

Victorian Health Service Management Innovation Council

Return to Work Review



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Executive Summary

Following an initial review of WorkCover premiums and claims and injury data within Victorian health services, the Management Innovation Council requested an in-depth review of return to work (RTW) practices within health services across Victoria, in particular looking at the scope and effectiveness of current RTW initiatives in health services and to identify issues related to accelerating and systematising best practice initiatives and strategies across the sector.

To gather evidence for the review, visits were undertaken to a range of health services, selected to ensure a representative mix of performance, size and location. A limited review of international and national literature relating to RTW good practice was undertaken and a number of health services in other states were contacted to discuss their approaches to RTW management.

Evidence collected from workplace visits indicates that most health services are broadly meeting the requirements established by the Victorian WorkCover Authority for RTW management. However, as would be expected, there are significant differences across health services, and between metropolitan and rural/regional health services, in how these requirements are met and the scope, content and implementation of RTW programs.

Across the sector there are a wide range of what could be considered as good practices currently in place within individual health services. Some health services have brought a number of these practices together and have developed very effective and innovative approaches to managing their RTW responsibilities.

From an assessment of current practices, relevant literature and practices in other jurisdictions, it is possible to identify the characteristics of a Good Practice Model for RTW management. These include:

- appropriate and effective systems
- competent and knowledgeable RTW staff and line management
- early intervention and early return to work
- active involvement from Boards and senior management in driving RTW performance
- a positive and supportive culture towards the return of injured workers to their normal duties
- the individual worker's understanding and expectations about their medical conditions, return to work and rehabilitation
- consideration of psychosocial and environmental influences on a worker's rehabilitation
- effective and timely communication and good teamwork between all stakeholders in the RTW process
- different interventions according to the phase of injury and rehabilitation and
- continuously improving systems, processes, skills and knowledge.

This review expands on these factors in developing a Good Practice Model and a Self Assessment Matrix which individual health services could use to assess their current

standard of RTW management performance and identify required actions to improve their performance.

The review puts forward a number of strategies to improve the management of RTW across the sector and to assist health services move towards the identified Good Practice Model.

Strategies are suggested for application at two levels:

i) Strategies which could apply across the sector and which could be initiated and sponsored by the Council. At this level, the Council could consider collaborating with the Department and VWA to draw on the resources and expertise available within the VWA to develop and promote specific projects to improve RTW outcomes across the sector. The suggested strategies at this level are:

- *Promotion of the Good Practice Model and Self Assessment Matrix*
- *Key Messages Campaign*
- *Board Awareness*
- *Sector Wide Networking*
- *Management Training*
- *Regional Resourcing*
- *Development of a RTW and Claims Management Database*
- *Development of a Job Analysis and Suitable Duties Register Template*
- *Improved Performance Data and Benchmarking*
- *Standardised Financial Model for Premium Devolution and RTW Budgeting*
- *Engagement of Treating Practitioners*

ii) Strategies which could be considered and applied by individual health services – in particular, individual health services could undertake an assessment against the proposed Good Practice Model to identify improvements which could be implemented relatively quickly and with limited resourcing to improve their RTW performance. The suggested strategies at this level are:

- *Adoption of Good Practice Model and Self Assessment Matrix*
- *Development of a RTW Strategic Plan*
- *Review of RTW Policy and Procedures*
- *Development of RTW Responsibilities*
- *Development of Skills and Expertise*
- *Communications and Consultation*
- *Stakeholder Engagement*

The Council could consider each of these strategies against their capacity to achieve the Council's objectives, their likely cost and resource implications and the capacity of health services to implement RTW changes.

In many cases the proposed strategies are based on measures already in place, which could be adapted for application across the sector, thereby limiting resource and change management implications.

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- 6. Improvement Strategies – Timeframes, resourcing and change management implications**

1. Background

The Victorian Health Service Management Innovation Council focuses on innovation and change management, developing and leading programs of work that are aimed at achieving system-wide improvements to both the efficiency and operational effectiveness of public health services.

The Council recently undertook an initial review of WorkCover premiums and claims and injury data within Victorian health services. This review, along with anecdotal evidence received by the Council, suggested that there is variation in the extent to which Victorian WorkCover Authority (VWA) strategies, plans and programs relating to the management of Return to Work (RTW) responsibilities are deployed.

Accordingly, the Council requested an in-depth review of RTW practices within health services across Victoria, in particular looking at the scope and effectiveness of current RTW initiatives in health services and to identify issues related to accelerating and systematising best practice initiatives and strategies across the sector.

The Council specifically asked that the review address:

- a limited review of recent national and international publications and documents related to RTW strategies and practices
- a scoping study of current practice across a range of Victorian public health services in relation to strategies developed to comply with RTW obligations
- a discussion of key RTW indicators and Victoria's position in relation to national and international best practice
- identification of RTW strategies that are effective for public health services
- assessment of available evidence on the impact and effectiveness of RTW strategies
- examination of the quality and depth of RTW strategies within health services, including identification of the scope to accelerate and systematise the most effective RTW initiatives

Fellows Medlock and Associates (FMA) was engaged by the Council to undertake this review. FMA has previously been engaged as part of the Victorian Government's Occupational Health and Safety (OHS) Improvement Strategy to work with budget funded health services to improve their management of OHS with the objective to achieve a 20% saving in WorkCover premiums over a 3 year period. As part of this project, FMA worked extensively with Victorian health services, both metropolitan and rural/regional, to assess their OHS management practices and identify areas of improvement. This work provided FMA with a good understanding of the issues facing the Victorian health sector and current practices in OHS and RTW management.

2. Approach

2.1 Approach

Given the range of organisations which make up Victorian health services, it is to be expected that the implementation of RTW strategies and programs across the sector will vary in content, depth and breadth.

Accordingly the approach to this review has been to gather data and information about RTW programs and practices in place across the sector and then to compare current practice:

- internally across health services
- with good practice from other jurisdictions, and
- with the findings of a limited good practice literature review.

The results of this comparison have provided the evidence base for identifying future strategies to improve RTW management across the sector.

The review has been conducted in three broad stages:

Stage 1 – Information collection

In consultation with the Project Steering Committee, a list of stakeholders was developed and a range of health services identified for workplace visits to examine and discuss their current RTW program and performance.

It was decided that health service visits and direct face-to-face interviews were more effective methods to gather valid information and evidence on current programs and performance in preference to telephone interviews or a written survey. This decision was made for the following reasons:

- given the range of influences on RTW outcomes, it would be difficult to elicit usable and evidence based responses from a survey.
- in survey form the required questions could be lengthy and require numerous free text responses.
- there was a high likelihood of a low rate of return to a survey given the demands on staff time.
- health service visits would provide greater opportunity to speak to a range of people in each health service.

Stage 2 – Review of literature and practice in other jurisdictions

A limited literature review was undertaken to identify and gather information about effective RTW approaches nationally and internationally, including public health services. Contact was also made with health services in other Australian jurisdictions, seeking to identify good practice in RTW management, with an emphasis on health. Whilst some health services were prepared to share their experiences, a number of health services were not willing to engage in discussions.

Stage 3 – Analysis

All available information was brought together and analysed as the basis for developing this report and identifying strategies for improving RTW management and systematising good practices across Victorian health services.

Proposed strategies were considered in terms of:

- relevance to Victorian health services.
- local or sector wide application.
- implementation requirements, including change management and resourcing implications.
- likely benefits.

2.2 Stakeholder Discussions and Health service Visits

Discussions were held with staff from the VWA with responsibility for RTW policy, deployment and monitoring across Victorian workplaces. The VWA has been conducting a series of workplace visits across both the public and private sectors to discuss RTW responsibilities under the Accident Compensation Act and what employers must do to meet these responsibilities.

In this light, the discussions with VWA staff were timely as they were able to provide initial responses from these visits and an indication of broad RTW practices currently in place across a range of workplaces.

Discussions were also held with representatives from registered insurance agents who provide workers compensation and claims management services to health service health services.

Seventeen health services were selected for workplace visits to ensure a spread of RTW performance and health service size, location and type. In doing so, performance data covering WorkCover premiums, claims numbers and claim costs was examined as a guide to the performance of individual health services.

The health services visited are listed below. These health services account for almost 60% of total WorkCover premiums paid across the sector.

Metropolitan health services	Rural and regional health services
Austin Health Bayside Health Melbourne Health Northern Health Peninsula Health Peter MacCallum Cancer Centre Southern Health Western Health	Alpine Health - Myrtleford Bairnsdale Regional Health - Bairnsdale Barwon Health Services – Geelong Central Gippsland Health Service - Sale Hepburn Health - Daylesford North East Health – Wangaratta Rural North West Health – Warracknabeal Stawell Regional Health Wodonga Regional Health

During the visits discussions were held with a range of people including CEO's, line managers, RTW coordinators and/or claims managers, HR managers and OHS managers.

To assist in structuring the discussions, an interview guide was developed and distributed to each health service prior to the visits. The interview guide structured the discussions under a number of broad headings with a range of questions within each section. A copy of the interview guide is at **Attachment 4**.

3. Current Practices

The VWA publishes a guide to RTW management (“Return to Work Guide for Victorian Employers” – 2005) to assist public and private sector employers to meet their responsibilities under the Accident Compensation Act.

This Guide provides practical assistance to employers in complying with the Act and in returning injured workers to work. The Guide is structured under four sections, addressing:

- Preparing Your Workplace – Occupational rehabilitation program
- Returning Injured Workers to Work – Return to work plans and offers of suitable employment
- Preventing Further Injuries – Risk management program
- Guidelines – for preparing RTW plans and additional matters to be provided for in occupational rehabilitation programs

Evidence collected from workplace visits indicates that practices across most health services are broadly aligned with the requirements set out in this Guide and that all health services have, as a minimum, established policies and procedures which meet their legal responsibilities.

However, as would be expected, there are significant differences across health services, and between metropolitan and rural/regional health services, in how these requirements are met and the scope, content and implementation of RTW programs.

The following sections summarise the evidence gained from workplace visits about current practices across the sector. Barriers which have been identified to effective RTW management are also considered. **Attachment 1** sets out case studies of four health services which have implemented positive and innovative programs to manage their RTW responsibilities.

3.1 Roles and Responsibilities

Line managers

It is generally accepted that line managers are responsible for injured workers and should be actively involved in the management of these workers. This involvement is also generally accepted to be a critical success factor in effective RTW management.

However, few line managers have specific RTW responsibilities or performance indicators built into their position descriptions. Whilst there may be specific documentation of OHS responsibilities, the responsibilities relating to RTW are generally expressed in broader terms such as “to adhere to health service policies and procedures”. More specific responsibilities may be established in RTW policies and procedures.

The extent of line management understanding and involvement varies across health services. In some cases, line managers are actively involved in managing RTW and work closely with RTW coordinators to make the initial contact with, and then follow

up, injured workers, find alternative duties, develop RTW plans and monitor the progress of workers in returning to the workplace.

In other health services, the RTW coordinator plays the primary role in managing RTW responsibilities. It was a commonly expressed concern that many line managers do not understand their responsibilities, feel uncomfortable communicating with injured workers or do not see it as a priority. Where managers are willing to engage with injured workers, they may not be equipped with the interpersonal skills that facilitate RTW.

Most health services are, however, attempting to have line managers take greater responsibility and to become more actively involved in RTW. This may involve more training and education or working closely with line managers on individual RTW cases to increase their understanding and knowledge of the process and their responsibilities.

In some health services, CEO's and Boards hold line managers responsible for their RTW performance. In combination with more training for line managers in RTW and also broader people management skills, this is being shown to be effective in driving improved RTW performance.

RTW staff

Most dedicated RTW staff have specific responsibilities to coordinate RTW set out in their position descriptions but only a small number have individual performance indicators in place. More commonly, limited RTW performance indicators may be established at the health service level.

Most RTW staff have undertaken specific RTW training through their insurance agents. A small number have also undertaken broader OHS, HR management and limited clinical training to assist them in their roles.

In health services with sufficient resources, the management of claims and RTW is sometimes separated as this is seen as a more efficient division of responsibilities.

In smaller health services, there may not be dedicated staff and RTW responsibility generally lies with administration or quality managers, the Director of Nursing or CEO. In these cases, it is difficult to address RTW as this is only one part of their much larger roles.

3.2 RTW Program

All health services visited had documented RTW policies and procedures in place. At a minimum, these are drawn from VWA guidelines and reflect the health service's legal requirements.

The policies and procedures provide a step-by-step process to be followed in the event of an injury and are usually published on the health service's intranet. Not all health services had hard copies available in individual workplaces and it was acknowledged that many workers are unable to access the intranet.

The policies and procedures may have been developed internally or by external consultants and, in most cases, OHS Committees or Health and Safety Representatives have been consulted in developing the documentation. In some health services, specific information packs have been developed and are made available in the event of an injury so both the worker and the manager have a clear understanding of the steps to follow.

Some health services actively review their RTW policy and procedures in light of performance in managing RTW cases so that a continuous improvement process is built into the RTW program.

3.3 RTW Management

All of the expected components of a RTW program were in place across health services. The effectiveness of the implementation of these components varied across each health service.

The more proactive health services were systematically planning for RTW and treating it as part of core business. These health services were developing comprehensive RTW strategies and measures and up-skilling their staff to deliver and continuously improve RTW performance.

These health services ensured that injuries were immediately reported to the RTW coordinator by the line manager and/or injured worker so that action could commence as soon as possible. The Riskman reporting tool or telephone reporting were often used to initiate RTW action. However, reporting processes were lacking in some health services and the RTW coordinator may not receive notification until a claim had been lodged or a medical certificate was received.

Initial contact with the injured worker was normally made by the RTW coordinator to identify the issues involved, explain the RTW process and commence development of a RTW plan. Some health services ensured that initial contact was made by the injured worker's line manager and that the line manager continued as a primary source of contact and support throughout the RTW process.

The level of contact with treating doctors varied. Some health services attempted to make contact as early as possible to explain the nature of the injury, the follow up action in place and the possibilities for return to the workplace with suitable duties. In many cases, however, doctors were difficult to contact or refused to discuss the case with the health service. In some cases, insurance agents were used to provide a conduit to treating doctors.

Most health services maintained a register of other treatment and rehabilitation providers who were generally cooperative and prepared to work constructively with the individual health service and its workers.

Most health services developed a RTW plan when it was apparent that an absence from the workplace of more than ten days was likely. However, a number of health services commenced the preparation of a RTW plan as soon as an injury was notified,

to ensure that workers could either stay at work or be absent from the workplace for the shortest possible period.

The RTW coordinator generally led the preparation of a RTW plan and involved the line manager and injured worker closely in the process. The RTW coordinator continued to monitor the implementation of the plan in conjunction with the line manager and injured worker. Formal review meetings were scheduled, usually fortnightly or monthly, depending on the nature of the issues involved.

In a small number of cases, the RTW plan was put together by the line manager who maintained responsibility for managing and monitoring the implementation of the plan with the injured worker and to address any issues as they arose. One health service, in particular, required the line manager to discuss progress with the plan with the worker at the end of each shift.

Few health services had a systematic approach to the development of suitable alternative duties. Most found the identification of suitable duties difficult, particularly to keep clinical staff in their own work area. Generally a combination of approaches was used including alternative duties in the normal workplace or alternative duties in other work areas (often in Medical Records Departments or undertaking specific projects). Use of supernumerary positions was not encouraged due to the additional costs involved, however, all health services used this approach for short periods when required.

A small number of health services had commenced the process of undertaking a detailed job analysis to develop a register of job tasks to facilitate the identification of suitable alternative duties. This process was linked to the examination of individual position descriptions and workplace assessments, often utilising external expertise to assist.

3.4 Insurance Agents

Many health services were not fully satisfied with the service and responsiveness of their insurance agents.

Some agents are more actively involved than others, usually depending on the approach adopted by individual claims managers.

As well as managing claims, many health services would like their insurance agents to be more proactive in providing advice and assistance on individual claims and to improve overall performance by taking a more strategic view in analysing data and current programs.

It would also be valuable if agents spent more time in the workplace to better understand the nature of the issues which are facing individual health services.

Perceived high levels of turnover amongst the agents' staff may undermine the development of good working relations with individual claims managers.

Some health services were not, however, informed clients and did not understand the services they should be receiving from their agents. Those health services that felt they received better services were more aware of what to ask for and what to expect from their agent.

3.5 Communications and Consultation

Communication specifically relating to RTW matters is generally limited to information being covered in staff inductions or more specific information being made available in the form of an information pack being made available in the event of an injury occurring. Policies and procedures documents are available in either electronic or hard copy but it is generally up to individual staff to access this information.

Consultation occurs through OHS Committees or Health and Safety Representatives on the initial development of RTW policies and procedures. OHS Committees may also consider and comment on RTW performance information.

Some health services communicate proactively with a constant reinforcement of RTW programs and responsibilities through ongoing training programs, OHS Committees, staff communications sessions and the sharing of performance data.

3.6 Training

Most health services do not provide specific RTW training for managers to assist in understanding and managing their RTW responsibilities.

A small number of health services are actively working to enhance the skills of their managers through specific RTW training and more general HR and OHS training to help managers communicate with staff, to identify and deal with issues such as stress, bullying and harassment and to identify and manage risks in the workplace.

Workers generally receive information on OHS and RTW during induction programs. Most health services have also implemented a range of specific training programs to address injury prevention such as the “No Lift” and back care programs and more general risk management programs.

RTW coordinators and claims managers have been provided with specific RTW training, usually through insurance agents or associated with OHS training from specialist advisers. Broader HR management training may also be provided. Some limited training has also been provided to assist RTW staff to understand some of the clinical issues relating to injury management and RTW.

3.7 Monitoring and Reporting

Most health services report on a regular basis to the Executive and Board on OHS/RTW performance. The range of indicators for RTW is limited – most health services report WorkCover claims, for example, by number, type and cost of claim. Some health services actively benchmark their performance in these areas with other health services.

A small number of health services report the status of individual claims and have established specific RTW performance targets based on the percentage of employees returned to work within 10 or 20 days.

The more proactive health services break down these performance reports and targets to a divisional level and work with individual managers to monitor and improve their performance measures. In some health services there are regular meetings between senior management and line managers to review RTW and the status of individual cases.

The level of involvement of the Executive and Board in actively monitoring and driving improvements in RTW performance varies.

CEOs in rural and regional hospitals are generally actively involved, often taking direct responsibility for managing RTW cases in conjunction with their line managers. Some CEOs in the larger metropolitan health services are also actively involved in reviewing performance and holding discussions with individual managers on RTW cases. In other health services, executive management involvement may be limited to when a particularly high profile injury or claim occurs.

Some Boards have required individual managers to regularly explain their RTW performance. However, not all Boards are similarly involved.

A limited number of health services have recognised the benefits in driving performance through financial accountability and have devolved WorkCover premium responsibility to individual cost centres (usually based on staff numbers or remuneration levels) and report WorkCover and RTW costs for individual cost centres.

3.8 Barriers

During the discussions a number of barriers were identified which generally apply across the sector and which mitigate against effective RTW practices.

i) Workforce composition

All health services identified workforce composition as a major issue. Generally, the workforce is ageing, predominately female and part time. This presents significant challenges in job design, workplace culture, managing change and education and training. Many examples were cited of workers' reluctance to adapt new approaches to issues such as manual handling where, despite extensive training, workers revert to old behaviours which make them more susceptible to injuries.

As would be expected, there are additional challenges in managing RTW for older and long term employees. The literature review shows that injured workers bring with them issues associated with both their psychosocial framework and the injury. These issues may be magnified for older employees and may impact significantly on their rehabilitation. Support from the outset of their injury from their line manager and the RTW coordinator becomes a critical factor in managing these issues.

ii) Workplace stress

Workplace stress was identified as a significant and emerging issue. Most health services noted that stress claims tend to relate to workplace change, performance management/discipline issues and staff interactions rather than staff/client issues. Some health services felt their positive workplace culture and management education helped them to avoid or better manage stress claims. Where claims do occur and relate to these issues, there is an increasing tendency to challenge the validity of such claims.

iii) Suitable alternative duties

This presented a major challenge for all health services. Given budget and staffing constraints, it is difficult to identify suitable duties to facilitate RTW, particularly in clinical areas where light duties or a phased return to work may be required.

iv) Culture

A number of cultural issues were raised as potential barriers. These included a view that staff care is not as important as client care. Prejudices against workers on RTW programs still exist and need to be addressed. Some managers are reluctant to take on workers on RTW plans out of concern that they require too much management time or will not be productive in the workplace. Some staff still see workers on RTW plans as in some way taking advantage of the system.

v) Management commitment

Most health services still need to enhance the level of line manager commitment and understanding of their RTW responsibilities. In some cases RTW is not seen as part of core business and is not given appropriate priority compared to other issues. Managers may see RTW as a time consuming process or feel uncomfortable talking to injured workers. Many managers have not had any formal training in RTW management.

vi) Treating general practitioners

Most health services found it difficult to establish cooperative relationships with treating GPs. Many GPs were unwilling to enter into discussions with the health services or were too busy to take calls. Examples were cited of GPs writing “light duties” on a medical certificate without any further description of what this means. RTW coordinators often found it difficult to have the GP understand what is involved in job tasks and therefore what constitutes “light duties”.

The GP can play an important role in facilitating effective RTW by:

- ensuring the injured worker is aware of the importance of an early return to work as well as letting them know that they may do this with partial capacity
- detailing the nature of work restrictions rather than making a generalised finding of incapacity
- recommending occupational rehabilitation or other services and
- encouraging “active” treatment programs in the home and at work.

The extent of GP knowledge of the RTW process, the time they can give to communication with the employer and their engagement in the process can therefore significantly affect RTW outcomes. When contact can be established between the health service and treating GPs and the issues properly explained, including RTW opportunities, there tended to be a more positive approach from GPs.

vii) Adequate and planned prevention activities

Many health services identified that, whilst the nature of musculoskeletal injuries was becoming less severe, the types of injuries were changing from lower back to shoulder and neck. This was attributed to the introduction of different kinds of risk controls such as lifting devices. RTW staff identified that a lack of focus on carefully assessed ergonomic design of equipment had created additional problems for RTW.

3.9 Rural and Regional Health services

Health services in rural and regional areas, whilst needing to address the same issues as the metropolitan health services, had a number of issues which they had to consider relating to their specific circumstances.

Many rural and regional health services did not have dedicated RTW or claims management staff, nor access to specific RTW expertise other than through their insurance agents who were often not located locally. In many cases RTW responsibilities were added to the roles of the CEO, Director of Nursing, Quality Manager or Corporate Services Manager. In the context of a much broader role, it was often difficult to give RTW the required priority.

Whilst rural and regional workforces generally reflected the same compositional issues as in metropolitan areas, there were other factors to consider. Often the health service was the major employer in a small community and many of the staff also worked part time on family farming properties. Cultural and change issues became harder to manage in a small community.

Access to treatment providers is also limited. Many treating GPs worked at the local hospital and had a close relationship with the health service's workers. In these circumstances it was often much harder for the health services to establish cooperative relations with doctors and to get them to consider the whole range of RTW considerations.

Rural and regional health services did not always have ready access to their insurance agents. In some cases the agents were located locally, but in other cases the agent was located some distance from the health service and did not have a good understanding of the local issues involved.

Location was also an issue for staff training and development, with many training courses held in Melbourne, necessitating considerable travel time, which many staff could not afford to spend away from the workplace.

3.10 Financial Impact of Improved RTW Performance

Those health services which had a proactive and comprehensive approach to RTW management could generally also show performance trends which were better, on average, than the sector as a whole. Whilst improved RTW management could be expected to, over time, lead to better financial outcomes, there is not necessarily a short term or direct relationship, particularly with WorkCover premium, as many factors may impact on the performance data.

For example, two of the health services cited as good practice case studies in **Attachment 1** achieved reductions in their preliminary premium costs for 2007/08 of \$700,000 and \$400,000 respectively. The two other health services used as case studies experienced increases in their preliminary premiums of around \$400,000 and \$600,000 each - one of these health services held its ranking in the total standardised claims rankings for metropolitan services. The other has shown a 50 % reduction in its musculoskeletal injuries in the two preceding years, however, it experienced two significant journey claims over the period which have affected its premium rate.

The VWA method of calculating premiums changed in 2004/05. From that time, health service health services were “pooled” with all health industry participants. This statistical claims estimate approach compares each claim with the average duration and costs of claims of that type for the whole of the health industry. This creates an attributed rate for the type of claims that is used to calculate the claims cost irrespective of where the claim occurs. Effectively, every health service has the same claims costs estimated for the type of claim.

Premiums calculations are now based on performance information over a three year rolling period, considering total costs (including statistical claims estimates) and total remuneration over the period. Accordingly it may take three years to show a change in RTW performance, unless there is radical change in workplace injuries.

The main influence on the statistical claims estimate is the amount of weekly payments to an injured worker. The longer an injured worker is off work, the higher the weekly payments. Each health service is able to influence its premium by reducing its claims through prevention and by returning workers back to work as soon as possible following an injury. There is less opportunity than previously for each health service to reduce its premium through demonstrating improvement in performance over a period shorter than the three year premium period. However, improved performance over the premium estimate period, should deliver an improved premium.

Over time, however, if performance in both injury prevention and injury management is maintained, a sustained improvement in premium, and therefore financial outcomes for the health service, can be expected. Any financial savings could be considered for further investment into OHS and RTW programs.

4. Good Practice in RTW Management

4.1 Sector Case Studies

Across the sector there are a wide range of what could be considered good practices in place. Many of these reflect the good practice identified from international research and in other jurisdictions – see below.

Several organisations have developed very effective and innovative approaches to managing their RTW responsibilities. These are summarised as four case studies in **Attachment 1**.

The key elements of good practice identified from these case studies include:

- a clear focus on injury prevention, supplemented by incident reporting and investigation procedures and a strong commitment to hazard and risk management.
- adoption of RTW as a core business capability with detailed responsibilities established and managers held accountable for RTW performance.
- a strong commitment to training and education in all facets of RTW management.
- continuous review of policies and procedures in light of RTW performance.
- early intervention and development of RTW plans as soon as an injury is reported.
- line managers are actively involved in all aspects of RTW management.
- good communication and teamwork between all stakeholders, including managers, injured workers, RTW staff, treating medical professionals and insurance agents.
- a proactive approach to planning for and identifying suitable duties to return injured workers to the workplace.
- a supportive culture with a broad approach to staff welfare including, for example, access to an Employee Assistance Program (EAP) offering independent and confidential support through financial, personal and relationship counselling.
- a rigorous approach to measuring and reporting RTW performance.
- devolution of financial accountability for RTW performance to line managers.

Whilst none of the health services visited could say that they have all of these practices integrated across their organisation, the practices currently in place provide the basis for developing a good practice model for RTW management for the sector as a whole – see **Section 5**.

4.2 Literature Review

Published literature was accessed through an internet search. In addition, other literature not readily available through commercial channels was accessed from a range of sources including scientific and technical reports, conference papers, government documents, newsletters, etc. Web sites for each Australian workers' compensation authority were searched, specifically for standards and research on effective RTW practices conducted by or on behalf of these authorities.

The results of the literature review and the identified sources are set out in **Attachment 2**.

In summary, research into workplace disability and RTW has established the importance of psychosocial factors in managing RTW. This requires treatment of the full range of factors that affect the injured worker, including factors such as depressive illness, fear, inadequate coping, negative attitudes towards returning to work, poor perceptions of general health, emotional distress and depression.

Other consistent predictors include demographic factors, occupation, work history, employment status, amount of time off work, social and environmental factors and biological factors (including previous injuries).

The research clearly indicates that effective RTW management must address:

- appropriate and effective systems, competent and knowledgeable RTW staff and line management and a positive and supportive culture towards the return of injured workers to their normal duties.
- the individual worker's understanding and expectations about their medical conditions and return to work, including negative emotions and attitudes towards their rehabilitation.
- effective and timely communication and good teamwork between stakeholders.
- early intervention and early return to work.
- different interventions according to the phase of injury and rehabilitation.
- continuously improving systems, processes, skills and knowledge.

The research also highlights major barriers to effective RTW including:

- poor communication between stakeholders.
- not returning a worker to work when fit for duty.
- delays in processing information or claims.
- a lack of teamwork, trust and credibility .
- failure to screen for or recognise psychological factors affecting RTW.

4.3 Practice in Other Jurisdictions

Discussions were held with a number of organisations from other Australian jurisdictions to understand their approach to managing RTW and to gain the benefit of any innovative approaches which have been developed. The outcomes of these discussions are summarised in **Attachment 3**.

Experience in these health services, points to the following features of good practice in RTW management:

- RTW is clearly established as part of core business and is a line management responsibility.
- dedicated education and training is provided for RTW staff, line managers and executives.
- a strong emphasis on managers having the required confidence and skills to communicate with injured workers.
- early intervention using incident notifications systems.
- standards are established for the time in which RTW plans must be developed.
- adopting a case management approach to RTW and ensuring that psychosocial issues are identified and managed as appropriate.
- engagement of GPs in the RTW process.
- strong communication between all stakeholders is maintained throughout all stages of case management.
- the capacity to act as an informed client in relation to insurers and establishing.
- clear service standards and access to information.
- a culture of safety and continuous improvement.
- integration of the prevention and management of workplace injuries with OHS planning and programs, especially in relation to procurement of equipment and work design.

4.4 Summary

Current practices in place across the sector, the results of an international literature review and experiences from other jurisdictions clearly establish the framework for a Good Practice Model for RTW management. The central components of such a model are set out in the following section. A RTW Self Assessment Matrix has also been developed to assist health services in evaluating their current practices and planning improvements to their current approaches in order to move towards the Good Practice Model.

5. A Good Practice Model

The application of RTW good practices will provide direct and indirect benefits to health services and their employees.

For the health service there will be better overall outcomes in terms of reduced lost time, reduced costs of replacement staff and lost productivity, improvements in staff turnover and morale, a stronger culture and, over time, reductions in WorkCover premiums and injury costs.

For employees there will be better personal health outcomes, a faster return to work, reductions in loss of pay and a more positive work environment.

Other stakeholders will also benefit. Treating health practitioners, rehabilitation providers and insurance agents will all benefit from clear communication, well defined processes, a cooperative relationship and early involvement.

This section describes the characteristics of a possible Good Practice Model for Victorian health services, based on the needs of the sector, the practices already in place across the sector and evidence drawn from the literature review and experiences in other jurisdictions.

Obviously, the Good Practice Model should not be applied prescriptively across each health service. Health services should consider their own circumstances and needs against the requirements of the model and then adapt the provisions of the model in a way which best reflects their needs.

The model is linked to a RTW Self Assessment Matrix (**Attachment 5**) which individual health services could use to assess their current standard of RTW management performance and identify actions to improve their performance. This matrix broadly aligns with the OHS Self Assessment and Performance Reporting Matrix set out in the DHS–Public Hospital Sector OHS Management Framework Model. This Management Framework was developed in 2003 to assist Victorian health services to adopt a structured and systematic approach to improving their OHS management performance.

Prior to adoption, the Good Practice Model and Self Assessment Matrix were tested and validated with representatives from a number of both metropolitan and rural/regional health services to ensure that they meet each health service's particular circumstances and needs.

5.1 Good Practice Model - Commitment, Policy and Procedures

RTW will be identified in the health service's business plan as a core management outcome.

A clearly articulated RTW Policy will be in place setting out commitment and objectives for RTW. As well as meeting all legal requirements, these will include commitment to:

- injury prevention.
- early intervention if an injury occurs.
- return to work as soon as an injured worker is fit for duty.
- where possible, provision of suitable employment to facilitate a speedy return to work.

The Policy will establish specific RTW responsibilities for managers and employees and provide for regular review and revision to reflect continuous improvement in RTW management.

The Policy will be signed by the CEO and communicated throughout the workplace and to external stakeholders. The Policy will be explained and reinforced during training programs and inductions so that new staff are aware of, and understand, the Policy.

The Policy will be underpinned by RTW procedures which establish a step-by-step process for dealing with all RTW matters so that managers and employees can see what has to happen at each stage of managing an injury and RTW. These procedures will be readily accessible throughout the workplace in both electronic and hard copy format.

The Policy and procedures will be promoted and explained to external stakeholders, including treating medical practitioners, providers of rehabilitation and other services and insurance agents.

5.2 Good Practice Model - Responsibilities

RTW responsibilities and accountabilities will be clearly defined and communicated across the health service so that senior managers, line managers and employees will all understand their roles and responsibilities in effective RTW management.

Specific RTW responsibilities will be defined and documented for all management positions. Managers will recognise that they are responsible to manage RTW for their staff, working with the guidance and assistance of the RTW coordinator. RTW will be a core management responsibility and will be reflected in relevant performance indicators linked to the health service's RTW goals.

Senior management contracts will specify RTW accountabilities and key performance indicators.

A dedicated manager will be given responsibility for the health service's RTW program and be provided with the appropriate skills, knowledge and support to undertake this responsibility. A RTW coordinator will be appointed and the position's responsibility defined to reflect legal requirements to manage the day to day implementation of the health service's RTW program.

RTW responsibilities will be regularly reinforced and managers will be held accountable for meeting their RTW responsibilities through regular performance discussions.

Employees should also have RTW responsibilities established and be encouraged to participate positively in the RTW program and follow all required procedures if they are injured at work.

5.3 Good Practice Model - Consultation and Communication

OHS Committees and Health and Safety Representatives will be involved in developing the health service's RTW Policy and procedures and will continue to be actively involved in monitoring and reviewing RTW performance through consideration of performance reports and presentations from line managers on RTW performance.

Effective communications will ensure that managers and employees are aware of the health service's RTW program and that the health service's commitment to effective RTW is reinforced at every opportunity through, for example, newsletters, communications forum, meetings and training and induction programs.

5.4 Good Practice Model - Training

RTW will be seen as a core competency for the health service. Specific training programs will be developed for managers to ensure that they are able to meet their RTW responsibilities.

As well as addressing specific RTW competencies, training for managers will also address broader HR management skills to enable managers to communicate effectively with their staff, resolve workplace conflict, identify and address early warning signs before an injury or claim occurs and address issues in the workplace such as aggression, bullying and harassment.

RTW and claims management staff will be provided with training to ensure they have the required skills and to continuously upgrade and refresh their skills. This will include an understanding of the broader psychosocial issues which can impact on RTW performance and ongoing development of their understanding of the key clinical issues associated with injury management.

Employees will also be trained to ensure they understand their responsibilities and the health service's policy and procedures and commitment to effective management of RTW. This will occur at induction and be regularly reinforced through communications and OHS training sessions.

5.5 Good Practice Model - Risk Management Program

In accordance with the *Accident Compensation Act 1985* (section 156/159) a risk management program to deal with individual cases must provide for the steps to be taken after an injury has occurred in the workplace to, as far as is practicable, reduce the risk of subsequent injury of that kind. This could be linked to the overall OHS risk management program.

As part of the health service's OHS and RTW management system, a comprehensive risk management program will be in place focussed on positive action to prevent injuries and rapidly responding to injuries should they occur. This program will establish processes to systematically identify the health service's major workplace risks and put in place programs to remove or control those risks. These will include, for example, long term planning for improved contract arrangements and specifications for ergonomic equipment renewal, replacement or redesign, work process redesign and staff training.

The risk management program will be developed in consultation with OHS Committees or Health and Safety Representatives. A range of strategies will be in place to identify hazards including incident and injury reporting and investigation, workplace inspections and OHS audits.

Managers and employees will be trained to identify hazards and manage risks and in the implementation of safe work procedures for hazardous activities.

5.6 Good Practice Model - RTW Management

5.6.1 Early Intervention

The health service's approach to RTW management will be based on early intervention once an injury occurs to facilitate speedy and effective RTW.

The health service will have a reporting system in place that notifies relevant managers and the RTW coordinator immediately an injury occurs. This will involve, in the first instance, verbal communication (possibly through an injury reporting hotline) on the nature of the incident and injury, which will be followed up with electronic or paper-based reporting.

Immediately on notification, the injured worker's line manager will contact the injured worker to ascertain the nature and extent of injury and the circumstances surrounding the injury and to ensure that appropriate action has been taken to care for the worker. Initial contact may be by telephone, followed by personal follow up within a short period. Personal contact between the line manager and injured worker will continue throughout the RTW process.

The RTW coordinator will follow up with both the line manager and worker to explain the injury management and rehabilitation process and discuss the involvement of medical practitioners. The RTW coordinator will talk with the treating GP, ensure all required paper work is completed and commence the RTW plan.

The RTW coordinator will make an initial assessment, in conjunction with the injured worker and line manager, of the duties that can be performed as part of the RTW plan, including changes to the workplace that may be required in order to return the injured worker to the workplace in the shortest possible time.

At this stage, consideration will also be given to possible psychosocial, behavioural and environmental factors that may affect RTW and any action required to address these issues will be put in place, including, for example, changes in the workplace to

address environmental problems or referral to appropriate counselling or support services.

Whilst the RTW coordinator will provide the critical link with the RTW planning process and ensure effective liaison with all stakeholders, the line manager will continue to be responsible for managing the injured worker, monitoring their progress in the workplace and ensuring all required actions are taken to facilitate a return to productive work.

If it is not appropriate for the injured worker's direct line manager to make and maintain contact with the injured worker they should nominate another management representative. Where this is not possible, the RTW coordinator will establish and maintain contact or will nominate another management representative to do so.

5.6.2 RTW Planning

The RTW planning process will commence immediately an injury has been reported and an assessment has been made of all the factors involved. RTW planning will not wait until the likely period of absence from work has been confirmed or a WorkCover claim has been lodged. RTW planning will apply equally in the case of either compensable or non-compensable injuries.

The RTW coordinator, in consultation with the injured worker and their manager, will develop an individual RTW plan. Where the injured worker has sought medical assistance, contact will be made with the treating practitioner to outline the options available for either remaining in the workplace or returning to the workplace as soon as possible. A RTW plan will be provided to the line manager, injured worker and treating practitioner within 48 hours, or as soon as possible, of an injury being notified.

Where possible, the injured worker will be able to remain in the workplace through a combination of suitable alternative duties, changes in the workplace and/or a graduated return to full duties whilst undergoing treatment.

If the injured worker is not able to remain at work, suitable duties will be offered as soon as possible to encourage an early return to work. The RTW coordinator will work closely with the injured worker and the treating GP to show how the health service can offer suitable duties to assist with the injured worker's rehabilitation.

Implementation of the RTW plan will be continuously monitored by both the line manager and RTW coordinator. The line manager should make contact with the injured worker on a frequent basis and to identify and resolve any issues with the RTW plan as they arise. Formal review meetings will also be held to monitor the injured worker's progress. The frequency of these meetings will depend on the nature and severity of the injury. Regular claims review meetings will also be held between the health service and insurer.

The RTW coordinator, in collaboration with the doctor, will identify any rehabilitation services required and provide options for access to those services to the injured worker. The RTW coordinator will also make contact with the health service's

insurance agent to notify them of the injury and intended action and seek any required assistance and input.

Regular contact will be maintained with treatment providers throughout the management of each case. For more complex cases, regular case conferences will be held involving the RTW coordinator, treatment providers and line managers to discuss progress in treatment and RTW and any changes required to the RTW plan.

The importance of a supportive culture in facilitating effective RTW will be recognised by the health service and measures will be put in place to develop and maintain such a culture. These will include ongoing communications about the importance and benefits of the RTW program, maintenance of links between the workplace and injured workers and development of staff welfare programs through, for example, a confidential Employee Assistance Program (EAP) to support and assist staff with both work and non-work related problems.

5.6.3 Suitable Employment

The health service will have undertaken a workplace assessment using a standardised template to examine each class of job across the health service to identify the essential characteristics of each class of job and explain these in written and pictorial format as a reference guide to developing suitable alternative duties for injured workers. The line manager and RTW coordinator will use the register to identify suitable duties and to provide relevant information to the injured worker and the treating practitioner to assist in the development of individual RTW plans. Some very large health organisations may find it more practical to undertake a register in a more general sense due to the complexity and size of the organisation. In some cases, suitable employment may be found outside the constraints of normal hospital staffing levels and budgets (eg: on a supernumery basis).

5.6.4 Stakeholder Engagement

There will be a strong sense of teamwork between all stakeholders in achieving good RTW outcomes for the health service and its employees.

The health service will have established a register of preferred treating practitioners and rehabilitation providers which can be provided to the injured worker. The health service will maintain regular contact with these service providers to ensure that they are aware of the health service's commitment to RTW and understand the health service's Policy and procedures and are aware of the health service's operating and work environment.

The health service will have a close working relationship with its insurance agent. The insurance agent will take a proactive role in working with the health service to analyse and improve RTW management and will:

- manage all claims and provide all necessary administrative services.
- provide advice and assistance on individual claims.
- facilitate independent medical assessments where required.
- keep claims information accurate and up to date.

- track claims and undertake regular claims reviews.
- provide training options for managers and staff.
- provide reports focusing on the key performance areas.
- undertake an analysis of performance data to develop options for improving overall RTW performance.

5.7 Good Practice Model - Performance Monitoring and Reporting

A case management system will be in place to track all claims and actions against those claims. The system will provide the same information to line managers and RTW coordinators/claims managers and will provide prompts for required actions. Ideally the system will link to the insurance agent's claims management software to ensure that both the health service and its agent are operating from the same information.

Claims management information will be reported at individual department level and regular claims management meetings will be held between the RTW coordinator and department managers to monitor the management of claims.

Regular meetings will be held between the RTW coordinator/claims manager and the insurance agent to address specific claims issues. Formal claims reviews will be held and the focus on managing long term claims will be as strong as short term claims.

KPIs and performance targets will be established to measure and improve RTW performance. These will address, for example, the time taken to develop and implement a RTW plan, the time taken to return an injured worker who is fit for duty to the workplace and management and employee training. Performance against these KPIs and targets will be reported regularly at both the health service and department level.

The Board and CEO will provide strong leadership in driving RTW performance and will be actively involved in establishing performance targets, reviewing performance reports and assessing performance, including holding individual managers accountable for their performance.

Board members and the CEO will have undergone training in the key elements of RTW management so they are able to assess performance and hold managers accountable.

Financial accountability will be devolved to individual cost centres to drive responsibility and individual performance. RTW costs will be established as a line item in department budgets and WorkCover premium will be devolved on the basis of a weighting of staff numbers, remuneration and claims performance.

5.8 Good Practice Model - Continuous Improvement

Implementation of the RTW program will be subject to independent audit and audit results and performance information will be analysed and used by the health service to continuously improve RTW performance.

Feedback from injured workers, managers and RTW staff on their experiences with the RTW program will be considered and built into the continuous improvement process.

The health service's RTW program and performance results will be shared and benchmarked against other health services to ensure that continuously evolving good practices are identified and applied.

6. Key Strategies

This section puts forward a number of possible strategies for consideration to improve the management of RTW across the sector and to assist health services move towards the identified Good Practice Model. Strategies are suggested for application at two levels:

- i) strategies which could apply across the sector and which could be initiated and sponsored by the Council. At this level, the Council could consider collaborating with the Department of Human Services and the VWA to draw on the resources and expertise available within the VWA to develop and promote specific projects to improve RTW outcomes across the sector.
- ii) strategies which could be considered and applied by individual health services – in particular, individual health services could undertake an assessment against the proposed Good Practice Model to identify improvements which could be implemented relatively quickly and with limited resourcing to improve their RTW performance.

The Council could consider each of these strategies against their capacity to achieve the Council's objectives, their likely cost and resource implications and the capacity of health services to implement RTW changes.

In many cases the proposed strategies are based on measures already in place in individual health services. These could be examined and adapted by selected user groups for application across the sector, thereby limiting development costs and resource and change management implications. This would be the case, for example, in developing a RTW and claims management data base, a job analysis template and a financial accountability model.

Attachment 6 lists possible time frames and resource and change management implications for each strategy.

6.1 Sector Level Strategies

A number of the strategies listed below could be developed and implemented in a relatively short time frame and with limited resource implications. These strategies should be the initial focus of the Council's consideration.

6.1.1 Promotion of the Good Practice Model and Self Assessment Matrix

If the Council accepts the proposed approach to a Good Practice Model and Self Assessment Matrix, Council could consider publishing the model and matrix and promoting their application across the sector.

The model and matrix were validated prior to publication. This involved selected health services assessing the validity and practicality of the proposals, against their particular circumstances and needs. This was a similar process to that adopted for finalising the DHS–Public Hospital Sector OHS Management Framework Model.

Once that model was published it was well accepted by those health services that recognised the need and/or lacked the resources to improve their OHS performance.

Benefits – promotion of the benefits and requirements to achieve RTW good practice.

6.1.2 Key Messages Campaign

Council could consider sponsoring a Key Messages Campaign to identify the central components of the Good Practice Model and promote these individually as key messages across the sector. These could include, for example, the importance of:

- injury prevention
- looking for the early warning signs
- early intervention
- manager involvement
- keeping injured workers in the workplace
- the role of the GP and treating health professionals

A range of mediums could be used to distribute and promote these messages, including simple posters, e-mail or online messaging and the use of RTW “experts” to talk at sector forums.

Benefits – promotion of the key issues which are central to RTW good practice.

6.1.3 Board Awareness

An education campaign could be developed for health service Board members targeting what they need to know about improving RTW performance in their organisations.

Board members have a key role in setting expectations and required standards in RTW management and holding management to account in meeting these expectations and standards. In order to do this effectively, Boards need to understand the RTW process, the key drivers of good performance, how their health services perform compared to other health services across the sector, what they can do to improve the health service’s performance and the benefits which will accrue in terms of better financial, client care and staff outcomes.

The evidence shows that those organisations where the Board is closely involved in setting expectations and driving performance have achieved far better RTW outcomes.

A simple publication could be prepared addressing these issues. This could be supported by short targeted presentations and/or training sessions for Board members.

Benefits – well informed Boards capable of driving improved RTW performance.

6.1.4 Sector Wide Networking

The current sector wide OHS forum provides a valuable mechanism for health services to network and exchange OHS experience and good practice and benchmark performance. This forum could either be extended to include the management of RTW or another forum developed with similar objectives but focussed on RTW.

Benefits – improved performance through sharing of experience and good practice and benchmarking of performance.

6.1.5 Management Training

Whilst a limited number of health services have developed specific RTW training for their line managers, the understanding and acceptance of RTW as a core management responsibility still needs to be developed and reinforced across the sector. The evidence shows that where executive and line managers have the required level of understanding and expertise and line managers are closely involved in managing injured employees in the workplace, RTW performance improves.

Council could consider sponsoring the development of a management training package specifically targeting the understanding and skills required by executive and line managers to accept and implement their RTW responsibilities as part of their day to day management roles.

As well as specific RTW understanding and skills, a key component of this training package, particularly for line managers, should be to address the broader HR skills required, particularly by line managers, to communicate effectively with staff on RTW issues, to identify and resolve conflict in the workplace and to understand the early warning signs and address issues which are likely to lead to injuries and/or claims.

Once the program has been developed, the Council could consider contracting an organisation to deliver the program at metropolitan and major regional venues. Alternatively, the Council could leave individual health services to fund delivery of the program through a contracted provider.

Benefits – better skilled managers who recognise their RTW responsibilities and have the capability to manage RTW effectively in the workplace.

6.1.6 Regional Resourcing

Rural and regional health services, particularly the smaller health services, lack dedicated resources and expertise to address RTW.

This was also an issue in developing improvements in OHS management performance as a result of the publication of the DHS OHS Management Framework. In response to this issue, the Department has put in place a pilot program to provide a regionally based resource to assist health services in developing their OHS management systems and improving OHS performance. This resource and the services provided are valued by smaller health services and proving to be effective in assisting them adapt a more systematic approach to OHS management.

A similar approach could be considered in assisting these health services address their RTW performance. A regionally based resource could work with smaller health services to assess their RTW performance and assist in developing an improvement program and implementing improvements, along with providing expertise to assist in RTW issues until the health service has been able to develop its own resources and expertise.

Benefits – improved understanding and management of RTW in smaller health services.

6.1.7 Development of a RTW and Claims Management Database

A number of models currently exist within the sector for a RTW and claims management database which enables health services to closely track, monitor and report the status and costs of each claim and individual RTW plans. These databases are broken down to individual departments and are available to RTW staff and line managers. The systems may also provide automated reporting to facilitate analysis of trends and RTW performance. In health services where such databases are in place, staff have found them invaluable in tracking and systematically managing RTW actions.

The Council could consider sponsoring a user group of RTW staff to assess current models and adapt these to develop a standard database to be made available across the sector to assist health services adopt a systematic approach to RTW and claims management. The system could be run effectively on an Access database and need not be costly to develop, implement or maintain.

Benefits – more effective and systematic claims management.

6.1.8 Development of a Job Analysis and Suitable Duties Register Template

A small number of health services are developing a more systematic approach to identify and plan for the provision of suitable duties to facilitate an injured worker's return to the workplace.

The Council could consider assisting health services to develop a standard job task analysis template. This would use diagrams and text to analyse classes of jobs within an health service and describe the range and frequency of actions involved in each position. This would lead to the development of a register of suitable duties to assist in determining what can be done by an injured worker. These could provide information for treating GPs to explain the nature of tasks that can and cannot be done at different stages of injury management and rehabilitation.

An occupational therapist or ergonomist may need to be engaged to develop the template, instructions for its use and possible examples to guide each health service in using the template to undertake its own job task analysis.

Benefits – a more systematic approach to identifying suitable alternative duties to facilitate the return of injured workers to the workplace.

6.1.9 Improved Performance Data and Benchmarking

Continuous improvement in RTW performance will need to be driven by detailed performance data enabling the analysis of statistical trends and performance characteristics and the development of targeted KPIs.

Currently the data available to health services is at a high level addressing a range of aspects such as claims counts, nature of injury, premium outcomes, number of claims and costs, percentage premium changes. Some comparisons are currently undertaken addressing Employer Performance Rating, premium versus remuneration and costs and claims data.

However, to be able to analyse and improve RTW processes and performance, a greater capacity is required to be able to interrogate data at a detailed level addressing, for example, comparison and analysis of RTW processes by organisational function, time off work, claim type, nature of afflictions, costs, closure rates for type of claims, RTW process metrics and other selected aspects of RTW management.

Once appropriate data systems have been developed health services will be better able to understand the key drivers, develop and measure KPIs to drive management reporting and improved performance and to benchmark key measures across health services and the sector as a whole.

The Council could consider sponsoring a user group of RTW managers, IT experts, and agents to improve the quality of data, the capacity to interrogate data and to provide comparable data at both a system wide and individual health service level.

Benefits - more effective analysis, measuring, reporting and benchmarking.

6.1.10 Standardised Financial Model for Premium Devolution and RTW Budgeting

To reinforce RTW as part of core business, the performance of each business unit needs to be capable of measurement and reporting. Allocation of financial accountability will drive understanding and improvements in RTW performance at the business unit level and facilitate better planning and delivery of RTW services.

The Council could consider examining existing approaches to financial accountability in place in some health services to provide the basis for a standardised financial accountability model by which premium and RTW costs could be devolved to individual departments. This model could be developed by a user group of RTW and finance managers from within the sector.

Benefits - a consistent approach to financial accountability for RTW performance.

6.1.11 Engagement of Treating Practitioners

A major problem for health services has been the difficulty in developing and maintaining positive and productive relations with treating GPs. Many GPs do not fully understand the RTW process and either refuse to talk with health services or do not have the time to discuss RTW issues.

Where a GP understands RTW requirements and has an open and cooperative relationship with health services, the quality of RTW outcomes can be significantly improved.

The Council could consider working with the VWA to initiate discussions with the Royal College of General Practice, representing treating GPs, as to how GP knowledge of the RTW process can be enhanced and how a more cooperative engagement can be achieved between GPs and health services in improving RTW performance.

The VWA could consider conducting a campaign of basic messages for GPs about their role in workers compensation and RTW. The recent VWA campaign on managers' responsibilities has received good feedback and had a positive impact on line managers in some health service workplaces.

Benefits – earlier RTW for injured workers by facilitating greater teamwork between health services and GPs in achieving improved RTW outcomes.

6.2 Health Service Level Strategies

The following strategies are put forward for consideration as the key initial steps to be taken by health services to achieve a long term improvement in their RTW performance. Most of these strategies could be implemented quickly by individual health services and lead to improved performance with limited resource implications.

6.2.1 Adoption of Good Practice Model and Self Assessment Matrix

Each health service should consider its current approach against the Good Practice Model and use the Self Assessment Matrix to assess their current level of performance and identify areas for improvement.

This will require an objective and evidence based approach to considering actual performance and application of the health service's RTW policy and procedures in the workplace, rather than a subjective assessment of what should, or is thought to be, in place.

Based on the evidence provided through health service visits and interviews, all health services should be able to identify areas for improvement which could be implemented relatively quickly and with limited resourcing to improve their overall RTW performance.

Health services should be able to conduct the initial assessment using their existing resources. However, health services may choose to engage external expertise or their insurance agent to assist in the process and the subsequent development of a RTW Strategic Plan.

Benefits – improved understanding of the requirements for good practice RTW.

6.2.2 Development of a RTW Strategic Plan

Once an health service has assessed its current level of performance against the Good Practice Model, the health service should consider preparing a RTW Strategic Plan setting out its RTW objectives and identifying key improvements and actions to move towards good practice. The plan would establish specific actions, time frames, performance targets and KPIs to monitor progress and enable the health service to demonstrate actual improvement in RTW processes and outcomes.

If not already in place, a key component of each RTW Strategic Plan should be a focus on early intervention as a key driver of improved performance.

A senior executive should be given responsibility for implementation of the plan and reporting requirements put in place to ensure that the Board and CEO are kept informed and remain closely involved in monitoring RTW improvement.

The plan would be widely promoted to show the health service's commitment to a positive approach to RTW and to assist in creating and maintaining a supportive RTW culture.

Benefits – identified opportunities and a specific plan for improvement in the management of RTW.

6.2.3 Review of RTW Policy and Procedures

Health services should review current RTW policy and procedures against the Good Practice Model and publish and promote a revised RTW Policy and Procedure Manual. Regularly reviewing RTW policies and procedures should be an ongoing task undertaken by management and OHS Committees.

Benefits – documented good practice RTW policy and procedures which are promoted widely throughout the workplace.

6.2.4 Development of RTW Responsibilities

Specific RTW responsibilities should be documented for all managers and RTW staff and included in position descriptions, along with KPIs linked to the health service's RTW objectives. Performance against these objectives and indicators should be assessed in regular performance discussions.

Benefits – clearly documented and understood management responsibilities for RTW.

6.2.5 Development of Skills and Expertise

Health services will need to develop the skills and expertise of line managers to be able to take an active role in managing injured workers. This should include, as well as specific RTW expertise, broader HR skills to communicate with injured workers, recognise and address early warning signs and address issues in the workplace such as conflict, bullying and harassment.

Health services could develop specific programs to up-skill their managers in this area. Alternatively health services could adopt programs sponsored by the Council or seek assistance from their insurance agents to provide relevant programs.

Benefits – managers will develop the skills and expertise to actively participate in managing injured workers.

6.2.6 Communications and Consultation

Assessment against the Good Practice Model and development and implementation of a RTW Strategic Plan provides a positive opportunity for health services to actively engage employees, OHS Committees and Health and Safety Representatives in the process of improving RTW management.

Benefits – a more supportive RTW culture.

6.2.7 Stakeholder Engagement

Health services should actively engage stakeholders in the process of assessing and improving RTW performance. This will provide a positive opportunity to communicate with service providers, including medical practitioners, and the health service's insurance agent about their views of the process and possible improvements and to keep them actively involved in any changes which are made.

Benefits – a stronger sense of teamwork between all stakeholders in achieving good RTW outcomes.

7. Conclusion

Victorian health services have a range of practices in place to manage the RTW of their injured workers. Based on the information gained from health service visits and interviews with a wide range of people involved in the RTW process, all health services are, as a minimum, meeting their legal responsibilities and addressing the criteria established by the VWA for RTW management, however this does not necessarily meet best practice standards.

Across the sector there are many examples of good practice in place and a number of health services have adopted innovative and proactive approaches to managing RTW. These health services are starting to see improvements in their performance data and can, over time, if performance is sustained in both injury prevention and injury management, expect to see improvements in their WorkCover premiums.

However, all health services have scope to improve their RTW management through identifying examples of good practice and applying these to their current approaches. Use of the Good Practice Model and Performance Assessment Matrix could help health services identify areas for improvement.

There is also scope to implement strategies across the sector to assist in lifting the performance of the sector as a whole in managing RTW. In particular, these strategies focus on lifting the levels of awareness and capability across the sector as to what constitutes good practice and how it can be applied in individual health services.

The strategies also aim to address common barriers to improved RTW and to put in place measures which will enable improved performance at an health service level.

Fellows Medlock and Associates
July 2007

ATTACHMENT ONE

CURRENT GOOD PRACTICE – SECTOR CASE STUDIES

1. Small Rural Health Service

This health service has improved its performance over recent years with significant reductions in premium and claims numbers. Claims costs are still high due to the on-going impact of a major stress claim.

The health service has had a strong focus on injury prevention through the appointment of an OHS “champion”, a commitment to hazard identification and risk management, a culture of reporting and immediate follow up of incidents, changes to processes and equipment and a more effective use of the OHS Committee and Health and Safety Representatives.

There has also been a broad focus on employee welfare and support where staff are offered assistance in dealing with both work and personal problems which may impact their work performance. This may include, for example, access to financial, psychological or relationship counselling.

This health service does not have a dedicated RTW coordinator. The CEO and management team play a direct and active role in both prevention and in managing any injuries or claims that occur.

Managers have been provided with broad management training to help them understand and carry out their management responsibilities, including responsibility for people management. Whilst RTW is not specifically mentioned in these responsibilities, it is understood and accepted that this is a line management responsibility. The entire management team participated in a two day RTW course run by the organisation’s insurance agent several years ago. With changes in the management team, not all current managers have yet received this training.

Line managers are expected to take full responsibility for all aspects of managing and supporting an injured worker. This may include assistance in dealing with injuries which are not work related. Workers will be offered assistance with the costs of doctors, other medical providers or rehabilitation providers to ensure that they are able to either stay at work or return to work at an early stage.

Where a worker is injured, initial contact must be made by the line manager as soon as possible after the injury. The line manager is responsible for developing a RTW plan immediately, in consultation with the injured worker, regardless of whether or not there is likely to be a compensable injury. In some cases, a “continue at work plan” will be developed to ensure that the worker is able to stay at work without losing time. A specialist rehabilitation provider may be involved in developing this plan and providing occupational therapist or physiotherapy treatment if required.

In some cases, the Corporate Services Director and/or the CEO may also be involved in developing the RTW plan to ensure that all issues are addressed.

Suitable duties, as would be expected in a small health service, are difficult to find. However, there is flexibility in modifying duties, using supernumerary positions for short periods or relocating returning workers to other areas. The clear preference is to keep injured workers in their normal work areas.

The line manager is totally responsible for managing and monitoring the RTW plan with the worker and addressing any issues as they arise.

Despite the lack of specialist RTW staff, this organisation has been successful in reducing claims and managing its RTW responsibilities, due to a number of definite strategies:

- strong leadership from the CEO has ensured that managers understand and accept their responsibility for managing staff
- a focus on creating a positive environment where staff feel supported and valued at work
- emphasis on injury prevention
- willingness to intervene at an early stage to address injuries, whether arising at work or outside work, and to develop plans and provide assistance to support workers to stay in the workplace

2. Regional Health Service

This health service has experienced steady claim numbers, actual costs and statistical claims estimates over the last four years, apart from one year in which two journey claims created a spike in claims costs and estimates.

The health service's pattern of injuries is similar to many other health services, predominately sprains and strains and musculoskeletal injuries with a rising numbers of stress claims. The severity of back injuries has decreased markedly, along with most other health services, due to the implementation of the No Lift program.

In this health service RTW is seen as part of core business and early intervention is central to a successful approach.

A monthly report provided by the insurance agent contains 16 detailed performance criteria. This report is used to identify trends and strategies and is the basis for a regular report to line managers in each program area with a detailed breakdown of the status of each claim, including identifying cost data for each program area.

The CEO meets monthly with the head of each division, who in turn meet with individual managers to discuss their RTW management performance. Position descriptions contain OHS obligations, but no specific RTW requirements.

RTW policy and procedures are documented on the intranet and within the health service's code of conduct. These are current and are reviewed regularly. RTW policy is communicated in orientation sessions, through in-house training programs and through various HR programs dealing with bullying and harassment, violence and aggression, "No Lift" programs and the health service's EAP. OHS and RTW management is audited as part of hospital accreditation audits.

Whilst the RTW coordinator adopts a lead role in managing RTW, line managers also have a high level of responsibility. Details of RTW responsibilities are included in a

general management training program and the health service is seeking funding for a specific RTW training package for managers at entry level.

Incident and injury reporting is a high priority. This health service uses the Riskman incident notification system but also uses a telephone system to ensure direct and speedy reporting. The system is supported through the reinforcement of a “no blame” culture.

Once an injury is reported, the RTW coordinator makes the crucial three point contact (manager, injured worker, doctor) quickly after notification. The RTW coordinator also undertakes an initial assessment of the claim and discusses the RTW process with the injured worker. Any issues associated with the case are identified and relevant information is sent to the injured worker’s GP. Key duties and the physical requirements of those duties are obtained from position descriptions and observations of the work area are undertaken if required.

The health service aims to have the injured worker undertaking suitable duties, and with a RTW plan, within two working days of injury.

The RTW coordinator has commenced assembling a database of all duties associated with the various positions in the health service to assist in communicating with stakeholders and identifying suitable duties to support RTW plans. The database is, for example, emailed to the worker’s line manager to help identify suitable duties in the RTW plan.

Line managers meet weekly or fortnightly with the RTW coordinator to progress required actions and ensure they manage, monitor and review RTW plans for injured workers in their area.

The RTW coordinator uses a spreadsheet format to actively monitor and track cases and plan work on a weekly basis including the identification of actions each day. It links to a reminder system in a calendar and includes planning for site visits.

The health service runs a clinic focused on staff care which provides a first call GP service. Staff are encouraged to use this clinic during normal office hours or the Emergency Department outside of these hours. The clinic began in the 1980s and the level and quality of service provided ensures that it is widely used by staff.

The health service has a good relationship with the local GPs’ association and is able to communicate with them about RTW issues.

On completion of a RTW case, the health service sends out a satisfaction survey to the injured worker asking for feedback on the workers’ experience of the program. This feedback is used to identify areas for improvement and for management training in RTW.

The health service is going to tender for its insurance agent to test the market for alternative approaches and services. An external provider has been engaged to help design the criteria against which the tender will be run.

Rehabilitation providers are used occasionally, where there is agreement between the health service and its employee that it could assist the case and where the agent will approve the costs of this service. This may be where a case has become “bogged down”, if it is difficult to develop rapport or if it is a long-term case.

The health service considers that their RTW culture is positive, although it can be improved in some areas. One of the biggest problems they identify is still that workplace injuries are rated as less important than client care. However, they believe they care for their staff well. They are aiming to provide more education and training, put in place more preventive actions and continue to improve their RTW performance. They believe that independent data analysis and objective benchmarking between health services would be very useful in assisting them improve their performance.

3. Large Metropolitan Health Service

This health service performs well and rates well against the major health services in Victoria. Premium has remained relatively steady despite an increase in remuneration and claims numbers have fallen. Claims costs have, however, risen by a small amount. Manual handling injuries constitute the greatest number of injuries. Currently the health service has experienced only a small number of stress claims.

There is a strong emphasis on safety first across the health service with a proactive and team based approach to RTW management. The health service has developed a comprehensive HR management framework and is developing the capacity of its line managers to manage all aspects of HR, including RTW.

RTW is regarded as a core business process and a key management responsibility. The health service promotes a very visible RTW function, aims to deal with issues quickly and escalates potential problem areas. It is well resourced with a dedicated RTW and claims management function where staff work as a close knit and flexible team. There is strong support and involvement from the CEO and positive stakeholder interactions ensure RTW runs smoothly. The health service considers that it treats its people with respect.

Management responsibilities are outlined in a roles and responsibilities document devolved from the Board Strategic Plan. This document contains over 20 measures that link directly to position descriptions, four of which specifically deal with RTW accountabilities. These are being gradually rolled out across the organisation.

The Board Audit Committee receives a six monthly performance report covering OHS and RTW, including data on how long employees are off work, number of injuries and the number of injured workers returned to work.

RTW issues are addressed in monthly meetings held by the CEO with the general managers of each campus.

The peak OHS Committee, chaired by the Chief Executive, measures annual RTW performance and directors receive breakdowns of WorkCover and RTW costs in their area.

HR training programs for line managers include a toolkit for RTW, along with other HR programs including managing aggression, de-escalating violence, Back Smart/No Lift, bullying and harassment and stress identification and management. The number of managers trained is tracked and reported in management reports.

RTW policy and procedures are kept up to date, reviewed regularly and changed as issues in RTW management are identified.

All managers are required to contact the RTW coordinator immediately an injury occurs and to continue to liaise throughout the RTW process. The RTW coordinator leads the process, working closely with the injured worker, their treating GP and the line manager. RTW plans commence immediately upon notification of injury.

A database is used to facilitate RTW management, tracking actions associated with case management and triggering review actions. This health service has a specific position for claims management and sees this as a more cost-effective approach.

A staff health clinic provides a range of services including an occupational physician, occupational hygiene services, psychologists and occupational nurses. Staff support programs also include an internal and external EAP service.

The health service sees itself as providing a comprehensive framework which is aligned with business processes, a well resourced and effective team and an increasing dialogue with its executive about RTW management and performance.

4. Small Metropolitan Hospital

This health service has experienced a considerable improvement in claims numbers and costs and its WorkCover premium through a robust approach to RTW.

Mandatory manager training has been developed to provide managers with an understanding of their responsibilities and the importance of early RTW. Managers are also provided with broad HR training including dealing with difficult people, managing aggression, conflict resolution, harassment and bullying and stress management. Managers are held financially accountable for their RTW performance through the allocation of WorkCover costs and premiums to individual cost centres. The introduction of this approach took considerable preparation and explanation.

The Board receives quarterly reports on OHS and RTW performance, including claims frequency, costs, injury type, average lost time rate and claims count.

RTW policy and procedures are contained in the health service's HR manual, which is available in every department.

Action is commenced immediately on notification of an injury. The RTW coordinator leads the process, however, initial contact is usually made by the line manager, with coaching by the RTW coordinator if required. Quickly establishing a positive relationship with an injured worker is seen as critical to effective RTW. Injured workers are placed in suitable duties as soon as possible after notification of injury.

This is facilitated by the RTW coordinator through direct contact with managers and careful consideration of available duties.

RTW is always seen as a priority and, generally, injured staff are back to work within two to three working days of an injury occurring.

The health service continuously reviews all of its claims as well as conducting formal claims reviews with their agent. Longer term claims are managed with the same emphasis as more recent claims.

The health service believes that further improvements in performance could be achieved through better education for GPs, ensuring that they understand their role and what “light duties” means. The development of task dictionaries would help GPs to understand the job tasks and thereby facilitate the identification of suitable duties. Other initiatives could include the development of case management software to enable the RTW process through the identification and prompting of actions, posting reminders and completing necessary RTW processes.

The health service has been running an EAP program for two years and considers that it genuinely cares about injured workers and returning them to normal work, whilst balancing the needs of the worker, employer and line manager.

ATTACHMENT TWO

LITERATURE REVIEW – SUMMARY AND SOURCES

1. Statistics and Background

The following information is sourced from the literature surveyed and provides relevant background to the issues addressed in this review.

- Sprains and strain injuries account for greater than 50% of all WorkCover claims and 70% of long term claims. Victorian evidence suggests that physical healing of most sprain and strain injuries occurs within 6 – 8 weeks. However, over 50% of workers with these injuries are still off work at 8 weeks, (VWA, 2007-1)
- NSW data analysis shows that :
 - 10% of workers, with a similar clinical condition to others, become long-term work disabled. This group constitutes 70% - 80% of the total costs of all workplace injury claims
 - 65% of work injuries are not serious clinical conditions. These comprise sprains and strains and musculoskeletal injuries. 46% of this group of injuries involve the back, 17% knees and ankles, 10% shoulders and 9% other locations (WorkCover NSW 2005).
- Victorian WorkCover Authority data shows standardised claims between September 1985 and 2004/05 totalling 809,874 for all industries. Musculoskeletal afflictions comprise 470,729 of this total number and mental disorder afflictions comprise 40,122. (VWA 2007-2).
- Health Services data provided by the VWA through the Department of Human Services shows the following number of claims:

Type of Injury data	Metro Health Services 2002 - 2006	Rural Health Services 2002 - 2006
Occupational Diseases (Stress only)	417	256
Musculoskeletal Disorders	2419	583

- The Australian Acute Musculoskeletal Pain Guidelines Group (AAMPGG - 2004) found that with 95% of sprains and strains it is not possible to identify the precise origin of pain. However, in 80% of cases, the condition will settle within 3 to 4 weeks and the injured worker will resume ordinary duties. 10% of workers will have a longer recovery period and a further 10% will experience long-term work disability.
- Abenheim *et al* (2000) classify pain according to its duration following an injury:
 - Acute - 3 to 4 weeks
 - Sub acute - 4 to 12 weeks
 - Chronic - greater than 12 weeks

- Dunstan and Covic (2006) cite an epidemiological study of low back injury which found the risk of long term disability rises exponentially post-injury. They identified three key phases of risk, which parallel the time based divisions of pain into acute, sub acute and chronic phases.

2. RTW Models and Understanding

Dunstan and Covic (2006) cite research into factors that affect workplace disability and conclude that focus on clinical practices alone is insufficient for effective RTW, and that a more comprehensive framework is needed. The model adopted is a bio-psychosocial model which holds that disability, pain and illness are the products of an interaction between physical and psychological factors, which are set in the background of influencing environmental and social factors. The World Health Organisation has adopted the bio-psychosocial model (WHO, 2001).

Medical authorities have developed bio-psychosocial based clinical guidelines for diagnostic triage and injury management. Dunstan and Covic (2006) cite studies that application of these guidelines can reduce time lost from work by up to 40% and total claims costs by up to 60%.

A study by von Korff, Ormel, Keefe & Dworkin (1992) applied this model to workplace disability and found clinical observations of injured workers with similar physical diagnosis reported differences in the intensity of pain and the level of disability experienced by injured workers. This implied that variability may be due to the effects of environmental and psychological factors. A number of other studies cited by Dunstan and Covic make persuasive cases for this model.

The Victorian WorkCover Authority has developed a Sprains and Strains Care Model which comprises a multidisciplinary assessment and an interdisciplinary rehabilitation service. The model has been endorsed by the Royal Australian College of General Practitioners. The model is based on the bio-psychosocial approach to workplace disability and is identified by WorkCover agents as valuable for the RTW for an injured worker. (VWA 2007-1)

WorkCover NSW (2003) commissioned research to identify the effectiveness of activity and exercise programs for workers with musculoskeletal conditions. The research identified an evidence base for the development of WorkCover's Guidelines for Work-Related Activity Programs for Prevention of Long-Term Disability in Workers with Musculoskeletal Injuries.

The report identifies four key points upon which the guidelines are based:

- resuming ordinary daily activity early post-injury prevents long term disability and improves RTW outcomes for injured workers.
- psychosocial risk factors can delay RTW and contribute to long-term disability and pain.
- in the sub acute and chronic stages, activity programs that involve cognitive behavioural approaches designed to respond to identified psychosocial factors are more effective than programs that do not.

- injured workers return to work about twice as often and in half the time when suitable duties are offered.

The Australian Institute For Primary Care (AIPC, 2006) found that “RTW and work disability have multi-determined outcomes that cannot be accurately predicted just from knowledge of the medical or physical dimensions of the injury or condition. On the contrary, a very wide range of determinants of return to work have been identified...”

AIPC identified factors influencing RTW outcomes that are independent of clinical diagnosis, and include:

- the characteristics of the injured worker
- the various components of the occupational rehabilitation and medical interventions adopted
- job characteristics, including physical and psychosocial aspects
- factors in the workplace
- the insurance/workers compensation scheme in operation and
- broader social factors for, example, labour market conditions, employment and legal frameworks.

A significant finding by AIPC was the inadequate recognition of workplace factors in identifying effective RTW practice.

3. Facilitators and Barriers to Workplace Disability

Dunstan and Covic refer to the work of Waddle, Burton and Main (2003) in studying the predictors of long term work disability. This found that in soft tissue injury the most powerful determinants of work disability were psychological factors. These included depressive illness, fear, inadequate coping, negative attitudes towards returning to work, poor perceptions of general health and emotional distress.

This study also showed that other consistent predictors of disability included demographic factors, occupation, work history, employment status, amount of time off work, social and environmental factors (including work dissatisfaction pre-injury, low unemployment rate and financial incentives) and biological factors (including previous similar injuries).

The study also identified a range of bio-psychosocial factors which may be targeted for intervention in RTW. These factors vary for the acute, sub acute and chronic phases.

In the acute phase, controlled studies tested extensive interaction and communication with the injured worker on the nature of injury. Encouragement to remain active, ergonomic advice and reassurance to the worker produced a 50% reduction in absence and a 15% improvement in long-term outcomes. The study also found that stakeholders other than clinicians identified credibility, trust and teamwork between all stakeholders as key facilitators to resuming work.

Based on the research, the study goes on to broadly set out the nature of treatment for each phase of injury. In the acute phase of lower back injury empirical studies support four key activities:

- encouraging workers to resume normal activities
- communicating between the relevant parties
- avoiding over investigation of the injury in the acute stage and
- avoiding passive treatment in managing the injury.

The Dunstan and Covic review shows that, during the sub acute phase, research is pointing towards the use of cognitive behavioural strategies to modify emotions and behaviours, along with exercises, graded work activities, and work focused intervention. One study, Karjalainen *et al* (2001), identified such interventions, as producing a 30% - 50% reduction in time lost when compared to not using such interventions.

The AIPC Report *Facilitators and Barriers to Return to Work: a Literature Review* (AIPC, 2006) was commissioned by the South Australian WorkCover Corporation to identify facilitators and barriers to RTW and to identify a research agenda for the development of best practice in RTW.

The AIPC report found that the following factors will improve RTW:

- addressing individual psychological characteristics, in particular, the thinking of the injured worker, negative emotions and attitudes and their expectations about their medical condition and RTW.
- coordinating activity between stakeholders, in particular linking RTW with workplace staff who were involved with the injured worker, the treating GP and other clinicians.
- development of best practice clinical management guidelines for treating practitioners.

The report noted the significance of the lack of a “proper assessment of workplace factors” and the importance of this to future improvements and understanding of RTW approaches.

WorkCover NSW (2003) identified a number of factors relevant to RTW outcomes for musculoskeletal injuries. These included family participation, worker emotions, attitudes and beliefs, workers compensation issues, treatment and diagnosis and older and recurring injuries.

This study identified that an injured worker’s beliefs and behaviours to do with pain and activity, their expectation of the effect of passive treatment and their willingness to remain socially active, affects their RTW.

Freisen and Yassi (2000) identified perceived barriers to RTW to include delays in treatment and processing information and ineffective communication between stakeholders. They found facilitators of effective RTW to be:

- establishment of workplace based RTW programs.

- early intervention.
- effective communication.
- teamwork, trust and credibility amongst stakeholders.

The study identified a range of RTW predictors, including:

- personal factors - age, gender, previous injury, perception of pain and disability and psychological status, including depressive illness.
- employment issues - degree of seniority at work, the availability of alternative employment.
- workplace factors - the existence of a progressive RTW program and a positive work culture.
- insurance and legal systems - complex arrangements result in a sense of disempowerment.

Durand and Loisel (2000) show the importance of placing the work site in the centre of the RTW and rehabilitation process, including graded work exposure with hours of work, tasks performed and output expected gradually increasing until the injured worker is ready to resume work on a full time basis doing pre-injury work.

The UK Health and Safety Executive (2006) found that “There is a considerable body of expert opinion, with continuing support from recent research, that successful intervention is not necessarily dependent on treatment.” RTW should not unduly focus on the medical aspects of treatment, but also “the use of practical considerations and personal, emotional, societal and work-related factors” to achieve rehabilitation.

The HSE report identified that early injury management should concentrate on the management of pain, whilst avoiding rest, withdrawal and inactivity. Whilst issues such as gender and ethnicity may be important factors, workplace culture plays a much larger role.

Literature Review - Sources

Abenhaim L, Rossignol M, Valat J-P, Nordin M, Avouac B, Blotman F. *et al.* (2000) *The Role of Activity in the Therapeutic Management of Back Pain: Report of the International Paris Task Force on Back Pain.* *Spine* 25(4S) Supplement 1S-33S.

Australian Acute Musculoskeletal Pain Guidelines Group (AAMPGG) 2004. *Evidence-based management of acute musculoskeletal pain. A guide for clinicians.* Brisbane: Australian Academic Press.

Australian Institute for Primary Care (2006), *Facilitators and Barriers to Return to Work: a Literature Review.* A report prepared for the South Australian WorkCover Corporation.

Dunstan D and Covic T (2006). *Compensable work disability management: A literature review of bio psychosocial perspectives.* *Australian Occupational Therapy Journal* (2006) pp 53, 67-77.

Durand M.J, Loisel P. *A therapeutic return to work: rehabilitation in place.* *Work* 17 (2001) pp 57-63.

Franche D.L, Krause N. *Readiness to Return to Work Following Injury or Illness: Conceptualising the Interpersonal Impact of Health Care, Workplace, and Insurance Factors.* *Journal of Occupational Rehabilitation*, Vol 12, No 4, December 2002.

Freisen M.N, Yassi A, Cooper A. *Return to Work: the Importance of Human Interactions and Organisational Structures.* *Work* 17 (2001) pp 11-22.

Karjalainen K, Malmivaara A, van Tulder M, Roine R, Jauhianen M, Hurri H. *et al* (2001). *Multidisciplinary Biopsychosocial Rehabilitation for Sub Acute Low Back Pain in Working Age Adults: a Systematic Review within the Framework of the Cochrane Collaboration Back Review Group.* *Spine*, 26, pp 262-269.

Marhold C, Linton S J, Melin L. *A Cognitive Behavioural Return to Work Programme: Effects on Pain Patients with a History of Long-Term Versus Short-Term Sick Leave.* *Pain* 2001 March: 91 pp 1-2, 155-163.

Motor Accidents Authority (2001). *MAA guidelines for the management of whiplash-associated disorders.* Sydney, Australia. Motor Accidents Authority.

Royal College of General Practitioners (1999). *Clinical Guidelines for the Management of Acute Low Back Pain.* London, UK: Royal College of General Practitioners.

UK Health and Safety Executive, Breen A. *Improved Pain Management for Musculoskeletal Disorders*.
UK Health and Safety Executive 2006.

Victorian WorkCover Authority [2007 (1)]. *2004/2005 Statistical Summary – VWA*
No date.

Victorian WorkCover Authority [2007 (2)]. *Sprains and Strains Model* - No date.

Waddle G, Burton A.K, & Main C.J. (2003). *Screening to Identify People at Risk of Long-Term Incapacity for Work: a Conceptual and Scientific Review*.
London, UK: Royal Society of Medicine Press Ltd.

WorkCover NSW (2003). *Work-Related Activity Programmes for the Prevention of Long-Term Disability in Workers with Musculoskeletal Injuries (non Red Flag conditions)*. Health-care provider guidance material. Discussion paper.
Sydney, Australia: WorkCover New South Wales.

WorkCover NSW (2005). *WorkCover New South Wales Workers Compensation Statistical Bulletin*.
Sydney, Australia: WorkCover New South Wales.

WorkCover NSW (2006). Blewett V, Shaw A, La Montagne A.D, Dollard M. *Job Stress Causes, Impacts and Intervention in the Health and Community Sector*.
WorkCover NSW (2006).

ATTACHMENT THREE

PRACTICE IN OTHER AUSTRALIAN JURISDICTIONS

1. South Australian WorkCover Corporation

The SA WorkCover Corporation operates a self insurers workers compensation scheme. Under this scheme, many larger employers, including hospitals, have achieved self insurance status.

The South Australia Self Insurer Performance Standards set a framework within which companies may self insure. The standards are based on the integration of OHS and RTW management into mainstream management systems and continuous improvement of these systems. The standard requires verification of performance through internal and external audits.

The five elements which make up the performance standard reflect the structure of a comprehensive and systematic approach with reference to both OHS and RTW management. These elements are:

- commitment and policy
- planning
- implementation
- measurement and evaluation and
- management systems review and improvement.

Overall, good practice in RTW under the standard includes the following key aspects:

- the principle of early reporting through, for example, an injury hotline. The completion of paperwork by itself, whilst necessary, does not deliver early reporting. The central objective is for the RTW coordinator and the line manager is to act quickly on any injury to get the injured worker back to work as soon as possible.
- ensuring the injured worker visits their treating GP as soon as possible and establishing contact between the employer and the GP to understand the limitations of the clinical condition and organise suitable duties.
- ensuring that injured workers are rehabilitated in the workplace, supported by the provision of standardised suitable duties.
- management accountability, performance review and the establishment of KPIs to ensure RTW is given appropriate priority.

2. Large Metropolitan Hospital - South Australia

This hospital has reduced its WorkCover premium by over \$3 million in a three-year period. Its long term claims have been reduced from 57 to one and it has also significantly reduced the number of claims opened annually over this period.

A key feature of the hospital's approach to RTW is early intervention through notification by phone call or e-mail, ensuring that a worker is contacted by their line

manager immediately upon notification of their injury so that the worker can be placed on suitable duties as soon as possible to facilitate their return to the workplace.

Other features include:

- good relationships with injured workers and excellent teamwork between all stakeholders in the injury management process.
- a strong focus on controlling long term passive treatments and open claims.
- if potential psychological issues are identified a worker will be referred to the hospital's EAP provider or to a psychologist.
- consideration of age, cultural and learning issues associated with RTW.
- direct relationships have been established with most treating GPs – doctors prefer discussions on RTW cases rather than written questionnaires.
- case conferences are held on a weekly basis and GPs are paid to attend.
- most staff attend the hospital's emergency unit when hurt.

With the assistance of an external consultant the hospital has developed job dictionaries based on a task analysis of every job to break down what can be done by an injured worker. This is sent to the treating GP to assist them understand what is required in a task and what can be done with the injury. The task analysis is in both picture form and written description and includes a description of where bending, lifting, sitting and walking is required, weight strength, grip strength requirements and so on.

There is strong executive support for a safe and healthy work environment. Management supports an active OHS prevention program, including significant upgrades to hospital equipment and facilities. For example, upgrading of the hospital kitchen floors and redesign of the dishwashers has reduced claims over three years from twenty to just three claims this year.

Extensive and ongoing training is provided for managers to assist them to meet their OHS and RTW responsibilities. The executive conducts regular reviews of RTW performance with line managers.

3. NSW Roads and Traffic Authority (RTA)

The RTA has been reforming its approach to RTW systematically over the last seven years. Responsibility for RTW has been assigned to line management. Line managers work collaboratively with RTW staff, who are responsible for developing RTW plans and liaison with treating health professionals.

Early intervention is achieved by use of an electronic incident-based reporting system which sends immediate notifications of incidents and injuries to key people within the organisation including the RTW manager and injury management coordinator. A tiered triage arrangement determines the urgency of treatment and response by the receiving manager.

Dedicated injury management coordinators are expected to make contact with injured workers and doctors within set periods of injury notification. If the injury is severe,

personal contact must be made within two hours or within 72 hours in the case of a less severe injury.

As the RTA is classified as a self administrator, it operates the same computer system as their workers compensation insurer. The system covers all aspects of claims management and RTW and ensures that the same information is available at the same time to all claims and injury management staff.

The RTA uses a preferred medical provider and employs a private administrator to negotiate with doctors so that medical appointments can be arranged as urgently as required. The administrator actively develops relationships with doctors to facilitate sound and direct communications between injury management staff and treating doctors.

Cultural background and potential psychosocial issues are considered by injury management coordinators when initially assessing a claim. Psychologists may be used if required during the process.

Extensive training has been provided to front line and executive managers in RTW and HR management issues, including the use of an organisational psychologist to develop managers' communication skills. This has included how to talk to staff, how to establish trust and rapport and how to treat someone fairly in the RTW process. The training has also addressed stress prevention skills.

RTW staff are also provided with training and education from external professionals covering, for example, practical clinical education on particular conditions building up an extensive knowledge base on a wide range of injuries.

The RTA has introduced a "Five minutes plus travel" program which requires a supervisor to ring the injured worker within five minutes of being advised of injury and then to travel to meet with the injured worker, wherever they are located.

A "myth busters program" identifies "stories" or behaviours in relation to RTW and workers compensation. These are investigated, and if no substance is found, this finding is communicated widely to all staff. If the stories have substance action can be developed to address the issue.

Job task analysis sheets have been developed on 20 key jobs. These adopt a standard template, including diagrams, to describe the actions involved in each position and the frequency of those actions. These are used to identify suitable duties and are sent to treating GPs to explain the nature of tasks that can and cannot be done at different stages of injury management and rehabilitation.

There is an established commitment to training for RTW staff. Regular training occurs with the insurer, retraining in legislative or administrative changes and general upskilling to build the knowledge and expertise of staff, including to develop their clinical knowledge base.

WorkCover premium is allocated to individual cost centres. KPIs have been developed addressing RTW issues and are measured and reported monthly, for

example, the provision of suitable duties within 10 days of a worker being found fit for duty.

Weekly meetings are held with the insurer to address specific claims issues. Formal quarterly claims management meetings are held to review all claims. Long term claims reviews are conducted as mini-projects and are run three times a year.

4. Large Metropolitan Hospital – Queensland

This hospital, with over 5000 employees, identifies barriers to RTW to be:

- management education and competence - managers are scared of what they can and cannot say to injured workers. Education is crucial to having managers understand how to talk to an injured worker and to be able to ask how they are, find out what they can and cannot do, to advise them to obtain medical treatment and to tell them about the process for RTW.
- identification of suitable duties – it is important to work with managers and encourage them to think laterally about what work activities can be undertaken when there are physical restrictions to work.

Facilitators for return to work include:

- establishing good relationships with GPs is crucial.
- having the staff and resources to take a systematic approach to RTW.
- an online incident management system that integrates rehabilitation and compensation information, including trigger dates for review periods, etc.
- having CEO support.
- reporting against KPIs for RTW – currently these are basic, but will be improved over time.
- timing and early intervention - once an injury is known a RTW plan should be developed within 24 to 48 hours, irrespective of whether or not a compensable injury is involved.

ATTACHMENT FOUR
RTW – HEALTH SERVICE VISITS INTERVIEW GUIDE

Victorian Health Services Management Innovation Council Review of Return to Work Practices – Interview Guide

The following provides a guide to the topics and issues to be discussed during visits to individual hospitals and health services to be conducted as part of this review of Work Practices.

Topic	Issue	Discussion Points	Documentation (if available)
Performance	<ul style="list-style-type: none"> ▪ current premium and claims performance 	<ul style="list-style-type: none"> ▪ an overview of performance over the last three years in premiums, claims numbers, claims frequency and claims costs ▪ what are the main injury types? ▪ what performance data is collected and monitored? ▪ Who in the organisation receives this data and what do they do with the information? ▪ what have been the key issues in the recent performance record? 	<ul style="list-style-type: none"> ▪ is a summary of performance data available?
Roles and Responsibilities	<ul style="list-style-type: none"> ▪ definition of roles and responsibilities 	<ul style="list-style-type: none"> ▪ is return to work seen as part of core business? ▪ who is responsible for the management of WorkCover claims and return to work programs? ▪ have roles been defined for Executive management, line managers, RTW coordinator, claims managers, service providers and agents? ▪ are these responsibilities clearly defined and documented, eg in position descriptions? ▪ Who takes the lead role in managing a worker's RTW? ▪ have performance criteria been established? ▪ how is performance against these responsibilities assessed? 	<ul style="list-style-type: none"> ▪ examples of positions descriptions
Return to Work Program	<ul style="list-style-type: none"> ▪ documented return to work policy and procedures ▪ return to work integrated into day to day management 	<ul style="list-style-type: none"> ▪ is there a documented return to work policy? ▪ are there documented procedures for claims management, return to work and risk management for managers and staff to follow? Do these work? ▪ how are the policy and procedures communicated to staff? ▪ is risk management and the management of claims and return to work a line management responsibility? 	<ul style="list-style-type: none"> ▪ copy of policy and procedures
Return to Work Management	<ul style="list-style-type: none"> ▪ speedy and effective management of claims and return to work ▪ early intervention ▪ durable RTW ▪ pre-claim interventions to reduce claims or improve 	<ul style="list-style-type: none"> ▪ who is responsible for immediate and on-going follow up with injured workers? ▪ are direct supervisors or managers involved when their staff are injured? If so, how soon after injury and what is that involvement? ▪ does this vary according to the kind of injury? ▪ how soon is three point contact (doctor – worker-employer) established? ▪ is it maintained? 	

	RTW outcomes	<ul style="list-style-type: none"> ▪ how quickly/regularly does this occur? ▪ are individual return to work plans developed for all injured workers? ▪ who is involved in developing these plans? ▪ how are the plans followed up? ▪ How is the RTW monitored? Who monitors? ▪ what capacity does the organisation have to offer a range of suitable duties? ▪ Do line supervisors organise suitable duties? ▪ has a task analysis been undertaken of all key job roles to assist identifying suitable employment? ▪ is a list maintained of recognised medical practitioners and occupational rehabilitation providers? ▪ how effective is the relationship with stakeholders – agents, rehabilitation providers, medical practitioners and treatment professionals? ▪ Are OR providers involved? How effective is the OR provider involvement? What do they do? ▪ how much do these stakeholders understand about the workplace; do they visit the workplace? ▪ how does the agent assist in managing claims and return to work? ▪ do claims reviews happen with the agents? If so, who with, how often and what claims are looked at? ▪ Is the progress of a claim/RTW reviewed regularly? What form of review is undertaken? How frequently? Who is involved? ▪ How soon is the RTW process employed when a worker is injured or an incident occurs? What is the process? Who does what? ▪ What is done to keep the worker at work? Who does it? ▪ What processes are in place to encourage RTW? Who? ▪ What processes are in place to support RTW? Who? ▪ Are there early intervention strategies? What are these? ▪ How involved are supervisors? ▪ Is ongoing communication with the treater maintained? How? 	
Consultation and Communications	<ul style="list-style-type: none"> ▪ processes to consult and communicate with staff, supervisors and treaters on return to work programs 	<ul style="list-style-type: none"> ▪ have staff been consulted in developing return to work programs? ▪ how has this occurred? ▪ is there a process for on-going communications on return to work issues? ▪ is return to work covered in staff inductions? ▪ what is the cultural attitude to return to work, does it vary between stakeholders and how? ▪ How is the worker involved in their RTW? 	
Training	<ul style="list-style-type: none"> ▪ return to work training ▪ inhouse training ▪ professional development 	<ul style="list-style-type: none"> ▪ are there specific training programs for managers and staff in claims management and return to work? ▪ is there specific training for return to work coordinators? ▪ who develops and provides this training? 	<ul style="list-style-type: none"> ▪ outline of training program

		<ul style="list-style-type: none"> ▪ What opportunities are there for ongoing development of RTW Co-ordinators? 	
Monitoring and Reporting	<ul style="list-style-type: none"> ▪ regular reporting, monitoring and assessment of performance 	<ul style="list-style-type: none"> ▪ what reports are prepared for the CEO covering claims management and return to work performance? ▪ what information do these reports include? ▪ is the RTW program regularly reviewed? ▪ is executive management budget performance in RTW analysed? ▪ What do management do with this information? ▪ What activity has resulted (from Senior management) when they receive these reports? 	<ul style="list-style-type: none"> ▪ copies of recent reports
<p>Other: What do you think you do well? What do you think you need to do more of? What strategies have been developed to improve RTW performance in this workplace?</p>			

**ATTACHMENT FIVE
RTW SELF ASSESSMENT MATRIX**

RTW SELF ASSESSMENT MATRIX

This section provides a self assessment guide to allow individual health services to consider and assess their level of performance against each of the elements which make up a Good Practice Model for managing return to work (RTW) obligations.

Self Assessment

There are three levels of performance under each element – **Satisfactory, Good and Advanced**. Satisfactory Performance is required as a minimum to meet legal obligations.

Each level describes what will need to be in place to be able to meet the requirements for that level.

The matrix has been developed on a “building block” approach. Working from the bottom to the top of the page under each element, once the current level of performance has been identified, the boxes above provide an indication of what has to be done to achieve a higher level of performance for that element.

For the matrix to be effective and to provide a useful guide to help health services in assessing and improving their RTW performance, it is essential that the assessment is based on objective evidence from the workplace.

Performance Reporting and Continuous Improvement

The matrix provides a format for reporting to management about current performance and to assist in developing a continuous improvement plan to progressively implement new actions to achieve higher levels of RTW.

RTW SELF ASSESSMENT AND PERFORMANCE REPORTING MATRIX -

PERFORMANCE LEVEL	RTW ELEMENTS – GOOD PRACTICE MODEL		
	1. RTW Policy & Procedures	2. RTW Responsibilities	3. RTW Consultation and Communication
ADVANCED <ul style="list-style-type: none"> RTW system measured and benchmarked for continuous improvement 	As for Good, plus: <ul style="list-style-type: none"> RTW Policy is promoted to external stakeholders including treating medical practitioners, providers of rehabilitation and other services and insurance agents RTW is identified in the business plan as a core outcome Procedures are shared with and benchmarked against other health services 	As for Good, plus: <ul style="list-style-type: none"> RTW responsibilities are periodically reviewed to make sure they meet health service goals & legal requirements KPIs are established in position descriptions reflecting health service RTW goals to measure and improve RTW performance. (eg: the time taken to develop and implement a RTW plan, the time taken to return an injured worker who is fit for duty to the workplace and management and employee training) 	As for Good, plus: <ul style="list-style-type: none"> The OHS Committee or Health and Safety Representatives regularly review and revise the RTW Policy and procedures as the basis for continuous improvement in RTW management Regular communications as appropriate have been established with all stakeholders (including treating medical practitioners, providers of rehabilitation and other services and insurance agents) to keep them informed on RTW issues
GOOD <ul style="list-style-type: none"> all required elements are in place and operating effectively 	As for Satisfactory, plus: <ul style="list-style-type: none"> Staff and managers are made aware of RTW Policy and procedures Policy and procedures are periodically reviewed to improve the RTW program Only current copies of procedures are available in the workplace 	As for Satisfactory, plus: <ul style="list-style-type: none"> A senior manager is assigned responsibility for the RTW system RTW responsibilities are defined & included in position descriptions Managers' performance is assessed against their RTW responsibilities as part of regular performance discussions People are trained in their RTW responsibilities 	As for Satisfactory, plus <ul style="list-style-type: none"> The OHS Committee or Health and Safety Representatives are actively involved in monitoring RTW performance through considering performance reports and management presentations Regular communications have been established to keep staff informed of RTW issues
SATISFACTORY <ul style="list-style-type: none"> basic system and legal compliance 	<ul style="list-style-type: none"> RTW policy and procedures are developed Policy defines commitment, goals & major responsibilities Policy is signed by CEO & dated Policy and procedures are collected into a RTW manual available in the workplace 	<ul style="list-style-type: none"> A RTW coordinator is appointed RTW responsibilities are not defined or included in job descriptions, other than in general terms to follow health service policies and procedures Workers compensation management (paperwork and payments) is done in an efficient and timely manner 	<ul style="list-style-type: none"> The OHS Committee or Health and Safety Representatives have been consulted in the development of the RTW Policy and procedures

PERFORMANCE LEVEL	RTW ELEMENTS – GOOD PRACTICE MODEL		
	4. RTW Training	5. Risk Management Program	6. RTW Management
ADVANCED <ul style="list-style-type: none"> RTW system measured and benchmarked for continuous improvement 	As for Good, plus: <ul style="list-style-type: none"> RTW training is continuously reviewed to reflect good practice and changes in the work and legal environment RTW training reflects broader HR requirements Refresher training is provided for managers and RTW staff. 	As for Good, plus: <ul style="list-style-type: none"> Risk management processes are benchmarked against industry practice 	As for Good, plus: <ul style="list-style-type: none"> There is a strong sense of teamwork between all stakeholders in achieving good RTW outcomes A job task analysis is undertaken to identify a register of suitable duties where appropriate RTW processes are benchmarked against industry practice
GOOD <ul style="list-style-type: none"> all required elements are in place and operating effectively 	As for Satisfactory, plus: <ul style="list-style-type: none"> A RTW training needs analysis is conducted A RTW training plan is developed & implemented Specific RTW training is provided for managers and RTW staff Employees are given refresher information on RTW policies and protocols within the organisation. 	As for Satisfactory, plus: <ul style="list-style-type: none"> Managers have identified responsibilities for risk management Outcomes from risk management are reported to senior management & the OHS Committee Risk management procedures are reviewed to make sure they continue to be effective Continuous efforts are made to identify hazards and control risks The effectiveness of risk controls is regularly reviewed 	As for Satisfactory, plus: <ul style="list-style-type: none"> Incidents and injuries are reported immediately and line managers make immediate contact with injured workers Line managers are responsible for managing RTW RTW planning commences as soon as an injury is reported RTW plans are developed for compensable and not compensable injuries
SATISFACTORY <ul style="list-style-type: none"> basic system and legal compliance 	<ul style="list-style-type: none"> RTW staff receive training from the health service's insurance agent Managers are assisted to manage RTW cases by the RTW coordinator Some RTW information is provided at induction. 	<ul style="list-style-type: none"> There is a procedure for risk management Safe work procedures have been developed for all hazardous situations Staff and managers are trained in safe work procedures 	<ul style="list-style-type: none"> The RTW coordinator manages the RTW process for individual workers RTW coordinators contact injured workers & liaise with any parties involved in the occupational rehabilitation of, or provision of medical or hospital services when notified of an injury RTW plans monitored by the RTW coordinator Suitable duties are only identified when a RTW plan is developed RTW planning commences for all compensable injuries and where appropriate for non-

			compensable injuries, when an injured worker will be off work for more than 10 days
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PERFORMANCE LEVEL	RTW ELEMENTS – GOOD PRACTICE MODEL		
	7. Performance Monitoring & Reporting	8. RTW Continuous Improvement	
ADVANCED • RTW system measured and benchmarked for continuous improvement	As for Good, plus: <ul style="list-style-type: none"> Financial accountability is devolved to individual cost centres Individual managers/line managers are held accountable for RTW performance 	As for Good, plus: <ul style="list-style-type: none"> Boards and CEOs actively drive improved RTW performance RTW performance is benchmarked against comparable hospitals & industry performance 	
GOOD • all required elements in place and operating effectively	As for Satisfactory, plus: <ul style="list-style-type: none"> KPIs and targets are established for RTW performance Boards and the CEO regularly consider RTW performance information Performance information is reported by individual cost centres A comprehensive case management system is in place Regular claims management meetings are held with individual managers 	As for Satisfactory, plus: <ul style="list-style-type: none"> Implementation of the RTW Policy and procedures is subject to independent audit Feedback is sought from injured workers, managers and RTW staff to improve RTW Policy and procedures Changes to RTW Policy and procedures are reported to staff & external stakeholders (including treating medical practitioners, providers of rehabilitation and other services and insurance agents) Managers review RTW indicators & performance information to identify possible improvements 	
SATISFACTORY • basic system and legal compliance	<ul style="list-style-type: none"> RTW performance measurement relies on injury data & workers' compensation costs supplied by the insurance agent RTW performance reports are provided to the OHS Committee Regular claims reviews are held with the insurance agent 	<ul style="list-style-type: none"> The OHS Committee is involved in considering improvements to RTW Policy and procedures 	

**ATTACHMENT SIX
IMPROVEMENT STRATEGIES – TIMEFRAMES, RESOURCING AND CHANGE MANAGEMENT
IMPLICATIONS**

1. Sector Wide Strategies

Strategy	Timeframe	Resourcing Impact	Change Management Issues
<i>6.1.1 Promotion of Good Practice Model and Self Assessment Matrix</i>	<ul style="list-style-type: none"> immediate, within 3-6 months 	<ul style="list-style-type: none"> limited resourcing required to validate model and matrix and publish for use by health services 	<ul style="list-style-type: none"> likely to be well accepted by those health services that recognise that they need to do more and/or lack the resources to improve their RTW performance some health services may assess that they have the resources and expertise and do not require external advice or assistance there may be a need to adapt the model to the differing circumstances of metropolitan and rural/regional health services
<i>6.1.2 Key Messages Campaign</i>	<ul style="list-style-type: none"> immediate, within 3-6 months 	<ul style="list-style-type: none"> limited resource impact messages could be developed using existing in-house communications expertise and VWA information 	<ul style="list-style-type: none"> the major challenge will be to find the best media to ensure that the messages are effective in raising awareness
<i>6.1.3. Board Awareness</i>	<ul style="list-style-type: none"> immediate, within 3-6 months 	<ul style="list-style-type: none"> resourcing would be required to develop guidance material 1 hour briefing/training session for each health service – could be to be delivered by internal resources, the VWA or a contracted organisation 	<ul style="list-style-type: none"> material and presentation will need to take account of different levels of capacity and current performance for each health service will require strong endorsement from the Council to ensure health service Boards are prepared to commit the required time to participate
<i>6.1.4 Sector Wide Networking</i>	<ul style="list-style-type: none"> immediate, within 3-6 months 	<ul style="list-style-type: none"> limited resource implications for the Council resource implications for individual health services through absence of RTW staff from the workplace and costs of travel to attend the forum 	<ul style="list-style-type: none"> the effectiveness of the forum will depend on the willingness of individual health services to support the forum and share information and experience, particularly those health services which currently have innovative practices in place
<i>6.1.5 Management Training</i>	<ul style="list-style-type: none"> medium term, within 6 -9 months 	<ul style="list-style-type: none"> Council would need to fund the development of the training program, based on the Good Practice Model delivery of the program could be either funded by Council or 	<ul style="list-style-type: none"> whilst the concept is likely to be endorsed by health services, there may be issues with releasing managers to undertake the training there may also be concerns about travel time to attend training from more remote health services the training could possibly be developed to be

		<ul style="list-style-type: none"> ▪ individual health services ▪ online delivery options could be considered to reduce attendance time 	<p>delivered in smaller blocks of time – this may be preferable to some health services, although health service views could be sought on the most effective approach</p>
<i>6.1.6 Regional Resourcing</i>	<ul style="list-style-type: none"> ▪ medium term, within 6 months 	<ul style="list-style-type: none"> ▪ will involve the cost of an additional resource to work with health services on a regional basis 	<ul style="list-style-type: none"> ▪ likely to be welcomed by smaller health services ▪ the role will need to be carefully defined to focus on building health service capability and providing short term assistance, not to take over the RTW function for an individual health service
<i>6.1.7 Development of a RTW and Claims Management Database</i>	<ul style="list-style-type: none"> ▪ longer term, within 12 months 	<ul style="list-style-type: none"> ▪ will require the commitment of resources to develop a standard model ▪ however, existing models could be assessed and adapted to provide a sector wide approach 	<ul style="list-style-type: none"> ▪ a standardised approach will not be achieved across the sector as some health services have a comprehensive approach in place which they will not need to change ▪ any standard will need to be kept simple to facilitate adoption in smaller health services ▪ may require negotiation between VWA and agents
<i>6.1.8 Development of a Job Analysis and Suitable Duties Register Template</i>	<ul style="list-style-type: none"> ▪ longer term, within 12 months 	<ul style="list-style-type: none"> ▪ should involve an RTW coordinator user group ▪ may require the engagement of external expert resources to develop a standard template ▪ models exist in other health services which could be adapted to provide a sector wide approach 	<ul style="list-style-type: none"> ▪ some health services are unlikely to see this as a priority, given limited resources ▪ smaller health services with only a small number of injuries, may not see any benefit in committing the resources required to undertake the analysis
<i>6.1.9 Improved Performance Data and Benchmarking</i>	<ul style="list-style-type: none"> ▪ longer term, within 12 -24 months 	<ul style="list-style-type: none"> ▪ will require the commitment of resources to develop a standard model based on existing models ▪ may require statistical analysis to ensure the data is appropriate 	<ul style="list-style-type: none"> • smaller health services or those with only a small number of injuries, are unlikely to see this as a priority, given limited resources

<p><i>6.1.10 Standardised Financial Model for Premium Devolution and RTW Budgeting</i></p>	<ul style="list-style-type: none"> ▪ longer term, within 12 -24 months 	<ul style="list-style-type: none"> ▪ will require the commitment of resources from within the sector to develop a standard model, including the involvement of finance and IT to develop and ensure that the systems interface 	<ul style="list-style-type: none"> ▪ may be difficult to achieve an appropriate weighting between remuneration, staff numbers and performance in developing a premium model
<p><i>6.1.11 Engagement of Treating Practitioners</i></p>	<ul style="list-style-type: none"> ▪ longer term, within 12 months 	<ul style="list-style-type: none"> ▪ may need DHS input on models for engagement of treating GPs ▪ limited resource implications, other than the time required from Council and Departmental staff to engage in discussions ▪ VWA resources may be required 	<ul style="list-style-type: none"> ▪ whilst the RACGP may agree to participate in discussions, there is likely to be much greater difficulty in getting positive engagement from GPs ▪ VWA campaigns are highly effective

2. Individual Health service Strategies

Strategy	Timeframe	Resourcing Impact	Change Management Issues
6.2.1 <i>Adoption of Good Practice Model and Self Assessment Matrix</i>	<ul style="list-style-type: none"> ▪ immediate, within 3-6 months, following publication of the Good Practice Model and Self Assessment Matrix 	<ul style="list-style-type: none"> ▪ limited resource impact – could be done by existing RTW or management resources ▪ health services may choose to engage external expertise or their insurance agent to assist 	<ul style="list-style-type: none"> ▪ it will be important to ensure that an objective assessment is carried out based on evidence of what is actually in place, rather than a subjective assessment of what should be in place ▪ this may be perceived as a threat by some managers or RTW staff ▪ some health services will believe that they have the resources and expertise in place and do not need to use the model
6.2.2 <i>Development of a RTW Strategic Plan</i>	<ul style="list-style-type: none"> ▪ medium term, within 6 months ▪ following assessment against the Good Practice Model 	<ul style="list-style-type: none"> ▪ limited resource impact as the plan could be developed by existing RTW or management resources ▪ some health services may lack the resources or expertise and may need to engage external expertise or their insurance agent to assist 	<ul style="list-style-type: none"> ▪ there may be a reluctance to elevate RTW to this level, particularly if RTW is not seen as a core business process
6.2.3 <i>Review of RTW Policy and Procedures</i>	<ul style="list-style-type: none"> ▪ medium term within 6 months 	<ul style="list-style-type: none"> ▪ health services may need to engage external expertise or their insurance agent to assist 	<ul style="list-style-type: none"> ▪ there may be reluctance to review and revise procedures which have only recently been put in place ▪ there may be “ownership” issues among existing staff who have developed the current Policy and procedures
6.2.4 <i>Development of RTW Responsibilities</i>	<ul style="list-style-type: none"> ▪ medium term, within 6 months 	<ul style="list-style-type: none"> ▪ health services may need to engage external expertise or their insurance agent to assist 	<ul style="list-style-type: none"> ▪ there may be opposition by some line managers to accepting greater levels of responsibility ▪ there will be a need to address the attitude that staff care is less important than client care
6.2.5 <i>Development of Skills and Expertise</i>	<ul style="list-style-type: none"> ▪ longer term, within 12 months 	<ul style="list-style-type: none"> ▪ health services may need to engage external expertise or their insurance agent to assist in developing appropriate programs 	<ul style="list-style-type: none"> ▪ smaller health services may need to share resources in developing programs ▪ there may be problems in releasing managers to attend training, particularly if travel is involved

<i>6.2.6 Communications and Consultation</i>	<ul style="list-style-type: none"> ▪ medium term, within 6 months 	<ul style="list-style-type: none"> ▪ commitment of management time to engage in communication and consultation program 	<ul style="list-style-type: none"> ▪ scepticism among staff
<i>6.2.7 Stakeholder engagement</i>	<ul style="list-style-type: none"> ▪ medium term, within 6 months 	<ul style="list-style-type: none"> ▪ commitment of management time to engage stakeholders in the process 	<ul style="list-style-type: none"> ▪ some stakeholders, particularly medical providers, may not want to participate with the health service