Volume 3;Issue 1

APRIL 1999

ANHOPS NEWS

Special points of interest:

- New working initiative between ANHOPS and the Faculty, NHSE, DOH and HSE.
- Occupational Health for Primary Care Groups
- Substance Abuse: final draft guidelines
- Mental Health at Work
- Manpower levels for OHDs
- Ill-Health Retirement (?)

WHAT A NICE IDEA!

Setting standards

National Institute for Clinical Excellence
National Service Frameworks
→ Clear standards of service

ANHOPS

ASSOCIATION OF NHS OCCUPATIONAL PHYSICIANS

LEGISLATION: What do we do? Find out about the Working Time Directive. Is latex allergy such a big problem? Read the report from the ANHOPS spring meeting.

Inside this issue:

Patient & public involvement → Professional self regulation | Clinical governance | Lifelong learning → Dependable local delivery

Formulation and dissemination of guidelines and clinical audit will be assisted by use of the internet. ANHOPS is ON-LINE.

SMART cards could help enhance patient and public confidence in the NHS by ensuring that appropriate assessments of fitness for work are performed on doctors and other healthcare staff. (Page 8)

Commission for Health Improvement
National Performance Framework
National Patient and User Survey
→ Monitored standards

Report on ANHOPS Spring Meeting 2nd March 1999 'Recent Legislation; What Do We Really Need to Do?'

The Spring meeting of ANHOPS at the Royal College of Physicians was well attended. A very brief summary follows;

1) Working Time and Health Effects

Prof. Flockard, Department of Psychology, University of Wales, discussed a number of points about shift work & night work.

- 25% of individuals have difficulty working shifts.
- Socially, 12 hour shifts are most acceptable, (longer duration free time).
- Rotating shifts and permanent night shift work both lead to complaints about sleep, but the disturbance is reversible when the individual returns to day work pattern.
- Sleep is clearly shortened when individuals work nights.
- Gastro intestinal complaints are increased in shift workers and ex-shift workers.

Accidents and Shift Work.

Accidents appear to be increased in afternoon shifts (Relative Risk 1.2) and nights (RR 1.3) when compared with morning work.

Conclusions:

There is no such thing as a 'good' roster. Rosters can be improved by self regulation; let the staff choose their contribution. It is of no value trying to spot individuals who are not tolerant of shift work, as there is no easy way of identification.

2) Health Surveillance in Practice (for Night Workers)

Dr Christine English, Consultant in Occupational Health at Northallerton, said that Employers are responsible for identifying night workers, ensuring they are given the option of a Health Assessment and keeping adequate records.

She outlined the actions taken at Northallerton NHS Trust. 400 letters were sent to night workers, 21 staff attended and as a result 11 actions were taken, of which only one resulted in a change in work.

3) Disability Discrimination Act

Ms Judith Gleeson, Employment Tribunal Chairperson, spoke on recent cases heard in Employment Tribunals under the DDA. She said that;

- employers will not be able to defend a case if they have **not** taken OH advice.
- proving or disproving that an individual fits the definition is a very difficult area.
- Normal day to day activities (NDDA) are considered **for the applicant, at home without the effects of medication**.

She advised that when OHPs give an expert report to an ET they should

- give the diagnosis. If the case is a mental health one, give the ICD 10 reference number as well.
- give details of the effects of the condition, the length of time the effects are likely to continue and if the condition is not symptomatic when it is likely to become so. She also advised us to refer to the Code of Practice and mention relevant clauses in the report.

4) Latex: Exposures & Solutions

Dr Myniar Jones, Consultant Immunologist, spoke about the increased incidence of Latex allergy, due to the large increase in use of Latex gloves for protection.

In explanation of the common observed problem that powdered gloves more often cause allergy than non powdered gloves, measurements of latex protein extracts in powdered gloves were more than 40 times those in non-powdered gloves.

The diagnosis of Latex allergy depends very much on **History**. Particular points determine are reactions to Domestic Plants, Fruits (banana, avocado, kiwi, and chestnuts.), Domestic Rubber exposure, or to medical/dental examinations.

Dr Tony Stevens, Consultant at Belfast, outlined the introduction of a Latex Policy.

He found that gloves were used inappropriately in many circumstances and although non powdered gloves were more expensive, a complete change to non powdered gloves plus appropriate use of gloves was more economical. Regional Purchasing was able to reduce the individual cost of gloves.

Actions to Reduce Latex Allergy

- Go Powder Free
- Education of Staff
- Appropriate Use of Gloves
- Maintain Glove Quality
- Non Latex Alternatives for allergic Staff
- General Skin Care for all
- Protocol for Management of Affected Worker

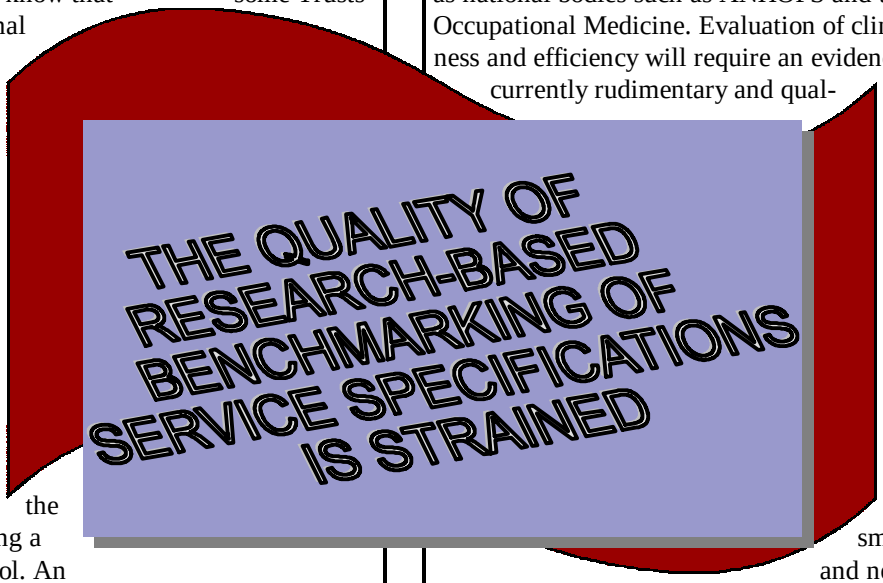
- Health Surveillance (Not needed)

- Pre-Employment Screening (Not Helpful)

Dr I Aston
Consultant Occupational Physician

April sees the dawn of a new era in the NHS: Clinical Governance has arrived. At a recent conference on Clinical Risk Management, held at the Royal College of Physicians in London, the audience was told that the effects of Clinical Governance "will be like an earthquake within the medical profession". We were told about clinical risk management in the new NHS, its relationship to clinical governance and how to develop a risk management strategy. We learnt about integrated care pathways and complaints management. We heard about the integration of risk management strategies into Trusts' clinical audit and quality strategies and about clinical risk management and the law. Nine years after losing Crown Immunity, the NHS is suddenly taking its organisational health very seriously.

Out of nine speakers, one mentioned occupational health and the importance of fitness for work. His Trust included a representative from occupational health on the risk management group. Progress? It could have been worse. Anecdotally we know that some Trusts have placed occupational health at the forefront of risk management, whereas in others occupational health is at the margins. The recent benchmarking exercise involving 28 NHS occupational health services (see Chairman's comments, ANHOPS Newsletter, October 1998) highlighted the diversity of activities within Trusts and also the difficulty in constructing a valid benchmarking tool. An unanswered question is "what is occupational health in the NHS?"



There has been a renewed attempt to give guidance on staffing levels for NHS occupational health services. As expected, comments have been received along the lines of " it depends on the type of Trust and the activities undertaken". This is, of course, perfectly true, but it does not take us very far in trying to describe an NHS occupational health service. Is there such a concept? After all, the NHS is comprised of several hundred Trusts each of which will decide on its own occupational health arrangements. The answer is yes, there is a concept of an NHS occupational health service, but at present it is not shared by all levels of the organisation. The Department of Health sees occupational health as part of the Public Health and as an important means of achieving the goals set out in Our Healthier Nation. It also regards occupational health as a key organisational resource for the NHS to control sickness absence levels and to support a hard-pressed workforce. The latter will be extended to include primary healthcare teams. The publication of the "blue book" has helped to define the remit of an occupational health service, although the status of the blue book is that of guidance. Nonetheless, we are now closer to establishing a core service specification than at any other time. Such a core specification should be accompanied by guidance on staffing levels and skill mix.

Clinical Governance is concerned with quality of services and with reducing the unacceptable levels of quality across the U.K. Quality may be defined in many different ways, but one way of looking at it is in terms of effectiveness, access, efficiency, acceptability, equity and responsiveness. There will be a need to set national minimum standards for all these determinants of quality. In the spirit of Clinical Governance, this will require the involvement of service users (staff and managers) as well as national bodies such as ANHOPS and the Faculty of Occupational Medicine. Evaluation of clinical effectiveness and efficiency will require an evidence base that is currently rudimentary and quality assurance will require the development of clinical guidelines that will be assessed by NICE (National Institute for Clinical Excellence).

How will it all happen? After all, we are a small specialty and new investment seems unlikely. We must maximise our use of existing resources, particularly sharing information about work that has been done already. ANHOPS is in a position to facilitate and co-ordinate joint ventures and to obtain national agreement on the priorities of work. Every effort should be made to evaluate our day to day clinical activities by establishing a series of on-going clinical trials to assess outcomes of clinical management. In addition, the research activity of our specialist registrars could be harnessed to answer specific research questions. We need to think creatively. We should be prepared to start simply in the hope of some early achievements. Uni– and multidisciplinary research will be necessary, that could be descriptive, mechanistic, disease focussed or problem focussed. In the new NHS size seems to matter. A nationally focussed and co-ordinated occupational health service can also make a difference.

John Harrison.

ANHOPS REVIEW

MORE SMART WORDS

A feature on SMART cards is not new in the Newsletter. However, we don't have a working solution, yet, to issues such as protecting patient and staff welfare, improving the efficiency of departmental administration and safeguarding locum appointments. We live in an age where information is increasingly transmissible but we are still lacking a "portable" occupational health file that is both user-friendly and confidential. Information technology must be the answer, but how? Dr Stuart Miller, Director of the occupational health service of the Hammersmith hospital, London may have moved closer to a solution, in conjunction with NBS Technologies Limited.

A SMART card system has been in development during the last two years. It has three key features:

- Writing OH information onto a SMART card
- Ability to read the card at a number of remote locations
- Access to need-to-know OH information by personnel to facilitate "out of hours" health clearances.

The front of the card bears a thermally printed colour photograph of the cardholder, name and GMC (or Calman) number. There is also a four-digit number based on the month and year of creation of the card. On the reverse side there is microchip-encoded information.

The health information is, essentially, vaccination status for relevant infections, including hepatitis B and tuberculosis. There is the facility to record chest X-ray information and a "Clothier clearance". A police check may be added in the future.

Confidentiality is protected by use of a pin number. Without it information cannot be accessed. The card is the property of the holder. From a data protection perspective, the information held on the card is basic essential information only, as is required to give health clearance.

Compatibility with other systems is important. It is possible to download from an existing electronic OH record. The card is read/write and can be updated, as required. There is also compatibility with other electronic systems, such as Sandwell and Hippocrates.

Use out of hours tackles the difficulties of employing locums. Reader software can be loaded onto any PC. A message is displayed on the screen relating to exposure prone procedures, or working with children, but no personal health data is shown.

A user group, comprising a number of London-based Trusts is overseeing additional pilots. A major provider of agency doctors has expressed an interest, as has the North Thames Post-graduate Dean.

GET ON-LINE

Never let it be said that ANHOPS lags behind the cutting edge of technology. Well not too much anyway. Thankyou to everyone who has contacted Peter Verow, or John Harrison, with their e-mail addresses. We have about a dozen now. We could set up our own e-mail discussion list, or join an existing one. Occenvmed is an academic originated list that has been going for almost two years. It has more than 160 members and only about 40% are "bookworms". The future of occenvmed is a little uncertain at the moment. It is hoped that the NHS, or a professional association (!?) might assist.

ANHOPS has a web site!! It is somewhat rudimentary, at present, but it's a start. For those of you who can access the web, try http://occmed.free-online.co.uk The home page is common to ANHOPS and EASOM (European Association of Schools of Occupational Medicine). Just click on the blue ANHOPS to go to the ANHOPS pages. You can download a previous Newsletter (you will need Adobe Acrobat Reader which is free). Feel free to visit the EASOM pages. Have a look at the EASOM Newsletter. Enjoy!!!

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