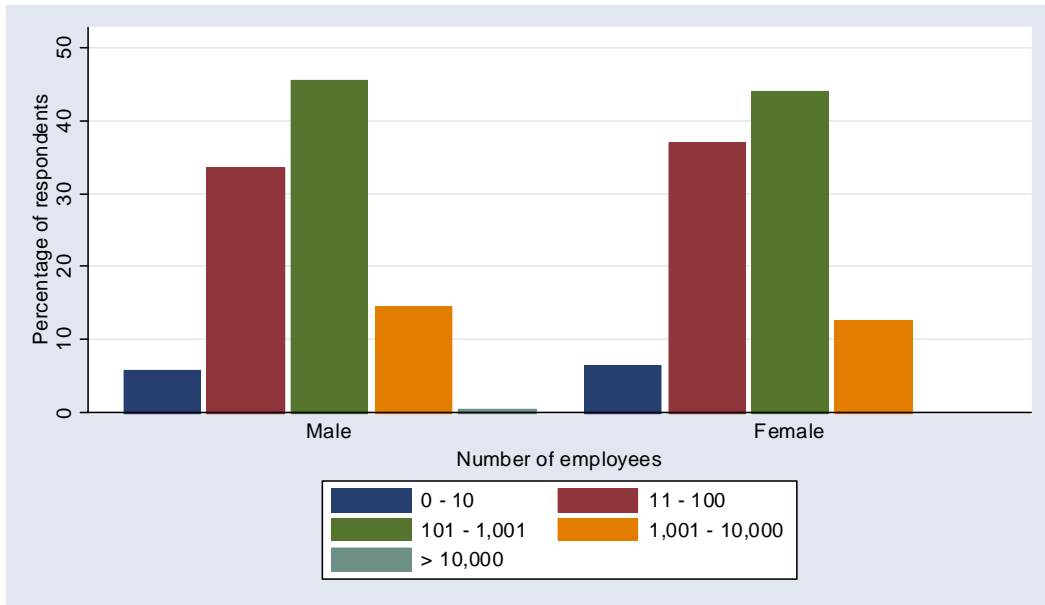


The breakdown of respondents into industries was broadly similar to that from TUC 2004. The two largest sectors, comprising of approximately 45% of all respondents, were manufacturing and public administration and defence. Many respondents also worked within the transport, other community and health sectors. These five sectors collectively accounted for over 75% of respondents.

3.1.4 Company Profile

Results of the number of employees located on the same site as the SR are given in Figure 4.

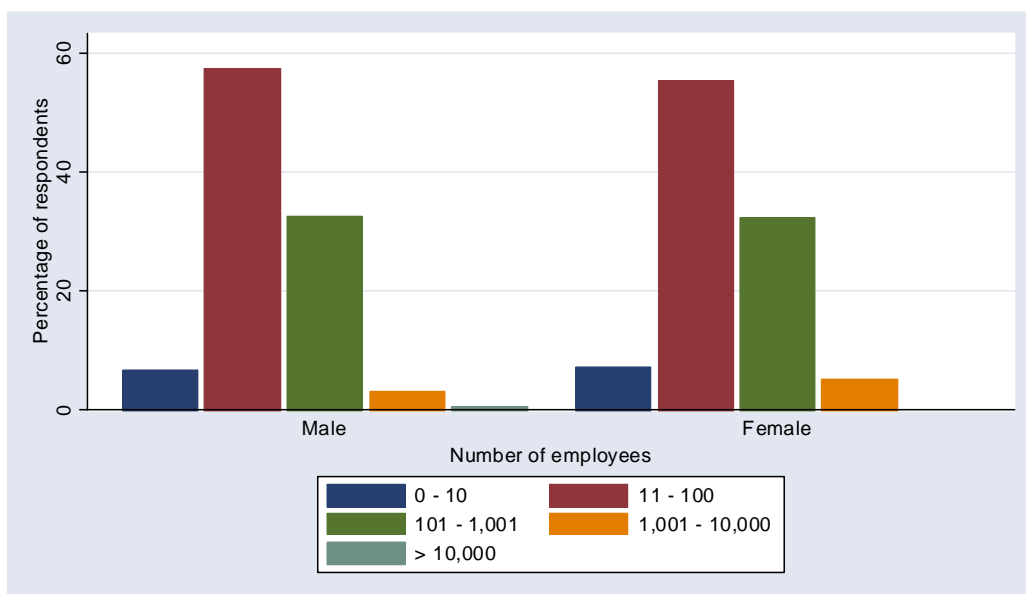
Figure 4: Distribution of the number of employees on site



The number of employees in the SRs workplace was extremely variable ranging from a minimum of 1 to a maximum of 20,000 with a median of 200 employees. The median was considered a better summary than the mean, 686, in this case since the distribution was heavily skewed. The number of employees on site was unrelated to the gender of the SR, and appeared to be consistent with results from TUC 2004.

The number of employees represented by the SR and gender of SR, are given in Figure 5.

Figure 5: Distribution of the number of employees represented by SR

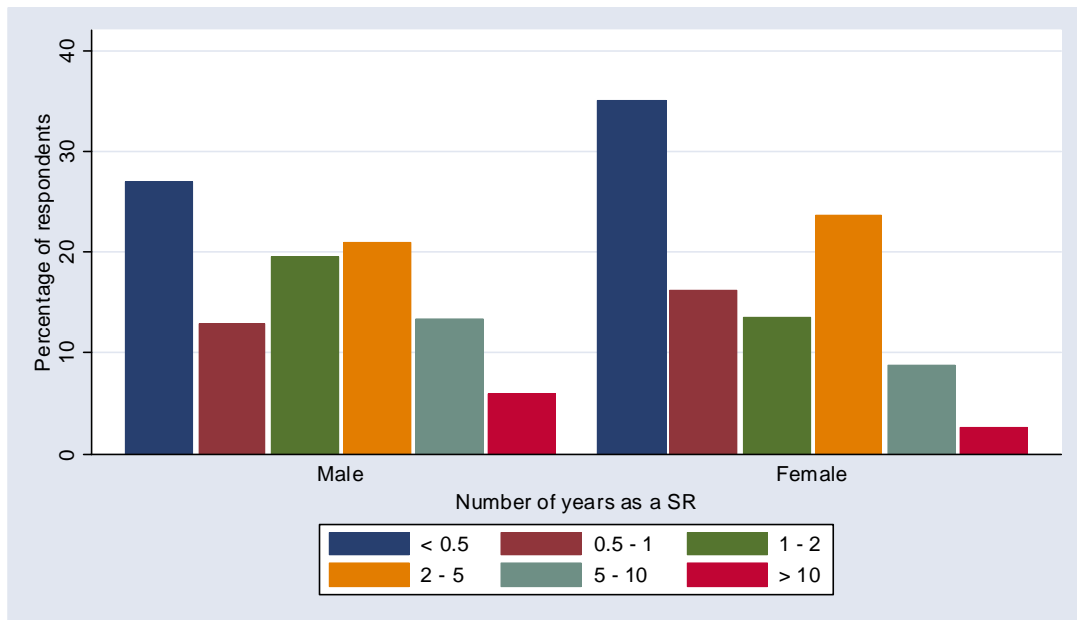


The number of employees on site was highly variable, ranging from a minimum of 1 to a maximum of 17,000 with a median of 67 employees. As Figure 5 shows, a large proportion of SRs represented between 11 and 100 employees. A detailed analysis of the responses was difficult because many respondents rounded their answers to the nearest 10 or 100 employees, whilst others gave a range in their response, e.g. between 100 and 300 employees. Given the large ranges provided by some respondents, there was a strong indication that many SRs were unaware of precisely how many employees they represented. In general, the analysis found that an SR was not responsible for more employees than were on site, although there were notable exceptions, with some SRs responsible for employees on various sites. Company size and the number of employees represented by the SR were weakly associated.

3.1.5 Experience

The responses to the length of time that SRs had been in the post and gender of SR are given in Figure 6.

Figure 6: Distribution of the length of time as an SR



The experience of SRs was extremely variable; the least experienced had been in the role for a few days whereas the most experienced SR had in excess of 30 years experience. For both males and females the largest proportion had been in post for less than 6 months (approximately 30% of all SRs responding to the question), and over half of these had less than 3 months experience. Approximately 40% of males and in excess of 50% of females had been a SR for less than a year. The length of time as a SR and the age of the SR were weakly correlated. These results were noticeably different from TUC 2004, where over 80% of respondents had in excess of one year of experience, and over a third had in excess of 5 years experience.

3.1.6 Summary Comments

In terms of gender, sector, company size and number of employees represented by the SR, the respondents to MSD 2005 were comparable with those from TUC 2004. However in terms of both age and experience of respondents the two surveys differed; respondents to MSD 2005 were, in general, younger and less experienced than those responding to TUC 2004.

The analysis of background information about SRs highlighted some correlations.

- Gender was associated with the type of work done by the SR (DSE or manual)
- Age was associated with the length of time as an SR
- Company size was associated with the number of employees represented by the SR.

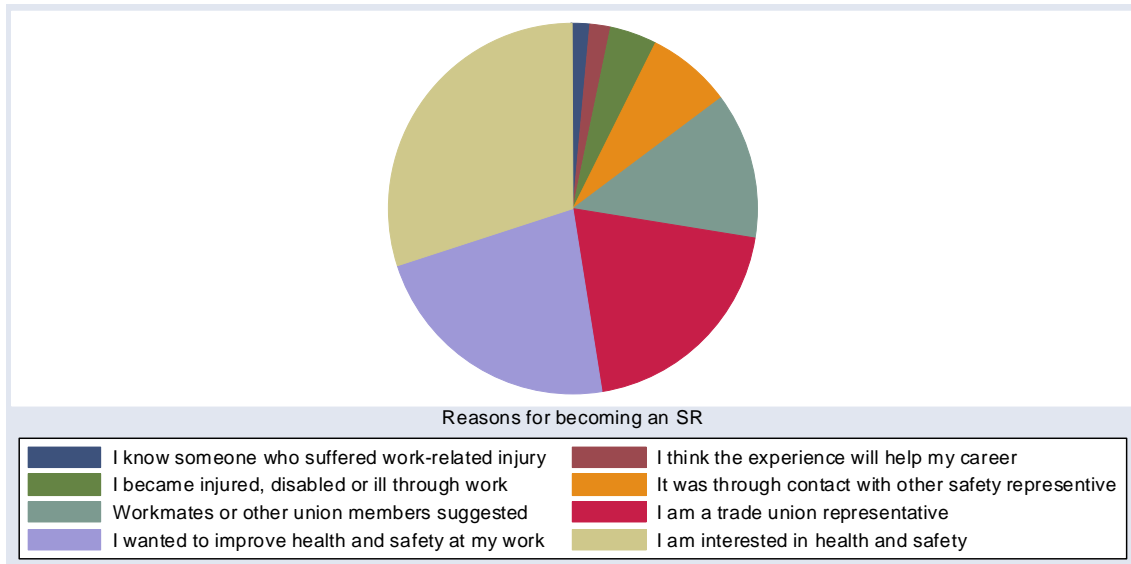
These associations needed to be taken into account when interpreting the SR responses to the questions of interest, discussed in the later sections of this report.

3.2 INDUSTRY WIDE RESULTS

3.2.1 SR Motivations

Responses regarding the primary motivation behind the decision to become a SR are given in Figure 7.

Figure 7: Primary reasons for becoming a SR



An interest in health and safety, wanting to improve health and safety, and the SR being a trade union representative were the three most common reasons for becoming a SR, collectively accounting for over 75% of responses. An interest in health and safety and wanting to improve health and safety were closely related, with many respondents listing one as their primary reason for becoming a SR and the other as a secondary reason. Approximately 5% of respondents became a SR after either they or a colleague had suffered a work related injury. Comparing the number of respondents who had become a SR because they or a colleague had been injured or made ill and those who wanted to improve H&S standards at work suggested that most people became SRs proactively rather than reactively. The responses differed from TUC 2004, where approximately 50% of respondents combined the role of SR with that of a trade union steward and only 50% were specialist SRs.

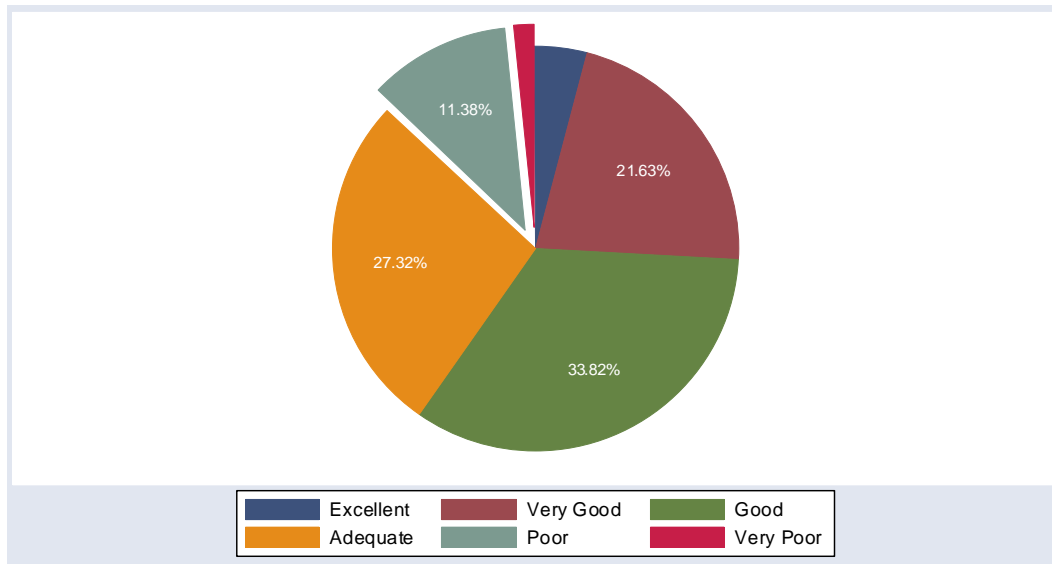
The reasons for becoming a SR appeared to be unrelated to age, gender, company size, number of employees represented and the length of time as an SR, although in some cases it was not possible to assess this relationship using statistical methods due to the small number of respondents in some categories.

Approximately 15% of respondents provided details about problems that they had encountered in becoming SRs. The problems reported were almost exclusively related to time, including absences away from work to attend training courses and the time required to perform routine safety checks and risk assessments. It would appear that some employers were reluctant to make allowances to individuals for the time taken to perform SR responsibilities. The respondents whose main motivation for becoming an SR was due to an injury, either to themselves or to colleagues, tended to encounter problems more frequently than other SRs.

3.2.2 SR Knowledge

Results of SR ratings of the H&S regime in their workplace are given in Figure 8.

Figure 8: Health and Safety standard at work rated by SRs



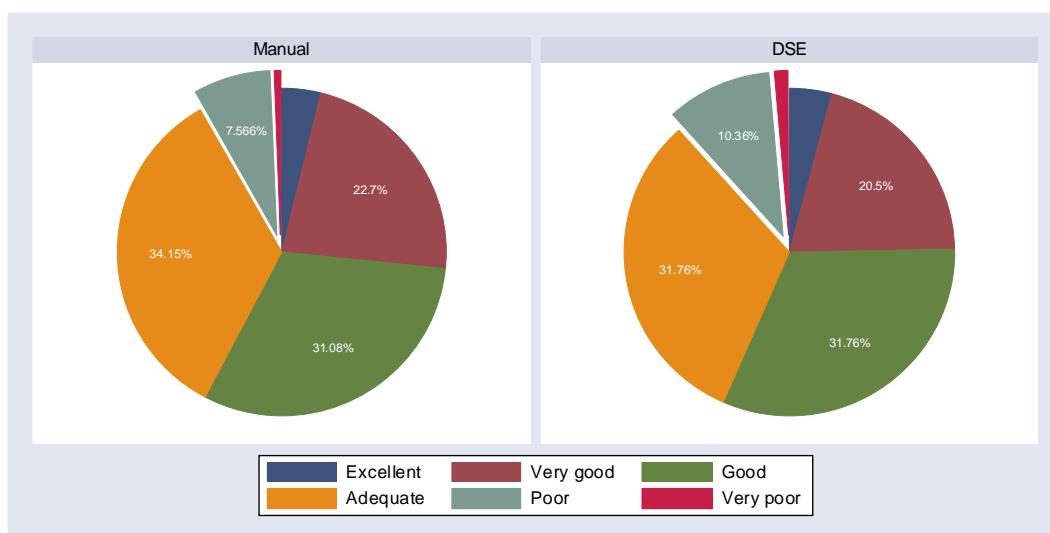
Approximately 5% of SRs rated the H&S regime in their workplace as excellent and 60% rated it as good or better than good, whereas 15% rated it as poor or very poor. Responses appeared to be unrelated to the background information about the SRs and their workplaces.

The SRs were asked if their workplace had assessed the risks from manual handling. Approximately 80% of them reported that their workplace had assessed manual handling risks, whereas 20% reported that manual handling risks had not been assessed. Answers to the question were strongly associated with the amount of time the SRs tended to spend on manual work. The association arose because the majority of SRs answering 'No' spent only a small amount of time on manual work. The converse relationship was also evident for time spent on DSE work – many more 'No' responses were received from SRs spending a large amount of time on DSE work. An association between the responses to the question and gender was found, but this appeared to be an artefact of the differing amounts of time spent by male and female SRs on manual and DSE work (Figure 2).

The SRs were also asked whether their workplace had assessed the risks from DSE, and approximately 75% of them were aware that a risk assessment had been undertaken. The answers to this question were associated with the amount of time the SR spent on manual and DSE work; the SRs who spent a large amount of time on DSE work answered 'No' less often than those who spent a small amount of time on DSE work. The converse was true for time spent on manual work; those who spent moderate and large amounts of time on manual work answered that they were unaware of a DSE risk assessment more frequently than those who spent a small amount of time on manual work.

SRs that were aware of risk assessments for manual and DSE work were asked to rate the quality of the risk assessments. The manual assessment was based on 489 responses, whereas the DSE assessment was based upon 445 responses.

Figure 9: Quality of manual handling and DSE risk assessments



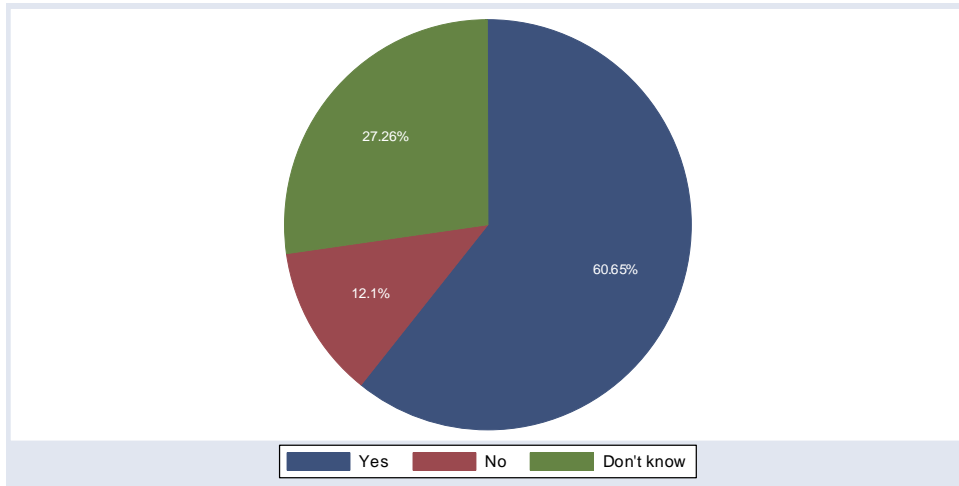
The results from the two assessments were similar, but also to the responses about the general standard of H&S (Figure 8). A small number of SRs, approximately 5% for both manual handling and DSE, rated the risk assessments as excellent and approx 55% rated the assessments as good or better than good, whereas poor or very poor assessments accounted for only 10% of assessments in both cases. The results from this survey contrasted noticeably with TUC 2004, which found approximately 50% of respondents reported that risk assessments were inadequate. In part the differences in responses between the MSD 2005 and TUC 2004 surveys may be explained by differences in the two questions, however it is unlikely that this is the only factor.

The quality of the manual handling assessment was not associated with any of the background information for respondents and their workplaces. An association was evident between DSE assessment and the amount of time spent on DSE work; SRs who spent a small amount of time on DSE work were less likely to rate the DSE risk assessment as poor than those who spent a large amount of time on DSE work. For SRs who were aware of both manual handling and DSE assessments in their workplace, there was a strong association between the qualities of the two assessments. SRs who responded excellent to the manual handling assessment accounted for approximately 75% of all the excellent rated DSE assessments, a rate 10 times larger than would be expected by chance. At the opposite end of the spectrum poor and very poor manual handling and DSE risk assessments frequently coincided. The quality of manual handling and DSE risk assessments was also associated with the general H&S standard. An excellent general H&S standard frequently coincided with excellent manual handling and DSE risk assessments.

For both the general H&S standard and the quality of the risk assessments, an association between the responses and the length of time as a SR was tested for; a specific hypothesis that the longer serving SRs were less enthusiastic about the quality of risk assessments and the general H&S standard was tested. There was no evidence to support this hypothesis.

SRs were asked if they knew of anyone in their workplace who was suffering from an MSD.

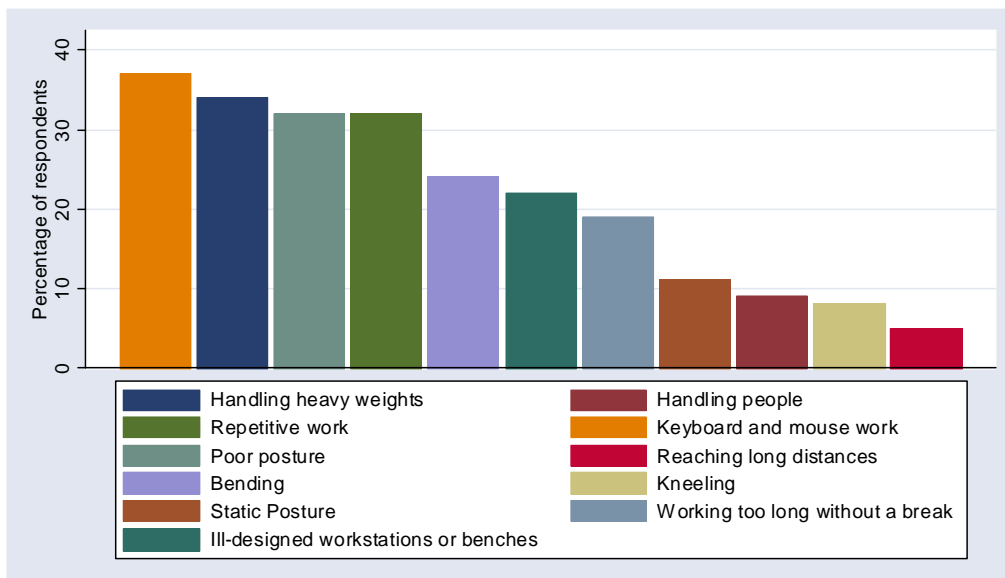
Figure 10: Awareness of MSD problems in the workplace



Approximately 60% of SRs knew of at least one person in their workplace that was suffering from a work related MSD, whereas just over 10% did not know of someone who was suffering, and approximately 30% were unsure. There was some evidence to suggest an association between the responses to the question and the length of time as an SR, although there was no obvious interpretation.

The SRs who knew at least one person suffering from a work related MSD were asked to identify the three most common causes.

Figure 11: Most common causes of work related MSDs



Only the respondents to MSD 2005 who knew at least one person in their workplace that suffered from a work related MSD were included in this analysis. After this filtering, there were 376 valid responses, with 4 of these SRs unable to provide any causes of an MSD. Responses were also discarded when the SR answered the question incorrectly, selecting more than three

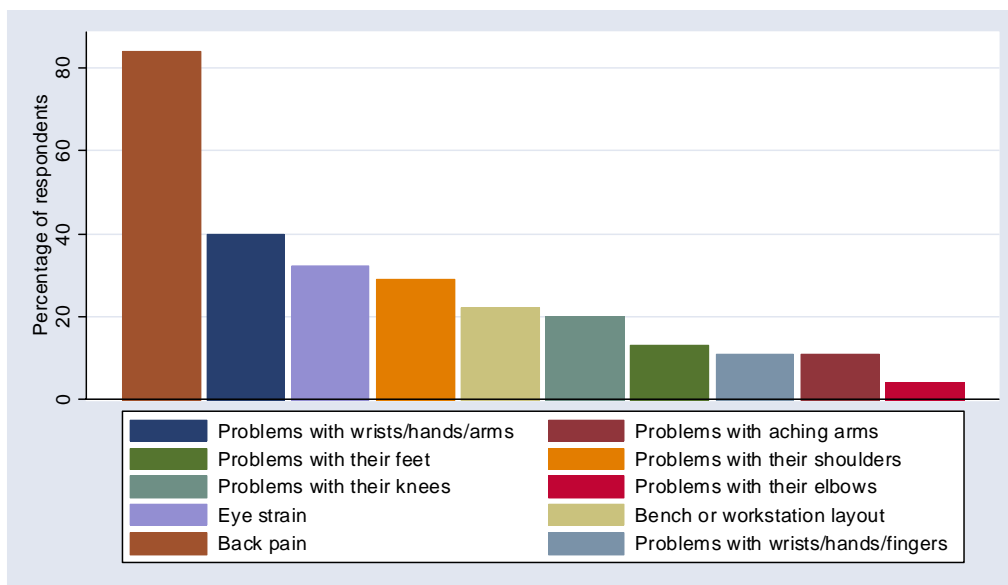
causes of MSDs in their response. In all this left 324 valid responses. Note that the causes do not sum to 300 in Figure 11 since not all valid respondents identified three causes.

SRs identified a wide range of causes. Keyboard and mouse work, handling heavy weights, poor posture and repetitive work were identified as being of similar importance, each identified by over 30% of SRs. Bending, ill designed workstations and benches and working too long without a break were also identified as common causes, and identified by approximately 20% of respondents.

There was a noticeable difference between male and female SRs in the responses to this question. Males SRs frequently selected causes that arose from physical tasks such as handling heavy weights, bending and kneeling, whereas females SRs identified causes that involved more static work and desk-based work in particular, with repetitive work, poor posture and keyboard and mouse work identified by many female SRs. However, the differences between responses from male and female SRs appeared to be the result of the differing amounts of time spent on manual and DSE work by males and females (Figure 2). The amount of time spent on DSE and manual work had a very large effect on the SRs responses. The SRs who spent a small amount of time on manual work tended to identify ‘office based’ causes such as poor posture and keyboard and mouse work, whereas those spending larger amounts of time on manual work identified causes associated with physical activity, such as bending, kneeling and lifting heavy weights. The converse was true for time spent on DSE tasks; the SRs who spent large amounts of time on DSE work were more likely to identify ‘office based’ causes of MSDs, whilst those who spent small amounts of time on DSE work tended to identify causes associated with physical activity.

The SRs who had been approached by colleagues for advice on MSD issues were asked to identify the three most common MSD problems they had encountered.

Figure 12: Most common MSD problems



In some cases SRs had experience of less than three problems and resultantly these questionnaires were incomplete; these were kept in the analysis. However, some SRs provided more information than they were asked for, listing more than 3 responses. These responses were omitted from the analysis. In all, 279 responses were omitted since the SR had no experience of MSD problems, and a further 51 questionnaires were omitted due to incorrect completion,

leaving a total of 290 responses. Note that the problems do not sum to 300 in Figure 12 since not all valid respondents identified three problems.

Over 80% of respondent identified back pain as one of the three most common MSD problems, making it by far the most common problem. Upper limb problems, sub categorised under wrists/hands/arms, shoulders, aching arms, wrists/hands/fingers and elbow problems were collectively of a similar importance to back problems, and these were supplemented by problems with the neck, an MSD problem that approx 30 respondents included on their questionnaire. Problems with the lower limbs, sub categorized into feet and knees problems, were less prevalent but still important. Collectively, these were approximately half as prevalent as upper limb and back problems. Many respondents also highlighted eyestrain and problems due to bench or workstation layout as important MSD problems.

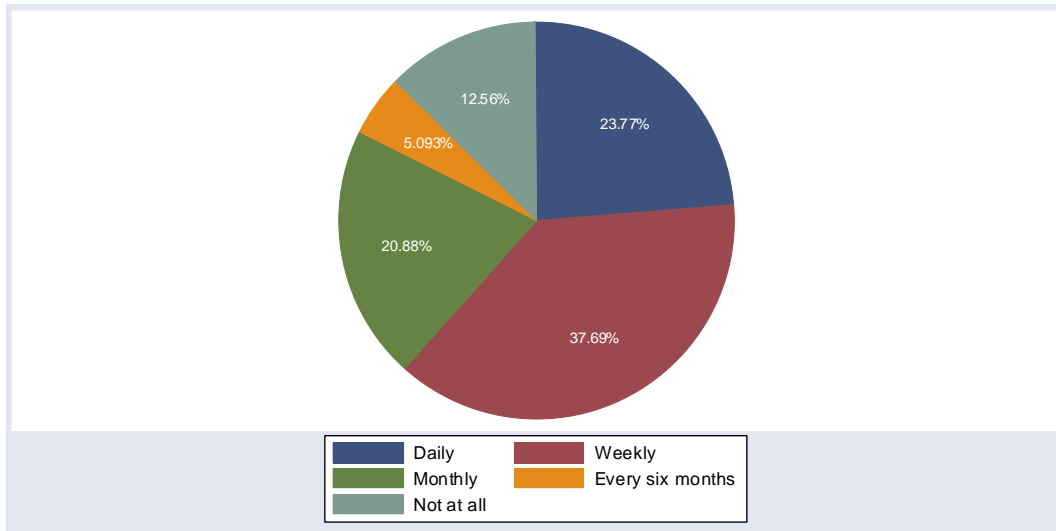
The responses were strongly associated with the amount of time the SR spent on manual and DSE tasks. The three most common problems; back pain, problems with wrists/hands/arms and problems with the shoulders were identified in the same proportion by all SRs, regardless of the amount of time spent by the SR on manual and DSE tasks. The large differences in responses were regarding problems with the elbows and knees, bench and workstation layout and eyestrain. SRs who spent moderate and large amounts of time on manual work identified knee and elbow problems more frequently than the SRs who spent a small amount of time on manual work. SRs who spent small amounts of time on manual work identified bench and workstation layout more frequently than those who spent moderate or large amounts of time on manual work. The converse was true for associations between common MSD problems and time spent on DSE tasks. A weaker association between the responses to this question and gender was also identified, however this appears to have arisen as a result of the association between gender and manual/DSE work (Figure 2).

Approximately 10% of the SRs had been involved in special activities for employees on MSDs. In the majority of cases this was manual handling training, sometimes tailored for specific jobs. A few respondents were involved in body mapping and activities directed towards DSE risks. The outcome from activities was generally positive. Approximately 33% of SRs felt the initiative resulted in an improvement in the prevention and control of MSDs, although 50% of SRs felt it was too early to say if the initiative resulted in an improvement.

3.2.3 SR Role

Responses to how often SRs were approached by workmates for advice on H&S issues are shown in Figure 13.

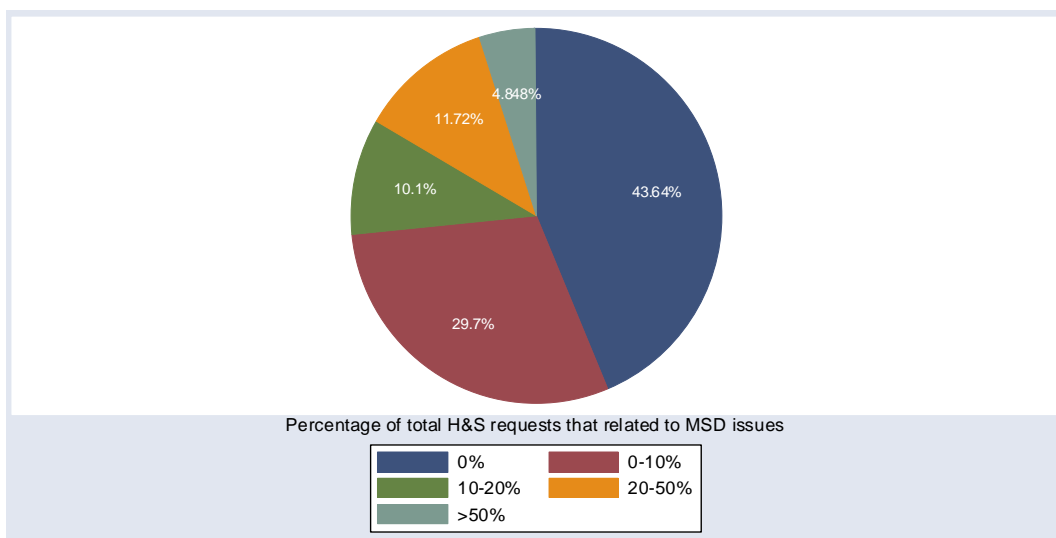
Figure 13: Frequency of health and safety advice



Approximately 20% of SRs were consulted on a daily basis, with approximately 60% consulted at least once a week, whereas only 20% of SRs were consulted less than once a month. The rate at which advice was sought was strongly associated with the length of time the respondent had been in the role of SR; those in the role for a long period of time were consulted on a more frequent basis than those in the role for a shorter period of time. The contrast was greatest between SRs in the role for in excess of 5 years with those in the role for less than 5 years. Responses were independent of age, gender, size of company and the number of employees.

The proportions of requests for H&S advice that related to an MSD issue are shown in Figure 14.

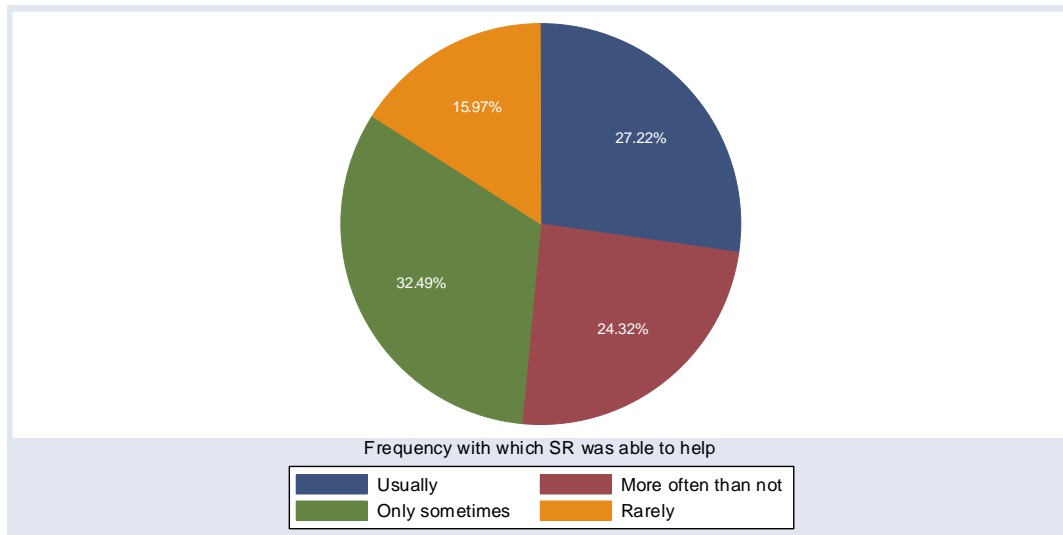
Figure 14: Advice relating to MSD issues



Over 40% of SRs reported that they were never consulted on an MSD issue and approximately 70% reported that less than 10% of consultations were related to an MSD issue.

SRs were asked if they felt they had enough knowledge about H&S issues in order to answer questions from their colleagues. Responses are shown in Figure 15.

Figure 15: Knowledge of SRs

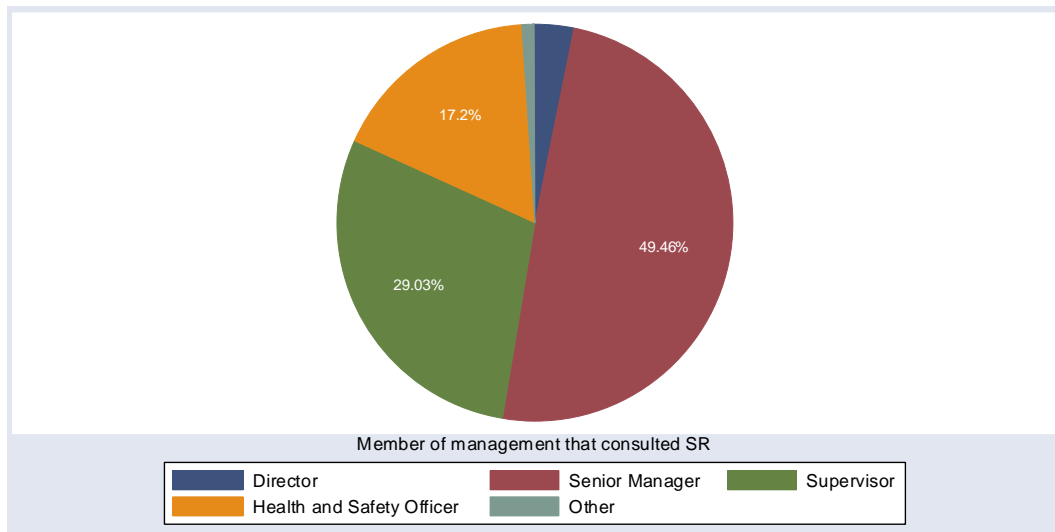


Over 25% of the SRs who answered the question felt they could usually help on H&S matters, with 50% able to help most of the time. Approximately 15% of SRs felt they could rarely help on H&S matters. Knowledge about H&S was strongly associated with the length of time as a SR; with those in post less for less than 6 months tending to lack enough knowledge to answer most questions, whereas SRs with in excess of one years experience tended to be able to answer questions more often than not, and those in post for in excess of 5 years tended to be able to answer most questions related to H&S. The number of employees the SR represented was also associated with the knowledge of the SR, with those who represented more than 10 employees having greater knowledge than those who represented fewer than 10 employees; it was unclear whether this was related to the knowledge of the SR or whether a smaller workplace resulted in different problems to a larger workplace. A final association between gender and the knowledge of the SR was found, with females SRs reporting that they had more knowledge than males SRs.

Approximately 15% of SRs reported that they had been consulted on at least one occasion by the management team regarding an MSD issue. The responses were strongly associated with the length of time as an SR but none of the other demographic information. SRs in post for in excess of 2 years were far more likely to be consulted by management than those in post for less than 2 years. Clearly, the longer an SR was in post the more opportunity there was for consultation but it could be suggested that management only consulted experienced SRs.

Responses to the member of the management team that consulted the SRs are given in Figure 16. Over 50% of all consultations were by a senior manager, with supervisors and health and safety officers also frequently consulting SRs. Based on the responses, it appeared that directors rarely consulted SRs however this may be due to relatively few companies having directors, whereas most companies have supervisors and senior managers. For this question it was not possible to assess if there were any associations with the demographic information due to the small number of respondents.

Figure 16: Consultations by management in the workplace



When a SR was consulted by a member of the management team a wide range of issues were discussed, including advice on specific MSDs, treatment of MSDs, and return to work plans for members of staff, including a change in job duties or job pattern.

3.2.4 SR Attitudes

Approximately 75% of SRs felt that they could usefully contribute to a general H&S risk assessment. In general most SRs felt they could contribute in some way however the responses were strongly associated with the length of time as a SR; those in post for shorter periods of time were less able to contribute usefully than those in post for in excess of 2 years. The responses also showed an association with the proportion of time spent on DSE tasks, with SRs that spent moderate and large amounts of time on DSE work feeling they could contribute to an H&S risk assessment more frequently than those who spent short periods of time on DSE work.

Just over 40% of respondents felt they could usefully contribute to an MSD risk assessment in their workplace. This was associated with the age of the respondent and the length of time as a SR. The positive association between age and knowledge arose as a result of the weak correlation between the SRs age and the length of time as an SR. The responses indicated that SRs in post for less than 2 years were less able to contribute than those in post for in excess of 2 years.

Approximately 25% of respondents felt their colleagues were sufficiently aware of activities that were likely to cause an MSD, and approximately 30% felt that their colleagues had sufficient information to plan work so that the risk of an MSD was minimized. In both questions approximately 20% of respondents were unsure. Respondents were asked to provide reasons why MSDs risks were still present even when workers were aware of risks. Responses to this question were varied but time pressures which lead to an environment where productivity came at the expense of good H&S practice, lack of task rotation for workers with repetitive jobs and a 'macho attitude' to H&S by employees, particularly males, were frequently cited reasons.

The SRs were asked if they had identified MSD risks in their safety inspections. Approximately 40% of respondents indicated that they had identified risks, with responses strongly associated with the length of time as a SR. The responses indicated a contrast between those in post for in excess of a year with those in post for less than a year, with the more experienced SRs better equipped to identify problems. Company size was also associated with the identification of risks in an assessment; the contrast was between large companies with in excess of 1,000 employees and those with less than 1,000 employees. SRs who worked in larger companies were able to identify risks more frequently than those who worked in smaller companies. SRs specified a wide range of risks that they had identified in safety inspections including poor posture, DSE problems and poor workstation layout, especially so when 'hot desking' was in operation. Manual handling and slips and trips were also commonly cited.

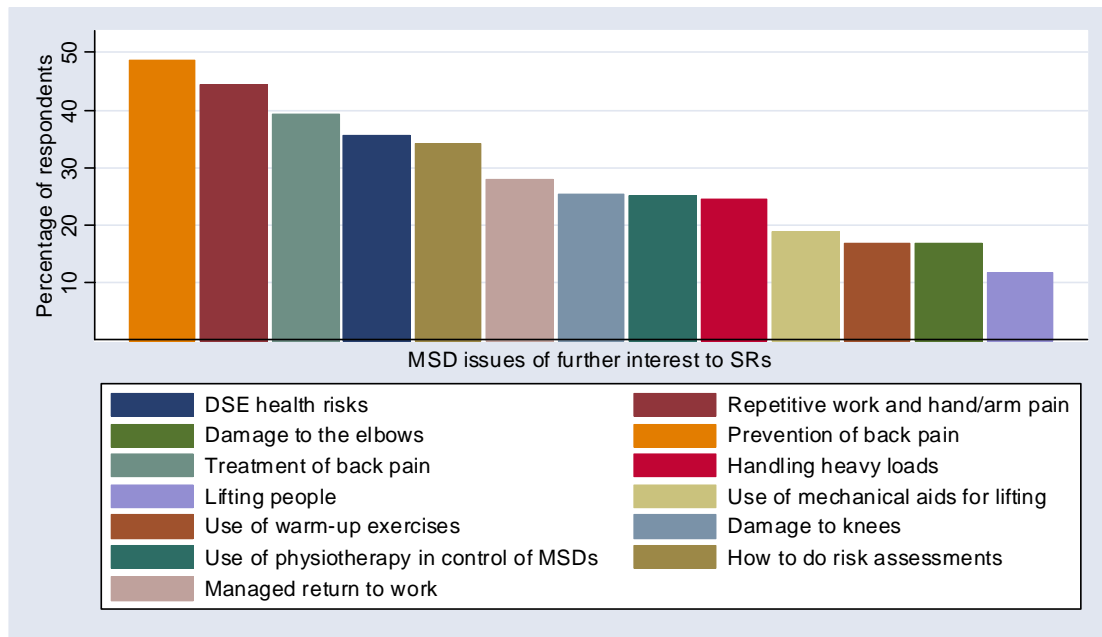
Of the SRs who had identified a risk during safety inspections approximately 25% identified an MSD risk where they were uncertain of how to handle or control the risk. Just over 50% claimed they had not found an MSD risk that they did not know how to control or prevent, with the remaining 25% unsure. In the cases where the SR was unable to control or prevent the hazard the problems were mainly related to repetitive work and the manual handling of awkward objects, particularly so in confined spaces.

The SRs were asked if they felt the training they received from either their union or employer was sufficient to deal with most health related problems. It should be noted that the scope of the question was general H&S matters and not specific to MSDs. Approximately 55% of SRs felt that they had and 45% indicated that they had not received sufficient training to feel equipped to handle most H&S matters. The responses were associated with the length of time as an SR; those in post for less than 6 months were less equipped than those in post for in excess of 6 months. Only 40% of SRs in post for less than 6 months felt they had sufficient training, whereas approximately 70% of SRs in post for in excess of 5 years felt they had sufficient

training. There was some evidence to suggest that SRs who worked in companies with in excess of 1,000 employees were better trained than SRs that worked in companies with less than 1,000 employees.

SRs were asked which MSD issues they would like to receive more information about. The responses are shown in Figure 17.

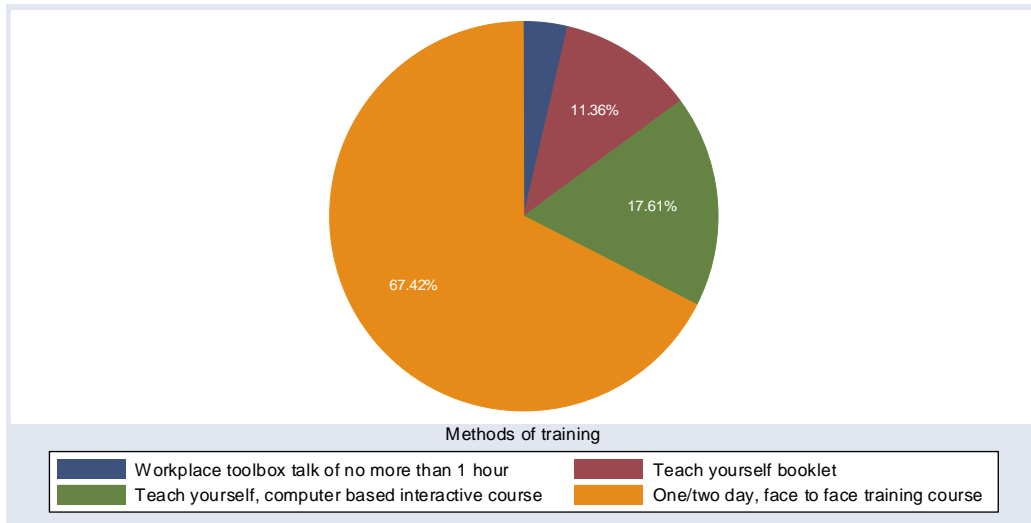
Figure 17: Issues of interest



From the varied responses it was clear that SRs were interested in a wide range of MSD issues, especially the prevention (almost 50% of respondents) and treatment (approximately 40% of respondents) of back pain, and arm/wrist pain (over 40% of respondents), which would be expected as they were identified as the two main MSD problems (Figure 12). Whilst SRs had a general interest in a broad range of MSD risks, some of the topics of interest to SRs were closely related to the amount of time the SR spent on manual and DSE work. Prevention and treatment of back pain, repetitive work and arm/wrist pain, damage to the elbows, the use of warm-up exercises, the use of physiotherapy in the control of MSDs, managed return to work and how to perform risk assessments were unrelated to the length of time the SR spent on manual and DSE work. The MSD issues that were related to manual handling work such as handling heavy loads, handling people, the use of mechanical aids for lifting and damage to the knees, were issues that SRs who spent moderate and large amounts of time on manual work expressed a greater interest in, whilst the SRs who spent large amounts of time on DSE work had a particular interest in DSE health risks, which were overall ranked fourth in order of importance.

Responses to how SRs would like additional training to be delivered are shown in Figure 18.

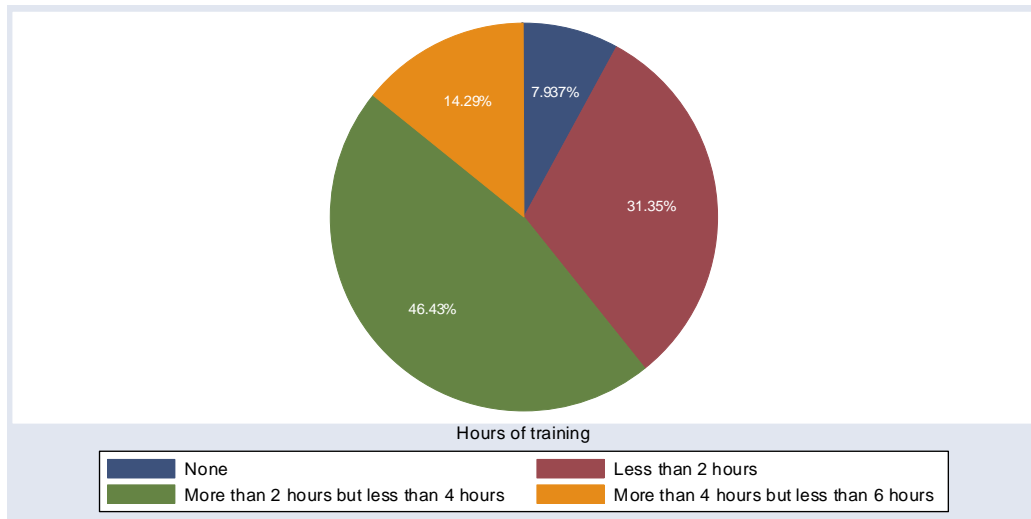
Figure 18: How SRs would like training delivered



Approximately 66% of responding SRs gave a preference for receiving training by way of an intensive one/two day course. Approx 25% of respondents preferred a teach yourself course, but opinion was divided about how this should be delivered with marginally more support for the computer based interactive course. Less than 5% preferred the work based 1-hour toolbox talk. The responses to the question were not related to the background information.

SRs were also asked how much time they would be willing to spend per week if training was given by way of a teach yourself course. The results are shown in figure 19.

Figure 19: Time SRs would spend on 'teach yourself' training



Of the SRs who responded to the question, approximately 45% were willing to spend between 2 and 4 hours on training, and over 75% were willing to spend less than 4 hours on training. However, approximately 60% of SRs did not answer the question, and resultantly it seems unlikely that these results were representative of the whole sample of SRs.

3.2.5 Return to Work

Over 85% of SRs knew their employer had a policy on managing sickness absence and helping employees return to work after illness. Just over 5% claimed their employer had no such policy, with the remaining SRs unsure. The responses were associated with the amount of time spent on manual work. SRs who spent a large amount of time on manual work reported their employer had no policy more frequently than those who spent a small amount of time on manual work. The responses were unrelated to the other demographic information.

Of the SRs whose employers had a known policy on managing return to work, approximately 30% were consulted on the content of the policy. The responses to this question were strongly associated with the length of time as an SR; those in the role of SR for less than 6 months were less likely to be consulted than those in the role for longer periods of time. Approximately 20% of SRs in post for less than 6 months were consulted, which contrasted sharply with those in post for in excess of 5 years, where 50% of SRs were consulted on the policy.

Approximately 80% of SRs were aware of their employer making use of professional advice from doctors/nurses/physiotherapists and other health professionals when planning the return to work of employees. Approximately 15% did not know if advice was taken, with the remaining SRs reporting that no advice was taken. There was some evidence that larger companies were more likely to take professional advice than smaller companies.

Approximately 25% of SRs whose workplace had a policy on returning to work were aware of how their employer had helped someone back to work after an MSD. The responses to this question were strongly associated with both the age of the SR and the length of time as an SR. The longer the SR was in post, the more likely they were to know of how an employee suffering from an MSD had been helped back to work. The sharpest contrast was between those in post less than and greater than 2 years.

When the SR knew of how their employer had helped someone suffering from an MSD back to work, they were asked to describe the steps taken. In most cases this involved light duties and a reduced working week with a gradual build up of hours. In many cases specialist equipment or a redesigned workspace was provided in order to reduce the risk of a relapse. Changes of job or job pattern were also mentioned by multiple respondents.

3.3 SECTOR SPECIFIC RESULTS

The analysis in this section of the report focuses on five sectors for which there were sufficient responses in order to assess differences across sectors. These were the Public Administration and Defence, Health, Other community and Social, Transport and Manufacturing sectors.

3.3.1 Background Information

The gender breakdown of SRs by sector is given in Figure 20.

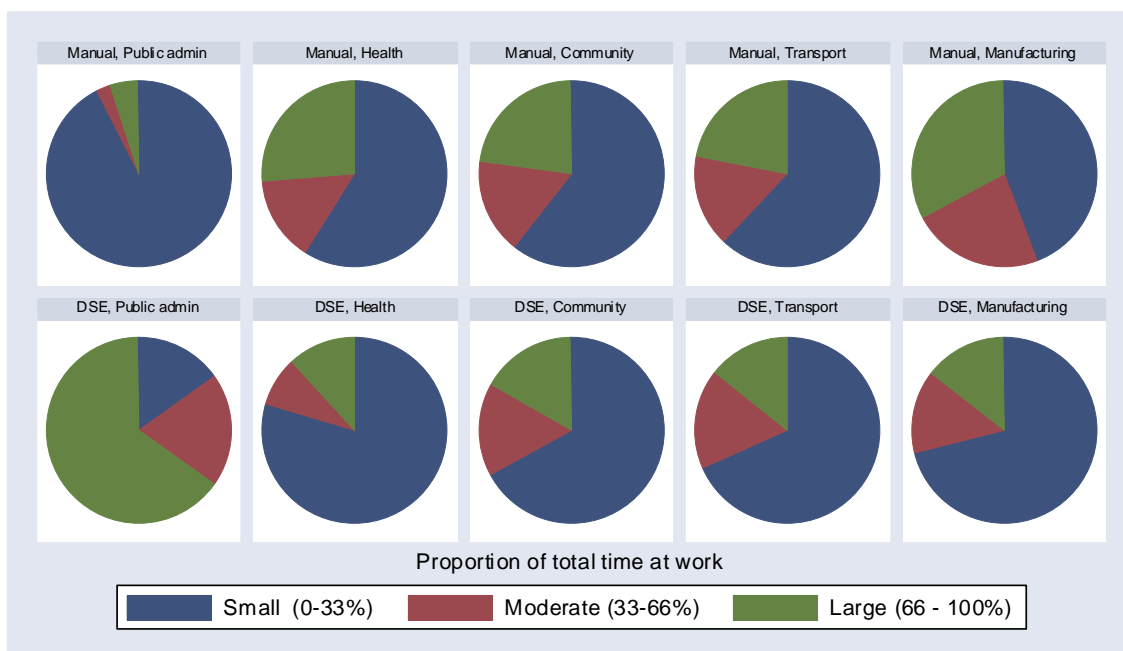
Figure 20: Gender breakdown by sector



Based on figures from *Wilson et al. (2004)* approximately 53% of people in employment in GB are male and 47% are female, whereas the responses to both the MSD 2005 and TUC 2004 surveys were approximately 75% male and 25% female. SRs are therefore, not representative of the workforce in general. The breakdown into genders by sector, given in Figure 20, shows that there are wide variations in the ratio of male to female SRs between sectors. In part the differences can be explained by the differing amounts of males and females employed in different sectors, but even after taking these differences into account, there were still noticeable differences between sectors. Figures from *Wilson et al. (2004)* show that the transport, storage and communications and manufacturing sectors both have male to female employee ratios of approx 3:1, yet the proportion of female responses to MSD 2005 from the manufacturing sector was 4 times larger than from the transport sector (12% compared to 3% respectively). The health and public administration and defence sectors have male to female employee ratios of approx 1:1 and 1:4 respectively, whilst the responses to the MSD 2005 had ratios of approx 2:1 and 11:9, respectively. Corresponding employment figures for the other community and social sector were not provided in *Wilson et al. (2004)*.

The length of time spent by SRs on manual and DSE tasks by sector, is given in Figure 21.

Figure 21: Time spent on manual and DSE work by sector



The amount of time spent on manual and DSE tasks varied substantially across sectors. In the health, community, transport and manufacturing sectors, similar proportions of SRs spent small, moderate and large amounts of time on DSE work, whereas in the public administration and defence sectors the majority of SRs (approximately 66%) spent a large amount of time on DSE work.

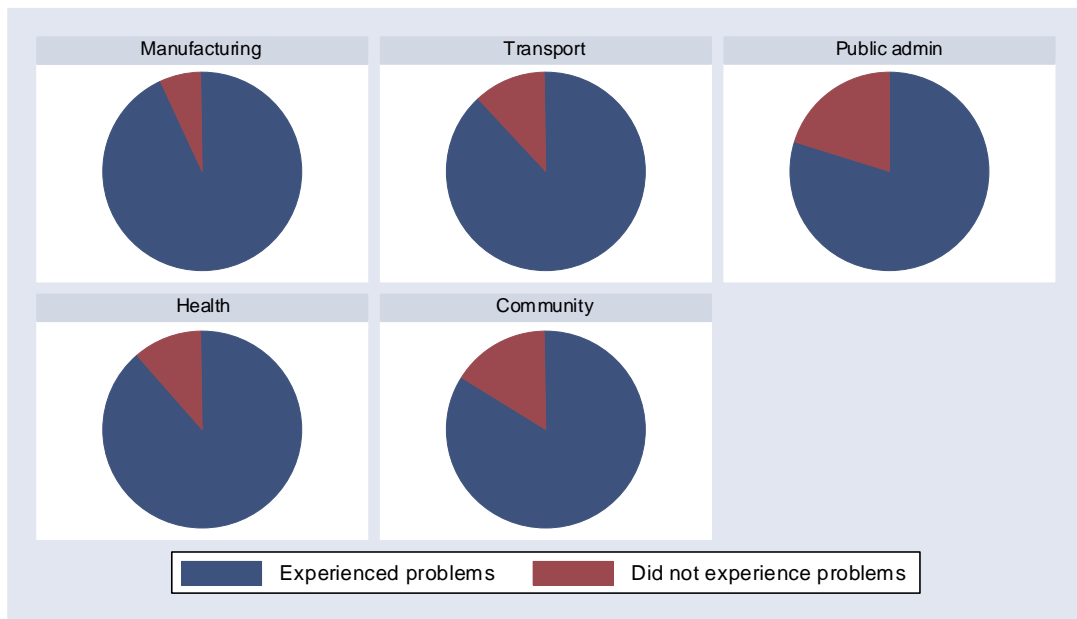
Approximately the same proportions of SRs from the health, community and transport sectors spent small, moderate and large amounts of time on manual work. The manufacturing sector differed in that a greater proportion of SRs spent both moderate and large amounts of time on manual work. The public administration and defence sector again showed the largest difference from all other sectors; the vast majority of SRs (approximately 90%) spent a small amount of time on manual work.

3.3.2 SR Motivations

The primary motivations behind the decision to become a SR did not differ by sector. However, the frequency with which problems were encountered when becoming a SR did.

The proportions of SRs experiencing problems are given in Figure 22.

Figure 22: Problems in becoming a SR by sector



The manufacturing sector had the lowest incidence of problems and the public administration and defence sector had the highest incidence of problems. These were the two sectors that differed the most in terms of the amount of time spent by the SR on manual and DSE tasks. The remaining three sectors had approximately the same proportion of SRs encountering problems.

3.3.3 SR Knowledge

Figure 23 shows sector-by-sector responses to the question asking SRs about the general H&S standard in their workplace.

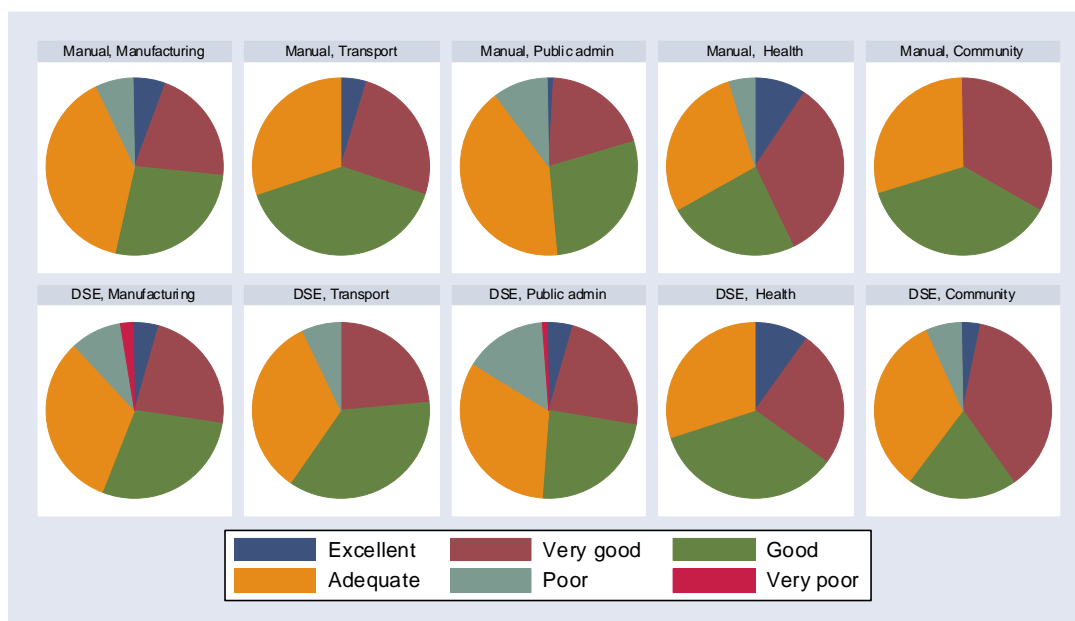
Figure 23: Health and safety standard at work by sector



Figure 8 showed that the general H&S standard at work was generally very good and that the responses to the question were unrelated to the background information on the SRs. However, the responses did differ slightly by sector, although due to the small number of respondents who rated their employers H&S standard as excellent and poor across all sectors, it was not possible to formally assess this using statistical methods. The responses from the transport, public administration and defence, health and community sectors were all broadly similar, although the community sector did have a slightly greater incidence of ‘very good’ responses. The manufacturing sector, in general, had a better H&S standard than the other four sectors; it had the highest proportion of excellent assessments (approximately 6%) and almost 75% of respondents rated the regime in their workplace as good or better than good. Overall, 15% of respondents described the H&S standard in their workplace as poor or very poor (Figure 8), however this figure was below 5% for the manufacturing sector. The manufacturing sector had the highest overall H&S, possibly as a result of SRs spending the largest proportion of their time on manual work (Figure 21).

The sector-by-sector responses to the question asking SRs about the standard of manual handling and DSE risk assessments are shown in Figure 24.

Figure 24: Quality of manual handling and DSE risk assessments by sector



The responses varied greatly, both in terms of the quality of manual and DSE assessments between sectors, and in the quality of the manual and DSE assessments within each sector. Both features are perhaps to be expected given the differing amounts of time spent on manual and DSE tasks between sectors. The community, transport and health sectors were broadly comparable in terms of the manual handling, with a similar proportion of SRs who rated the manual handling assessments as good or better than good. The quality of assessments within the health sector was slightly more variable; this sector had the largest proportion of excellent responses, but also had approximately 5% of assessments rated as poor. Neither the transport or community sectors had any poor assessments. The manufacturing and public administration and defence sectors were broadly comparable.

The health sector had the highest quality of DSE risk assessments; it had the largest proportion of excellent responses, and over 75% of respondents rated the assessment as good or better than good. The manufacturing, transport and public administration and defence sectors were broadly comparable in terms of good and better than good assessments, with public administration and defence having a larger proportion of poor and very poor risk assessments. The quality of DSE risk assessments within the community sector was extremely variable, with approximately 45% of respondents that rated the assessment as excellent or very good, and a large proportion that reported the assessment was adequate.

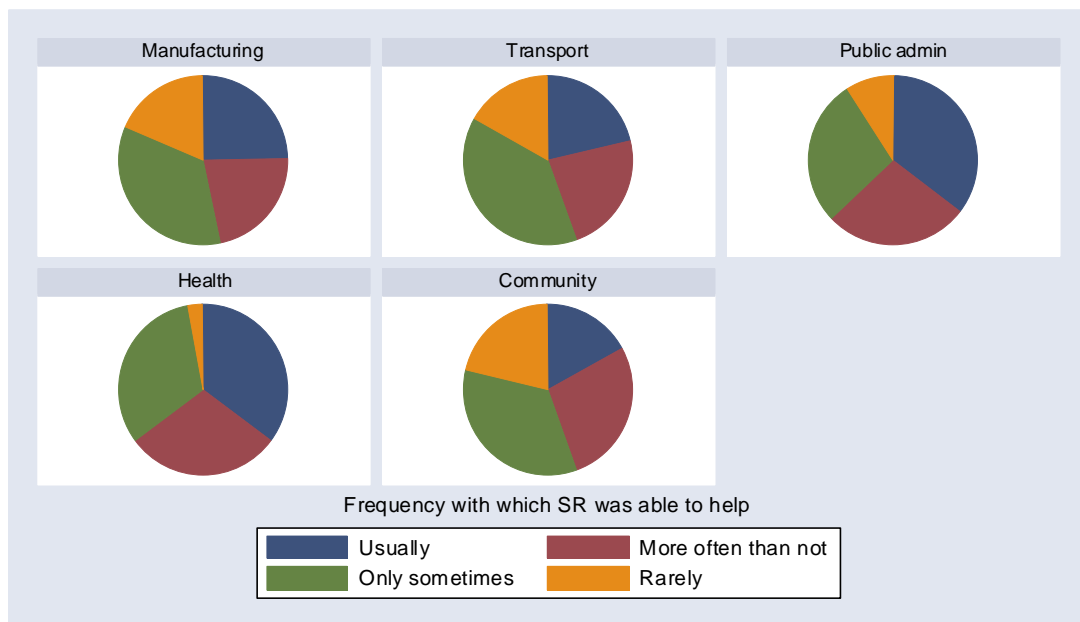
Some differences in the major causes of MSDs were noted across sectors. However, in general, these appeared to be an artefact of the length of time spent on manual and DSE work by the SR, rather than a result of the specific sector. One notable exception was in handling people, a problem that was almost exclusively associated with SRs who worked within the health and community sectors. Likewise, some differences in the major MSD problems were evident according to sector. However, these also appeared to be an artefact of the type of work (length of time spent by the SR on manual and DSE tasks).

3.3.4 SR Role

The frequency that SRs were approached for advice by their colleagues was not associated with sector, nor was the proportion of consultations that were related to MSD issues. A within sector analysis of the responses to these two questions attempted to identify whether the responses differed by gender for any of the sectors, however no differences were found. The sector the SR worked within was also unrelated to the proportion of SRs that had been consulted by a member of the management team regarding an MSD issue; again the within sector analysis found there were no gender differences. The member of the management team that consulted the SR did not appear to vary by sector.

The responses to the question that asked the SRs about their knowledge about H&S, specifically how often they were about to help with regard to H&S issues, are given in figure 25 for each of the sectors.

Figure 25: Knowledge of SRs by sector

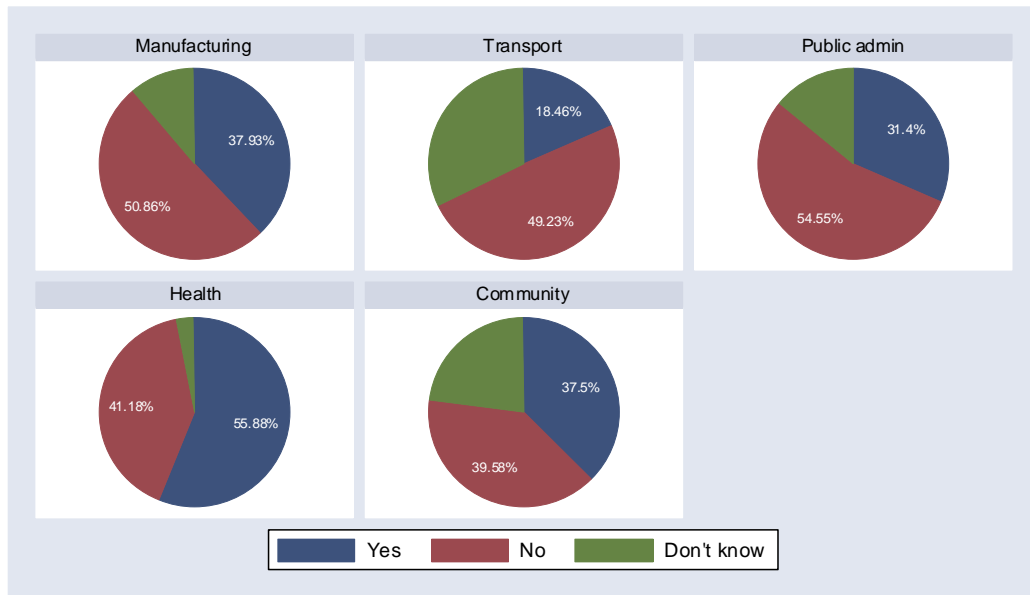


There was a clear split in the knowledge level of SRs between sectors. SRs from the public administration and defence and health sectors were broadly comparable in terms of their ability to help with H&S matters; approximately 33% of SRs felt that they were usually able to help, with a further 33% of SRs able to help more often than not. A smaller proportion of SRs were rarely able to help within the health sector than the public administration and defence sector. The responses from the manufacturing, transport and community sectors were almost identical. Responses were examined in order to assess for a gender effect in the within sector analysis, however no differences were found.

3.3.5 SR Attitudes

Responses to a question asking SRs if they felt their colleagues were aware of what activities might cause an MSD are given in Figure 26 for each sector.

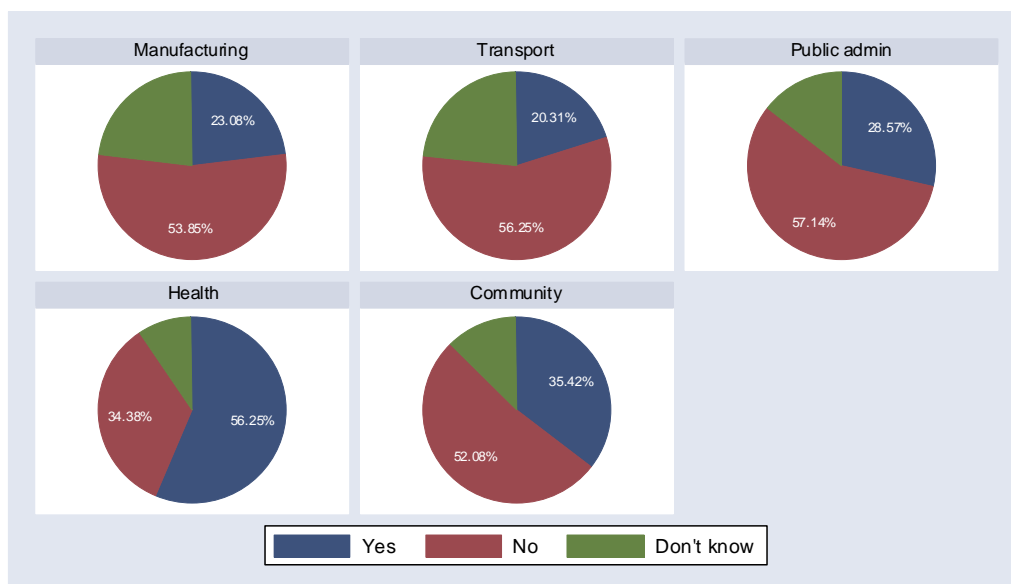
Figure 26: Awareness of employees about activities that may cause MSDs



The responses to the question were strongly associated with sector. The manufacturing, community and public administration and defence sectors had similar responses; approximately 33% of SRs felt their colleagues were aware of work activities that might cause a work related MSD, and approximately 50% felt their colleagues were not sufficiently aware of the hazards. The transport and health sectors differed substantially from these sectors; the transport sector had a small proportion of SRs (approximately 20%) who felt their colleagues were aware of work activities and an inflated proportion who were unsure; the health sector had a much larger proportion of SRs (approximately 55%) who felt their colleagues were aware of the hazards and a very small proportion who were unsure.

Responses to a question asking SRs if they felt their colleagues had sufficient information to plan work so that the risk of an MSD might be reduced or eliminated are given in Figure 27 for each sector.

Figure 27: Sufficient information to plan work by sector



The responses were again strongly associated with sector. The contrast was between the health sector and the other sectors. The health sector had a far higher proportion of SRs (approximately 55%) who felt their colleagues had sufficient knowledge to plan their work in order to minimize the risk of an MSD.

There were some differences across sectors in terms of the MSD issues about which SRs would like further information. However, the differences could largely be explained by the differing amounts of time spent by SRs in differing sectors on manual and DSE tasks. One notable exception was information about lifting people, which was of particular interest to the health and community sectors.

3.3.6 Return to Work

With regard to return to work and rehabilitation, there were no differences across sectors.

3.4 HSE WEBSITE

Approximately 60% of respondents had made use of the HSE microsite on MSDs. Of the SRs that had visited HSE's web pages, almost all respondents (98%) found the material to be useful. Only a small proportion, approximately 20%, of those who visited HSE's web pages had used the Manual Handling Assessment Chart (MAC). SRs were more likely to access HSE's web pages if they had been in the role of SR for greater than 6 months, and if they spent a moderate or large amount of time on DSE work; this latter demographic could be a proxy for availability of Internet access whilst at work.

4 DISCUSSION

The results from the MSD 2005 survey show that SRs who have attended training courses run by TUC education have a good general knowledge about health and safety at work, and can be a real asset to their employer in terms of improving work practices. Most respondents also had a good level of knowledge about MSDs, including the most common causes and problems and how work practices could be amended and improved in order to minimise the incidence and severity of work related MSDs. However, there is still substantial room for improvement in terms of increasing the knowledge of SRs, increasing the role they play in the workplace, and in ensuring that they are representative of their workplace.

The major findings from the analysis are presented in more detail below.

4.1 SUBJECTS

In terms of gender, sector, company size and the number of employees represented by the SR, the respondents to MSD 2005 were comparable with a previous study by the TUC in 2004.

In terms of gender the respondents to MSD 2005 were not representative of the working population; the respondents to the MSD 2005 survey were 73% male and 27% female, whereas the ratio of male to female employees is approximately 1:1 for GB (Wilson *et al.* (2004)). In terms of age, company size, number of employees represented and length of service there was little or no difference between males and females, whereas there were large differences in the amounts of time spent on manual and DSE work, with female SRs spending more time on DSE work and vice versa for manual work.

The respondents to MSD 2005 were younger and less experienced (with experience measured in terms of years in the role of SR) than the respondents from the biennial surveys on the role of SRs in managing H&S funded by the TUC. The results from the latest of these surveys along with trends from 1998 to 2004 were reported in Kirby (2004). The TUC 2004 survey found that 80% of respondents had been in the role of SR for in excess of 1 year, whilst approximately 33% of respondents had been in the role for in excess of 5 years. Of the respondents to MSD 2005, 40% of males and 50% of females had been in the role for less than 1 year, and just over 10% in the role for over 5 years. The differences between MSD 2005 and TUC 2004 in terms of the experience of SRs can in part be explained by the differing methods in the selection of subjects. The respondents to MSD 2005 had recently attended level 1 or level 2 H&S courses provided by TUC education, and as a result many recently appointed SRs would be expected to be included in the survey, whereas TUC 2004 was open to both experienced and recently appointed SRs. However, a comparison of the responses to some similar questions in MSD 2005 and TUC 2004, notably the general H&S standard and quality of risk assessments suggested that the respondents to MSD 2005 tended to be based at companies with a better overall H&S standard than the population average. The results from MSD 2005 suggest that companies with higher H&S standards make effective use of SRs.

A more detailed analysis by sector was possible for the five sectors with the largest numbers of respondents, namely Public Administration and Defence, Health, Other Community and Social, Transport and Manufacturing. Large differences in the gender breakdown of SRs in the different sectors were found. In part the differences between sectors could be explained by the different proportions of males and females working within the sectors (Wilson *et al.* (2004)), but even after taking this into account, female SRs were underrepresented in all sectors. Transport, manufacturing, health and public administration and defence had only 12%, 50%, 55% and 66% of the female SRs that would be expected respectively. Data were not available to make the

same comparison for the other community and social sector. An analysis of this ratio by the amount of time spent on manual and DSE work showed that SRs who spent a large amount of time on DSE work were equally likely to be male or female. However, a gender bias was observed in favour of male SRs by a ratio of 4:1 in roles that did not involve a large amount of time spent on DSE tasks, wherein the same pattern was apparent over all sectors. The differences in the ratio of male to female SRs, highlighted in Figure 20, could be explained almost entirely by the ratio of males to females working within the sector, and whether or not the job involved a large amount of time on DSE tasks.

4.2 MOTIVATIONS

The decision to become an SR seemed to be largely proactive rather than reactive; SRs tended to have an interest in H&S or wanted to improve the H&S standard in their workplace. Frequently these two reasons were cited together. Reasons did not appear to be correlated with the H&S standard at work, although there were insufficient data to use statistical methods in order to assess this.

A relatively small proportion (15%) of respondents indicated that they had encountered problems in becoming a SR. The problem was generally related to time, either the time off work that was required to attend occasional training courses or in their employer failing to make allowances for the amount of time that was required to perform routine safety checks and risk assessments. SRs whose primary motivation for taking on the role was in reaction to an injury suffered by themselves or a colleague were more likely to encounter problems in becoming an SR. The SRs that were currently experiencing problems or had experienced problems in the past were more likely to rate the H&S regime in their workplace as poor or very poor whereas SRs who encountered no problems were more likely to rate the H&S regime in their workplace as good, very good, or excellent.

The analysis of the responses from different sectors showed that the public administration and defence sector had the largest proportion of SRs encountering problems, whilst the manufacturing sector had the smallest proportion.

4.3 KNOWLEDGE

The general H&S standard was higher than that in found in studies funded by the TUC (survey results from 1998-2004 are summarised in Wilson *et al.* (2004)), with 60% rating the H&S standard in their workplace as good or better than good, whereas only 15% rated the H&S regime in their workplace as poor or very poor. There was some variability between sectors, with manufacturing having the highest standard; over 75% rated the H&S regime as good or better than good and less than 5% rated it as poor.

Approximately 80% and 75% of SRs knew that their workplace had undertaken a risk assessment for manual handling and DSE work respectively. The question did not distinguish between cases where the SRs were unsure of whether a risk assessment had taken place and knowing that a risk assessment had not taken place, so a thorough comparison with TUC 2004, which did distinguish between these categories, was not possible. The TUC 2004 study found that a larger proportion of SRs, 85%, knew a risk assessment had been undertaken. However, TUC 2004 did not distinguish between DSE and manual handling risk assessments, so to compare studies the proportion of SRs from MSD 2005 that were aware of at least one (manual, DSE or both) risk assessment being undertaken should be used. In all, 90% of SRs knew that at least one of the risk assessments had taken place and 65% knew both risk assessments had taken place. In general, a workplace that undertook a manual handling risk assessment was likely to undertake a DSE risk assessment.

The standard of the risk assessments was far higher than that of TUC 2004, with approximately 55% of respondents rating risk assessments as good or better than good, compared with 8% (manual handling) and 12% (DSE) respectively reporting that risk assessments were poor or very poor. The SRs who spent a large amount of time on DSE work were more likely to rate the DSE risk assessment as poor or very poor. The general H&S standard and the quality of the risk assessments were highly correlated; a high H&S standard usually corresponded to high quality risk assessments. The by sector analysis showed that although the general standard of risk assessments was fairly high, there was considerable variability in the quality of assessments both within and between sectors. The transport and community sectors had the best quality manual handling assessments and the health sector had the best DSE assessments. Overall the health sector was the best performing in terms of the quality of risk assessments, with public administration and defence the worst performing sector.

Approximately 60% of SRs were aware of at least one person in their workplace who they believed to have suffered from a work related MSD. Keyboard and mouse work, lifting heavy weights, poor posture and repetitive work were deemed to be the leading causes of MSDs. The SRs who spent large amounts of time on DSE work were more likely to identify 'desk based' causes of an MSD, whilst those spending large amounts of time on manual work were more likely to identify causes associated with more physical work activities. It appears that SRs are more effective at identifying MSD issues in a work environment that they are most familiar with.

Back pain was identified by SRs as being by far the most prevalent MSD problem. Problems that could be classed as upper limb problems (shoulders/neck/arms/wrists/elbows) were collectively of similar importance to backs, with lower limb problems (knees/feet) less than half as prevalent. The prevalence of these problems, relative to each other, was consistent with the results published in Jones *et al.* (2003) and Jones *et al.* (2005), showing that the knowledge of SRs was consistent with the self reported ill-health results from the Labour Force Survey. Eyestrain was identified by SRs as the third most prevalent MSD problem. This was not specifically identified in either Jones *et al.* (2003) or Jones *et al.* (2005). There was an association between the MSD problems reported and the amounts of time spent by the SR on manual and DSE tasks; those SRs spending large amounts of time on manual work were more likely to report problems associated with physical work activities and the who SRs spent large amounts of time on DSE work were more likely to identify 'desk based' MSD problems. Some problems, particularly back pain, can be caused by both manual and DSE work and were identified by all SRs, regardless of the amount of time they spent on manual/DSE work.

4.4 ROLE

Approximately 20% of SRs were consulted about H&S matters on a daily basis and 60% were consulted at least as regularly as once a week, whereas just over 10% of SRs were never consulted. The frequency with which advice was sought was associated with the experience of the SR, measured in terms of the length of time in the role of SR. The more experienced the SR was, the higher the frequency of consultation. There was a particularly large contrast between those SRs in post for less than 5 years with those in post for in excess of this. Of the SRs who were approached for advice, almost 45% of them were never consulted on an MSD issue and for 70% of respondents less than 10% of consultations related to an MSD issue. This was surprising given that 60% of SRs believed at least one person in their workplace was suffering from a work related MSD. For some reason SRs were not consulted as frequently as would be expected.

Just over 25% of SRs felt that they had enough knowledge to be able to answer most H&S queries from their colleagues, with a further 25% able to answer questions more often than not,

whereas 15% felt that they were rarely able to answer questions. The by sector analysis showed that the responses to this question were strongly associated to sector with those from the public administration and defence and health sectors being the most knowledgeable, with 33% able to answer most queries, and a further 33% able to answer queries more often than not. Gender was also found to be associated with knowledge however it was unclear whether this association was due to a genuine gender difference or simply an artefact of most female SRs working within the health and public administration and defence sectors. Not surprisingly, within all sectors it was found that the more experienced the SR was, the more knowledgeable they were about H&S matters. Moreover, those in the role in excess of 5 years were especially knowledgeable.

Management had consulted around 15% of responding SRs, with senior managers the most likely to consult an SR, accounting for approximately 50% of all consultations. However, directors tended to consult SRs the least. The likelihood of an SR being consulted by management was related to the length of time in post. Indeed, of those in post for less than 6 months, only 6% had been consulted, whereas 33% for those in role for in excess of 5 years had been consulted.

4.5 ATTITUDES

Almost 75% of SRs felt that they could usefully contribute to a general H&S risk assessment; whereas only 40% felt they could contribute to an MSD specific risk assessment. SRs were far less confident about their abilities to control risks from MSDs than they are about general H&S risks. In both cases the responses were associated with the length of time in the role of SR with the more experienced SRs feeling more confident in their abilities. However, whilst 90% of SRs in post for in excess of 5 years could contribute to the general H&S assessment, only 50% of SRs in post for in excess of 5 years, and 75% of those in post for in excess of 10 years felt they could usefully contribute to the MSD risk assessment. The responses to the two questions were correlated in that those SRs able to contribute to a general H&S assessment were more likely to be able to contribute to an MSD specific risk assessment. The responses to both of these questions were associated with the amount of training the SR received from their union or employer; the more training they received the more confident they were. Approximately 55% of SRs felt that they had received sufficient training from their union or employer in order to deal with most H&S problems. However, only 40% of SRs in post for less than 6 months felt they had received sufficient training, whilst 70% of those in post for in excess of 5 years felt similarly.

Only 25% of respondents felt that their colleagues were sufficiently aware of activities that were likely to cause an MSD however this varied a great deal between sectors. The health sector performed best, with over 50% of SRs feeling that their colleagues were aware of activities that may cause MSD problems. The transport sector was the worst performing, with fewer than 15% of respondents feeling their colleagues were sufficiently aware of risky activities. Not surprisingly responses to this question were highly correlated with the SRs views on whether their colleagues had sufficient information in order to plan work in order to minimize MSD risks. Once again the health sector performed best, with over 50% of respondents claiming that their colleagues had sufficient information and the transport sector was the worse performing sector. Even in the best performing sector however, the proportion of workers who are aware of how to organise their work was low and could be improved upon.

SRs appeared to be aware of their knowledge gaps, and resultantly were interested in receiving further information on a wide range of MSD issues. Understandably, the prevention and treatment of back pain were both identified by a large proportion of SRs. DSE health risks were identified by over 35% of respondents, and SRs who spent a large amount proportion of their time on DSE work were especially interested. Damage to knees and elbows, and handling heavy

loads were issues that SRs who spent moderate and large amounts of time on manual work had a greater interest in. Over 30% of respondents expressed an interest in learning more about conducting risk assessments, which was consistent with the large number of SRs who felt unable to usefully contribute to a risk assessment. The inexperienced SRs had a particular interest in this, although even experienced SRs expressed an interest in increasing their knowledge. Overall, the large numbers of SRs requesting further information on a wide range of topics showed a keenness to increase knowledge.

Nearly 70% of respondents expressed a preference for further training to be delivered in intensive one or two day face-to-face training courses. The responses suggested that this was the only manner of training that many SRs were willing to accept, with 60% of SRs not answering subsequent questions on how much time they would be prepared to spend on teach yourself training. Of the SRs that were willing to use teach yourself training, either delivered via booklet or computer based, the majority of respondents were prepared to spend between 2 to 4 hours per week outside their working hours.

4.6 RETURN TO WORK

About 85% of SRs knew that their employers had a sickness and return to work policy. Of the remaining SRs, around a half knew no policy existed, and the other half were unsure of whether a policy existed or not. In the cases where the SR was aware of a policy, approximately 30% of respondents had been involved the creation of the policy. Responses were strongly associated with the experience of the SR. A much larger proportion of employers, approximately 80%, were known to have made use of professional help in drawing up a return to work policy, whereas only 5% were known to have not utilized professional help. There was a weak association with company size; large employers more likely to make use of professional help. The employers that were known to have not used professional help in drawing up a return to work plan had, in general, a poorer general H&S regime.

5 RECOMMENDATIONS

Even experienced SRs, who felt able to contribute to general risk assessments and able to answer most H&S questions did not necessarily feel able to contribute to MSD risk assessments. Obviously, this needs to be addressed more fully such that training that is specific to MSDs is made widely available, on the causes of MSDs, the most common problems, how to minimise risks and how to conduct MSD risk assessments. If possible training should be tailored for specific environments differentiating between DSE and manual work.

Females SRs are significantly under-represented, and a sustained effort needs to be made to recruit more into the role. Females SRs are particularly underrepresented in sectors where DSE tasks do not form the majority of the workload.

SRs are most comfortable and most effective when identifying risks within their own working environment. Some respondents to MSD 2005 indicated that they were responsible for premises spread over large areas and varied work environments and it could be concluded that they may not be as effective as an SR based permanently within a single working environment. Efforts need to be made to ensure that trained SRs are located in all premises.

This study has found that companies with a good H&S culture tend to embrace all facets of health and safety, including good quality risk assessments (both manual handling and DSE), and a positive attitude toward SRs. At the opposite end of the spectrum, companies with a poor attitude towards SRs, and who are obstructive to SRs receiving training and taking an active role in workplace health and safety, often have a poor general health and safety culture.

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