ANHOPS REVIEW

GUIDANCE ON LOW BACK PAIN

The Faculty of Occupational Medicine, in conjunction with the British Occupational Health Research Foundation and Blue Circle Cement PLC, have published the results of a project on the occupational health aspects of low back pain. There are 3 publications:

- A systematic review of the scientific evidence
- The full evidence statements and recommendations based on them for occupational health practitioners
- A leaflet summarising the evidence-based guidelines.

The recommendations have been grouped into occupational health categories:

1. Background
2. Pre-placement assessment
3. Prevention
4. Assessment of the worker presenting with back pain
5. Management principles for the worker presenting with back pain
6. Management of the worker having difficulty returning to normal occupational duties at 4—12 weeks.

The strength of the evidence supporting the statements has been graded into strong, moderate, limited or contradictory and no scientific evidence. Some of the strongly supported statements are in the table at the bottom of the page.

To support workers with LBP it is recommended that employers and workers be made aware that LBP is common, but often self-limiting, that physical demands at work are but one factor influencing LBP and that both prevention and case management need to be directed at the physical and psychosocial factors.

At pre-employment, LBP is not a reason for denying employment in most cases and routine clinical examination, lumbar X-rays, back function testing, general fitness or psychosocial factors should not be included in the pre-placement assessment.

When assessing workers with back pain screening for red flags (serious spinal disease and nerve root problems) can be done via diagnostic triage. Screening for yellow flags (see below) may help to identify workers at risk of developing chronic back pain. Occupational health practitioners can effect rehabilitation via communication with primary health care, the worker and the employer to facilitate an early return to work. The management of workers who still have pain at 4—12 weeks presents a real challenge. Whilst the evidence is strong that increasing length of absence reduces the chance of a successful return to work, the evidence to support the choice of intervention is not. There is moderate evidence to support temporary work modification, focussing on rehabilitation rather than symptomatic treatment and the provision of a package of measures rather than single interventions.

The strongest evidence for prevention is that lumbar belts and supports do not reduce work-related LBP and that low job satisfaction is an important, yet modest, risk factor. Back pain seen as an injury may be an unhelpful model for reducing future back pain.

PSYCHOSOCIAL RISK FACTORS "YELLOW FLAGS"
• A belief that back pain is harmful
• Fear avoidance behaviour
• Tendency to low mood and withdrawl
• Expectation of passive treatment

The single most consistent predictor of future LBP and work loss is a previous history of LBP
X-ray and MRI findings have no predictive value for future LBP or disability
For symptom-free people, individual psychosocial findings are a risk factor for the incidence of LBP
Most workers with LBP are able to continue working or return to work within a few days or weeks
The longer a worker is off work with LBP, the lower their chances of ever returning to work
Various treatments for chronic LBP may produce some clinical improvement, but are ineffective for R.T.W.

ANHOPS
ASSOCIATION OF NHS OCCUPATIONAL PHYSICIANS

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ANHOPS

TAKING OCCUPATIONAL HEALTH FORWARD

APRIL 2000

Anhops News

THE VOICE OF OCCUPATIONAL HEALTH IN THE NHS

PLUS ÇA CHANGE

Anyone who has worked in the NHS for more than a few months will be accustomed to change. Unfortunately, occupational health in the NHS has not, in general, benefited from it. It is understandable, therefore, that Alan Milburn's recent speech, spelling out a new vision for NHS occupational health has provoked a mixed response from clinicians. Delivering the LSE Annual Lecture "A healthier nation and a healthier economy: the contribution of a modern NHS" the Secretary of State argued that it is time to reverse conventional thinking that health spending is a debit, not a credit. "Health care", he said, "should be regarded not just as current consumption but as social investment." (http://www.doh.gov.uk/speeches/)

The speech, which made the front pages of several broadsheets, does not appear to have attracted the interest of the professional journals. However, judging by the activity generated in occenvmed, the occupational medicine e-mail discussion list (http://www.mailbase.ac.uk/lists/occenvmed/) the suggestions made about occupational health have stimulated numerous doctors and nurses to voice their opinions about the future of NHS occupational health. Overall, the response has been favourable, but guarded. The specifics of the proposals are not new for many occupational health services, that already provide services to industry.

The basis for health care as a social investment is efficient organisation and the delivery of preventative not just sickness services, it was argued. The contribution of occupational health services in tackling absenteeism, retention of skilled staff, reducing litigation costs and improving the quality of working has been highlighted. Two "beacons" of good practice were quoted as making a tangible contribution to business by marketing their services to the public and private sectors. Such practices were considered to be unusual. One wonders who the SofS consulted before giving the speech??

The extension of existing NHS occupational health services is considered to be good for the NHS, not a burden. Reduction in GP appointments, reduced employment costs and reallocation of expenditure currently purchasing private health care to fund effective workforce health interventions are the expectations of what has been called "NHS plus". Given that it was acknowledged that the NHS has to make sure that its own house is in order, it must be assumed that the DOH will now persuade NHS Trusts of the benefits of investing in their occupational health services (sic).

The argument that occupational health should be an integral part of good organisational management, as well as a key component of a public health strategy is one that few occupational health clinicians would argue against. The reality is that many NHS Trusts view occupational health as a necessary evil and the concept of *investing* in occupational health is anathema to them. It is encouraging that ANHOPS has been approached by DOH regarding the implementation of NHS-plus (?). Will this be a performance objective for the NHS? Will the Government back its rhetoric with funding? How will this affect services to NHS staff? Will this be another case of plus ça change, plus la mème chose?

INSIDE THIS ISSUE..

FROM THE CHAIRMAN OF ANHOPS: Dr Peter Verow

This will be my final contribution to the Newsletter, as the Chairman of Anhops. My original two-year term of office was extended for an additional two years in 1998 – it is now definitely time for some new blood! Hopefully, members have felt that Anhops has continued to grow and develop. Our objectives are simple, to raise the standard of NHS Occupational Medicine – the process to achieve this is less simple. As a voluntary organisation we are indebted to the efforts of the keen few who are willing to squeeze in additional Anhops commitments to their ordinary day-to-day activities. As our individual daily commitments steadily grow there must be some doubt as to whether this type of arrangement will be sustainable in the long term.

In 1998 Anhops set out a two-year strategy.On reflection, I am pleased to see that the proposed targets have been met. We now need to refocus once more. I am personally convinced that Anhops needs to develop clear, auditable and evidence based guidelines for everyone involved with NHS Occupational Medicine. Such guidelines take a great deal of time and effort to develop, with the most difficult part being to get the first draft version onto paper. The education committee have revised the standardised format for our guidance and hopefully this will result in even more useful guidance in the future.

In 1998, we established regular meetings with all key players within NHS Occupational Medicine. Particularly useful has been our links with the NHS Executive and the Department of Health. This may become even more essential in the future following the recent statements from Alan Milburn which indicate that he would have NHS Occupational Health Services play a greater role in the new NHS – NHS Plus! We urgently need to develop our information technology systems. John Harrison has already set up the basis of our web site, which will be used for discussions, and reviews of new guidelines. This site needs to develop close links with other relevant organisations and any interested computer whizkids who may be able to help us in this objective would be very welcome. We are currently exploring professional expertise to support us in this aim, however there will always be the need for an interested Occupational Physician to assist in the process.

Our financial position is currently good. As a result the Education Committee are planning to provide free training for NHS specialist registrars on management issues. How will we fund the increasing number of guidance documents that are being produced? It is essential that a reserve is available to cover the cost of our educational meetings.

Free of the burdens of office I will have a little more time to spend on developments in Sandwell. Taking advantage of Health Action Zone initiatives may be a way forward for many Occupational Health Units in the future. (see page 5)

Clinical governance, controls assurance, CME and revalidation are just a few of the burning issues, which Anhops needs to address. It is in all of our interests to make these initiatives work. This is likely to be much easier if we can work together with the Faculty and the Society of Occupational Medicine – as we all should have similar long term objectives, and as there is such a shortage of Specialist Occupational Physicians.

Dr PG Verow M.B.B.S., F.F.O.M.
Chairman of ANHOPS

Points of Interest

"I would like to thank the rest of the Executive and Education Committees who have all put a great deal of time and effort into driving Anhops forward. Each of us is also indebted to our personal Secretaries who are rarely seen, but make much of what we do possible."

The Education Committee are planning to provide FREE training for NHS specialist registrars on management issues.

The targets set in the ANHOPS two-year strategy have been met.

"Clinical governance, controls assurance, CME and revalidation are just a few of the burning issues, which Anhops needs to address."

The objectives of ANHOPS are simple—To raise the standard of NHS occupational medicine.

Are there any computer whizkids out there?

From the REGIONS

REGION	Name
Wales	G Denham
Scotland	J Morrison
N Ireland	L Rodgers
North/Yorks	C English
North-West	J McNamara
Trent	I Aston
Anglia	N Irish
West Midlands	vacant
North Thames	vacant
South Thames	N Mitchell-Heggs & J Carruthers
Oxford	A Ross & M Roberton
Wessex	vacant
South West	G Woodroof

We are up-dating our database of members. Please let us know if there are any inaccuracies when you receive your copy. We rely on YOU to keep us informed of any changes.

EXECUTIVE COMMITTEE MEMBERS

NAME	TITLE	ADDRESS
Peter Verow	Chairman	Sandwell 01216073417
Alison Rimmer	Secretary	Sheffield 01142714161
B Platts	Treasurer	Kings Mill Ctre, Sutton in Ashfield, Notts. NG17 4JL
A Robertson	Education	Birmingham 01212233762
J Harrison	Newsletter	Newcastle 01912228748

PLACEMENT FOR AN OH STUDENT?

To the editor

The University of Exeter has an imaginative and innovative programme of distributed learning courses operating in the Far East. It is presently in discussion with the Sultanate of Brunei concerning an Occupational Health course for post graduate OH nurse advisors. There is likely to be a requirement for OH placements of 4-6 weeks duration in the UK during the Autumn of 2001.

We need about a dozen places, in a mix of industries across the UK: can you help? We are very flexible, so if you can't offer a 4-5 week placement but could take a student for a shorter period do please still get in touch.

Please contact Dr Gerard Woodroof,
email: gerard.woodroof@sdevonhc-tr.swest.nhs.uk
or Gail Lansdown, email: g.e.lansdown@exeter.ac.uk

ADVISORY COMMITTEE ON DISTINCTION AWARDS

Consultants in the NHS and those in academia with honorary NHS consultant contracts are eligible to be considered for merit awards. The Faculty of Occupational Medicine has asked me to chair the Faculty's committee to put forward nominations. I have received a list of eligible consultants but this appears incomplete. I have, therefore, written to several colleagues asking for information that will allow their names to be added to the list. The ANHOPS membership list has also been checked. I assume that all eligible consultants belong to ANHOPS (?) Please check with your employing Health Authorities/Trusts to ensure that your name has been forwarded to the Department of Health/ACDA. Alternatively, contact me with your details and I will forward it to the ACDA.

Ching Aw, IOH.
0121 4146026; t.c.aw@bham.ac.uk

RE-DEPLOYMENT - the pressure is on

Anecdotally, many occupational physicians have seen the potential for re-deployment on health grounds diminish with the development of NHS Trusts. One of the barriers is the internal Directorate or Divisional structure which allows each Directorate's business need to mitigate against cross-Directorate/Divisional re-deployment. This has given rise to the approach of making ill and disabled employees compete for alternative work within the organisation.

Those of you who recognise this problem and would like to influence the re-deployment process in your own Trust(s) will be interested in the case law cited in this article. This case has prompted a new personnel policy in Southampton University Hospitals NHS Trust, giving candidates for medical re-deployment preference for suitable posts and removing the competition stage.

In summary, an Employment Tribunal has ruled that a Trust was not justified in making a disabled employee compete for suitable posts. This, and the change in policy, has been welcomed warmly by the occupational health department! Trusts that still have competitive re-deployment procedures may wish to reconsider their policies, in light of this ruling.

ANGEL v NEW POSSIBILITIES NHS TRUST (Employment Tribunal March 10th, 1999)

This case concerned a nursing assistant who, in the winter of 1996, sustained a fall at work and was referred to the occupational health physician. It was suggested that, in the medium term, she should be considering alternative work.

The nurse went off sick in June 1997 as a result of back problems and the occupational health doctor reported that she was unfit for her job and should consider alternative work. The Trust paid for computer awareness training and arranged for short-term clerical and secretarial work. Arrangements were made for her to be notified of internal vacancies and two other Trusts were contacted about her. Subsequently, she was guaranteed an interview, if she met the criteria for the job, and she attended a number of them. As no alternative employment was found for her, she was dismissed on June 5th, 1998.

The Tribunal held that, although it was clear that there were no adjustments that could have been made to enable her to continue as a nursing assistant, the Trust should have ensured that she was transferred to one of the available clerical posts for which she met the basic criteria.
Dr Julia Smedley
Consultant Occupational Physician.

INFORMATION & REFERENCES

From the West Midlands Region Safety, Health & Environment (COSHH) Group, from Dr T-C Aw

Meningococcal disease and healthcare workers. *The risks to healthcare workers are very low.* BMJ.1999;319

Surgeon infects patient with hepatitis C. BMJ. 1999;319

Technical consultation on the safety of hepatitis B vaccines. This WHO supported report of the viral hepatitis prevention board found no evidence of a link between hep B vaccine and multiple sclerosis, although the data is limited.

Occupational exposures to antineoplastic agents: self-reported miscarriages and stillbirths among nurses and pharmacists. JOEM. 1999;41(8) A statistically significant increase in spontaneous abortion in female HCWs handling these agents (OR 1.5; CI 1.2-1.7) Despite recent improvements in exposure control, agents still found in urine.

AROUND THE WEB

Health surveillance at work
http://www.open.gov.uk/hse/press/e99203.htm

Work accidents and ill health cost society billions—new report estimates
http://www.open.gov.uk/hse/press/e99207.htm

NHS zero tolerance zone. Managers' guide to stopping violence against staff working in the NHS.
http://www.doh.gov.uk/zero.htm

Health at work in primary care.
http://www.hawnhs.hea.org.uk

HSC seeks views on greater employee involvement in workplace health and safety. Press release CO51:99
http://www.open.gov.uk/hse/disdocs/dde12.htm

Help for GPs and other occupational health practitioners.
http://www.helpdoctor.co.uk

New ANHOPS discussion list
http://www.topica.com/anhops_discuss

OCCENVMED http://www.mailbase.ac.uk/lists/occenvmed

Inside this issue:

ANHOPS SUBSCRIPTIONS

ANHOPS annual membership subscription has remained at £30 p.a. since it was introduced 5 years ago.

In response to rising costs, including chasing late payments from members, it has been agreed to increase subscriptions to £35 p.a. for members paying by cheque, for 2000/2001. The rate of £30 p.a. will remain for payment by standing order.

Dr Brian Platts.

PERSONAL VIEW: Supporting doctors, protecting patients

This document from the DOH was issued in Nov. 1999. It is a lengthy publication (83 pages) seeking views on possible ways to address the small minority of problem doctors in England. (Scotland & Wales will have similar consultation papers with similar outcomes.) What does the document contain and what is in it for occupational health?

The first four chapters describe the current, unsatisfactory, situation. Most of us are aware that the public standing of the medical profession has taken a battering in recent months. The care delivered to patients has been very poor in some circumstances and the mechanisms in place to identify below-par services have been very crude, and some would say painfully slow. In most cases, there has been evidence of poor performance for a long time.

The document also deals with the difficulty in taking disciplinary action against medical staff in the NHS; the process is again very slow and, in most situations, becomes very acrimonious. I am certainly aware of doctors who have been suspended, pending investigation or disciplinary action, for a number of years until the situation is resolved. This is clearly very unsatisfactory, with highly qualified professionals prevented from practising because the system will not allow them to work. It is difficult to imagine this occurring in a commercial organisation: the situation would be investigated and prompt action taken.

There are many strong reasons to improve matters, but what is proposed?

- Appraisal for all doctors
- Stress reduction and management training
- Improved handling of sick doctors (NHSE will have to develop a policy to address the needs of sick doctors)
- External peer review & accreditation
- Surveillance data to detect poor performance
- Regional, national and international audits

Chapter 6 covers the proposed solutions, the main tenet being the establishment of "assessment and support centres" (ASCs) where a doctor can be "assessed in a timely manner and an appropriate solution devised". The present disciplinary procedures will be replaced by more effective processes. These will be extended to all doctors, including General Practitioners. The ASCs will have a Medical Director and a Board of Governors. Para. 6.7 states "The details of how the centres will work will have to be worked out in consultation with interested parties." It is thought that the process will be rapid; the ASC will provide a full written impartial assessment of the problem and recommendations for action. Advice will be given to both the doctor concerned and the employing Authority. It will be the responsibility of the employer to manage the support for the doctor or for resolving the problem.

I am concerned about:

- The scant mention of Occupational Health. Poor performance is sometimes due to ill health and I would argue that an occupational health opinion should be sought early, before considering any other referral.
- The very thin detail on the make-up of ASCs. One would assume that only experienced doctors who have a good track record of assessing complex situations will be involved. Will they have time? Who will do their work during the assessments? How will this be funded?
- The thought that doctors who are concerned about their clinical performance will self-refer to the ASCs. I feel that few will do this and that it is naïve to think that they will.

Overall, I feel that the role of Occupational Health is very much overlooked and that the role of ASCs is lacking in any detail. The concept is sensible, but when the practicalities are examined, I cannot see ASCs being established without considerable extra resources being invested and without a great deal of consultation.

The closing date for any comments was February 25th 2000, but if you feel strongly about these proposals, you can always send in a late reply.

Dr Ian Aston.

Consultant Occupational Physician,
Nottingham.

Why we need the blocked Guidance

PRIMARY CARE O.H. IN THE SOUTH WEST

Dr Gerard Woodroof and Dr David Longdon, a local GP principal are interested in the health of doctors. They have met on a number of occasions to explore how an occupational health service might be added to the existing schemes in Devon & Cornwall, and more importantly be widened to include all primary care staff, not just the GPs.
What became clear was that opening the doors of the hospital sector OHS to GPs and their staff would not be appropriate: The OH priorities are different, and the local GPs felt very strongly about ownership of "their" OH service with reluctance to be drawn into a hospital-based OHS.

A steering committee, comprising representatives from the Health Authorities and the LMCs, meet quarterly to endorse and promote the scheme at the political (small p!) level. The service is funded by and answerable to the steering committee rather than an existing or proposed Trust. The insurers Medical Sickness are also supporting the project. For the last 6 months, Sue Abbot and Lesley Burke, senior OH advisors, have worked for the project on a consultancy basis. They have been meeting with Practice Managers - a key influential group - and visiting Practices. Such visits are presently paid for by the project and free to the practice, but this may need to change. They have run workshops on Violence and Home Visiting as well as working up practical guidelines on matters such as immunisations for primary care staff. They provide a single 'phone call point of contact, from which the developing network of OH advice can be accessed. A bi-monthly OH newsletter has been produced for all practices.

The provision of general OH and health and safety advice seems straightforward. What is far more challenging is having a system that can respond rapidly and highly-confidentially to the clinically and ethically demanding cases of sick GPs. Assessment and support outside practice boundaries are seen as vital. Establishing trusted and respectful professional contacts in relevant disciplines, with clinicians sensitive to and experienced in dealing with medical colleagues, needs great care and time.

OH is new to many GPs and their staff; they welcome our support, but for those of you considering offering a service be aware it is totally different to hospital OH!

Dr Gerard Woodroof, Consultant occupational physician, South Devon NHS Trust. This project is independent of the Trust.

THE SANDWELL HEALTH ACTION ZONE PROJECT

The Government has identified additional funding to improve and modernise health services within areas of social deprivation. Sandwell, a socially deprived area, is one area that has been able to embrace these opportunities. The government has approved an extensive Health Action Zone programme that also incorporates an occupational health project. The "Workwell" project plan that was jointly prepared by occupational health and public health, was approved as part of Sandwell's HAZ programme in 1998. A multidisciplinary steering group of representatives from the health and business sectors oversee the project, and ensure that the agreed objectives are being met.

The "Workwell" team is complete, consisting of a Project Director (myself), a Project Co-ordinator (Barry Wilkes), an Occupational Health Nurse Adviser (Marie Carroll) and a Physiotherapist (Tina Hadley). Although the team reports to myself they have been located within the local "Business Link" which gives them excellent access to their target business population. A pilot programme within 8 companies has been completed, and from which a long-term strategy is being finalised. The strategy will be formally launched on May 11th, by representatives from the Department of Health, and the Health and Safety Commission.

The project offers companies a free assessment of their main health and their main safety hazards. These results, together with other evidence from sources such as the Health and Safety Executive, NHS Executive Direct, A&E and Public Health, have helped the project to identify its key priorities. The evidence so far has shown that back pain is the largest issue of concern within the Sandwell working population, and therefore significant efforts are being made to address this problem. This was the reason why a physiotherapist was appointed.

A project aimed at reducing the incidence of chronic and recurrent back pain within the working population has gained additional funding under the Department of Health, Back in Work programme. Free health assessments will be offered to employees who have been off work for a period of 4-6 weeks with back pain. Following the assessment, the employee will be offered a variety of different treatments, aimed at returning them to work as soon as possible. The treatment options will include a psychosocial element provided by a clinical psychologist.

A major difficulty is to evaluate effectiveness. However the project is being used as a pilot for an academic evaluation tool that has been designed by Stafford University. This tool should ensure that progress is being made against the agreed project plans, but is unlikely to determine whether accident or ill health rates actually fall.

We have also received funding from Sandwell's Health Improvement Programme, in order to deliver an Occupational Health Service for GPs, Dentists and their staff. A full time Occupational Health Nurse Adviser is leading this initiative. The Nurse has already had contact with over 20 practices and undertaken a baseline safety audit of many of their surgeries. Training days have being provided on risk assessments, and regular stress management programmes are available for employees. GPs and Dentists are also able to use the service for pre-employment, immunisation and management referrals. Early feedback has been extremely positive – only time will tell if we are able to cope with the demand!

Dr Peter Verow.

ALCOHOL & DRUGS

In many commercial organisations, safety-critical operations are taken very seriously. Some companies have introduced alcohol and drug screening to ensure that their employees do not endanger processes, people or the environment. It is disturbing to read, therefore, in the Newsletter of the Medical Council on Alcoholism, that alcohol and sleep deprivation leads to an increased number of mistakes in surgeons, as assessed using a computer-based system of surgical dexterity. A study carried out by Smith et al (2000;19(2):1-3) looked at simulated laparoscopic task performance in agroup of trainee surgeons and students, all familiar with laparoscopic techniques. The effects of alcohol prolonged the time taken to undertake simulated diathermy, when the mean blood alcohol level was 77.9 mg/dl. Impaired learning with reduced efficiency of movement existed up to 6 hours after ingestion of alcohol. Effects on real surgical tasks were impaired learning ability I.e. reduced ability to improve after repeated performance. This lasted for 8 hours post ingestion. It was suggested that the medical equivalent of the "bottle to throttle" time, used in pilots, might be 6 hours for levels of ingestion no greater than might be acceptable to drive legally on U.K. roads. This could be longer following the ingestion of larger quantities of alcohol. Should surgeons avoid alcohol on the night before operating?

The results of such a study should be seen in the context of evidence about drinking habits. Smith et al suggest that as many as 42% healthcare workers present for work with a hangover. In addition, the trend is for increasing alcohol and drugs consumption amongst young people. A study of medical students by Pickard et al (Medical Education 2000;34:148-150) found that, of the 86% who admitted to drinking alcohol, 52.6% men and 50.6% women exceeded the recommended weekly limit. 33.1% students admitted to illicit drug usage, mainly cannabis but also amphetamines (4.3% men; 6.7% women) LSD (2.2% men; 3.3% women) ecstacy (2.2% men; 3.3% women) amyl butyl nitrate (2.2% men only) and magic mushrooms (4.3% men; 3.3 % women). High scores on anxiety or depression scales did not correlate with high levels of alcohol consumption.

Tackling the issue of alcohol and drug abuse in doctors and other healthcare workers in the NHS is politically sensitive. However, an ostrich-like approach will only make it more difficult when circumstances dictate a more managed intervention. Lifestyle data and the new data about the effects of alcohol on competency suggest that clear guidance for Trusts is needed now, in order to support doctors and to protect patients.

Dr John Harrison.