ANHOPS REVIEW

ICOH CONFERENCE, 2000

The 26th International Congress on Occupational Health (ICOH) was held in Singapore, August 27th—September 1st. There was good support from the U.K. and occupational health for healthcare workers was an important topic area. There were 6 sessions devoted to this, including the occupational health of physicians and protecting healthcare workers and patients from infection. In addition, there were sessions on relevant issues such as musculo-skeletal disorders, accident prevention, the ageing worker, respiratory disorders, reproductive hazards and work organisation and psychosocial factors. The scientific committee overseeing the meetings and conferences for healthcare workers elected Dr Ian Symington as its new chairman.

The general sessions covered a wide variety of topics. Professor Giuliano Franco, from the University of Modena, presented an exciting paper on the "virtual hospital", the result of what must have been hours of work developing an internet-based information source describing the hazards in a hospital. For more details go to http://www.medlav.unimo.it/ov/eindex.htm

Many papers were concerned with exposure to blood and body fluids. Friedrich Hofmann, from Wuppertal, Germany, has conducted a series of studies looking at seroprevalence rates in different regions of Germany. There has been a reduction in the seroprevalence of markers of hepatitis B infection, following contact with blood, over a 15-year period, attributed to the effectiveness of vaccination programmes. This research group has also looked at the incidence of unreported needlestick injuries during operations, using markers gloves and testing gloves for perforations, post-surgery. They estimated that there was a 10% chance of transmission of blood to or from the surgeon, based on the occurrence of perforations.

Papers from the U.K. included Ian Symington (Strategies to support doctors with impaired health), Sandy Elder (Influenza: costs and benefits of vaccinating healthcare workers), Thelma McGuire (An audit of sickness absence: a longitudinal study of healthcare workers in a cross section of UK hospitals) and a paper from Southampton entitled a multi-disciplinary approach to managing back injuries in British healthcare workers. Elizabeth Murphy, newly appointed consultant in Aberdeen, submitted a poster "an audit of health surveillance of workers exposed to respiratory sensitisers in the NHS and industry.

The theme of the conference was healthy worker, healthy workplace: a new millennium. The plenary presentations examined the global context of occupational health, particularly the challenge of providing occupational health to Asia, Africa and South America. Discussions of OH provision, when there is a shortage of food, inadequate sanitation and a rudimentary health care system were both poignant and salutary. 70% of the world's working population faces such challenges. New technologies and the ageing worker both featured, again demonstrating the global perspective. From the U.K. Professor Malcolm Harrington discussed the challenge of ensuring that occupational health remained a saleable commodity. Market research suggests that the need is there, we just have to design the right package, at the right price!!

JH.

A UNIFIED VOICE FOR NHS OCCUPATIONAL HEALTH NURSES?

The lack of single representative voice for OH Nurses working in the NHS presents one of the difficulties in taking forward our objectives to improve NHS Occupational Health. The Executive Group has agreed that ANHOPS could support the development of a group. We are not proposing to extend ANHOPS membership beyond doctors, but a similar group for OH Nurses in the NHS with good communications in both directions. ANHOPS could fund a meeting for interested Senior Nurse Managers in NHS OH Departments to enable them to take this forward.

Would you please draw this to your Senior Nursing Manager's attention and ask them to drop me a line if they are interested… any thoughts they have on how to develop the idea would be useful, and once I know who is interested, I'll organise a meeting.

Alison Rimmer
Secretary, ANHOPS

ANHOPS

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ANHOPS

TAKING OCCUPATIONAL HEALTH FORWARD

SEPTEMBER 2000

Anhops News

THE VOICE OF OCCUPATIONAL HEALTH IN THE NHS

THE NEW EXEC.

A new century, a new leadership team to take ANHOPS forward to face the challenges of promoting occupational health in a rapidly changing NHS.
Occupational Health has had a chequered history, generally, but in the NHS in particular. It is a tribute to the previous leaders of ANHOPS that the association is both known and respected in the higher echelons of power.
Of course, such success is ephemeral if the momentum is lost. We must invest in the future by supporting new executive as much as possible. To misquote the famous saying....Don't ask what ANHOPS can do for you...!
None of us have the luxury of free time: All of us can benefit from sharing what little we do have.

September 2000 is the month when the eyes of most of the world will be on Sydney, Australia, to watch a re-enactment of the Olympian ideal, twenty-first century style! This makes an appropriate backdrop for the *ANHOPS NEWS* which is concerned with the fulfilment of the occupational health ideal in the first decade of the new century.

Like the proverbial corporation bus, after a long period of waiting, three important documents have been produced by Government, all of which will shape occupational health practice. We feature summaries of *REVITALISING HEALTH AND SAFETY, ACCESS TO OCCUPATIONAL HEALTH* and *AN OCCUPATIONAL HEALTH STRATEGY FOR GREAT BRITAIN.* These three documents are examples of the "joined up" thinking that we have been promised and there are indications that there is a political will to follow through. The effect of Devolution is discussed in a new series and new problems relating to the importation of labour are highlighted. A report from the ICOH conference in Singapore indicates that many of our occupational health concerns are shared around the world.

INSIDE THIS ISSUE..

FROM THE CHAIRMAN OF ANHOPS: Dr Anne Ross

I take over from Peter, as Chairman, at an exciting and demanding time for Occupational Health in NHS.

Firstly, a big thank you to Peter for all the work he has done with the executive in the past four years. He has been keen to keep ANHOPS profile high, encouraged people to complete new guidance notes and revise old ones. He has established valuable contacts with the NHS ME and other agencies in Occupational Health. so that at the "friends of ANHOPs" meetings there is an exchange of ideas and discussions, enabling us to speak in one voice, which must be good for the speciality.

That reminds me that clinical governance and revalidation will play an important part in our lives over the next few years. It will be important for those doctors working within the NHS without Occupational Health qualifications to consider taking the diploma. Giving opinions without the backing of relevant qualifications is likely to be a risky business in the future. The courses, which are essential for the diploma, are informative and if such doctors feel ANHOPS can help in any way, we will be happy to try and support you. We will also work towards making our meetings relevant with up to date topics. Remember these meetings are acceptable for CME and even if Occupational Health might not be your primary speciality, you will be expected to show that you are keeping up to date by attendance at the relevant meetings. In order to reduce the expense and time needed to attend meetings, we will be combining with ALAMA in the Spring in Newcastle, and the Society of Occupational Medicine in the Summer in Belfast. Ideally we would like to have one combination meeting a year, but the situation next year allows us to fulfil previous commitments.

With the establishment of primary care trusts and the government's commitment to Occupational Health for all in the NHS, (complete with funding!), NHS Occupational Health Services are in ideal positions to extend our care. While many of our colleagues will be well used to Occupational Health Services in the Community trusts, the challenge will come from the GP practices. Some General Practitioners are very familiar with Health & Safety, practising Occupational Health themselves, either in the NHS or industry, but others are not. They will need considerable advice if they are to come up to standards, and many of their routine practices may have to be challenged. For example, is it appropriate for General Practitioners to be looked after by their own Practice Colleagues? I think not.

In hospitals, we have had enough new reports to cope with. The latest guidance on Hepatitis B carriers means considerable work for some units who do have surface antigen positive health care workers doing EPP's. Have you sufficient back-up with computers to make life easier to fulfil your obligations for management? If not, it is important you remind management that it is their responsibility under COSSH to make sure that staff are protected and not putting patients at risk. The guidance on post-exposure-prophylaxis for HIV infection makes it easier to ask for the appropriate tests to be done from the donor, following all inoculation injuries. The sooner everyone accepts that donor blood can be taken with pre-test discussion and be tested for Hep B, C and HIV routinely, the better for our Health Care Workers.

The RCN is getting tough on inoculation injuries, particularly sharps injuries affecting nurses, and trusts are likely to be sued for unsafe practices. It is vital that doctors in particular are reminded of their duty to dispose of a sharp if they use it. Anyone talking at induction courses are advised to make a very definite point of this. If only the medical schools would teach this practice from the beginning of the course!

In order to help myself and the Executive take ANHOPs forward, it is important that we know the feelings and needs of our members. Please keep in touch with us through your regional representatives, or directly by phoning me on 0118 9877634 or e-mail: westberkshire.occupationalhealth@ rbh-tr.anglox.nhs.uk

AR.

ATTENTION !!!

"There are lots of things to keep ANHOPS members busy. I believe our membership is our strength."

We are shortly going to be conducting a survey to find out what is going on out there. We need to know where our members are, and who is not a member.

How many sessions do you do? What grade are you practising at? This isn't just 'being nosy'! It is vital manpower information.

We are **happy** to support the NHS Plus idea, but only if it is to be adequately funded, and it must not be practised at the expense of services to our own trusts.

Working alongside our General Practitioner Colleagues, looking after Primary Care Trusts, the whole ethos of Occupation Health can be spread, and this will help us to help colleagues to have a better knowledge of Occupational Health and it's practices, and therefore reach a wider population.

From the REGIONS

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

Please let us know if there are any inaccuracies in your address when you receive your copy. We rely on YOU to keep us informed of any changes.

EXECUTIVE COMMITTEE MEMBERS

NAME	TITLE	ADDRESS
Anne Ross	Chairman	West Berkshire OH
Peter Verow	Past Chairman	Sandwell 01216073417
Alison Rimmer	Secretary	Sheffield 01142714161
B Platts	Treasurer	Kings Mill Ctre, Sutton in Ashfield, Notts.
A Robertson	Education	Birmingham 01212233762
J Harrison	Newsletter	Newcastle 01912228748

Impact of devolution on OH in Scotland

Eugene Waclawski. Consultant Occupational Physician.

The National Health Service in Scotland had a separate identity from the NHS in England and Wales prior to devolution. The Scottish Home and Health Department existed with its own administration and Chief Medical, Dental and Nursing Officers. Health is one of the parts of government devolved to the Scottish Parliament, although health and safety is not. HSE has had to agree a method of consultation with the Scottish Parliament.

Members of the Scottish Parliament are elected by proportional representation. The Scottish Executive is a coalition of political parties (Labour, Liberal and Scottish Nationalist). The Parliament is a single chamber (no House of Lords). Legislation is produced via a committee structure, which informs the Parliament on specific new Acts. It has been fortunate that both Sam Galbraith, the previous Minister, and Susan Deacon, the current Minister, support occupational health.

There are fundamental differences between the NHS in England and Scotland following the latest reorganisation. There has been a reduction of the number of NHS Trusts. Community care is based on Primary Care Trusts, which are combinations of primary care and community Trusts, and Local Health Care Co-operatives, which have replaced GP fundholders. Some areas of Scotland do not have Trusts and continue to have Health Boards. (Western Isles, Orkney, Shetland) The term healthcare worker is a term that includes those contracted to supply services to the NHS, such as general medical and dental practitioners and their staff, pharmacists and opticians. The provision of an OH service to all healthcare workers is a development which is seen as important within Scotland.

Major initiatives that impact on OH have been the review of Public Health and the Scottish Human Resources Strategy for the NHS *Towards a New Way of Working. The Plan for Managing People in the NHS in Scotland.* A series of Partnership Information Network (PIN) Guideline Development Groups have been created, dealing with aspects of Human Resources. These PIN guidelines, including one on the management of health at work, are equivalent to the SIGN (Scottish Inter-collegiate Guideline Network) guidelines in clinical practice. The PIN guidelines have been produced expeditiously and may lack the most rigorous evidence base, but they are a step in the right direction.

There is a proposal to establish The Health Department Occupational Health Forum. This will include Directors of occupational health, with a direct link to the Scottish Executive. An additional £1 million for occupational health has been announced to fund initiatives such as: advice on musculo-skeletal problems, work-based health lifestyle advice services (including stress reduction) and "well man/ well woman" advice from nurses visiting workplaces.

A Scottish perspective on UK guidelines is emerging. For example, the guidance on HIV post-exposure prophylaxis was delayed after the front cover was modified to include the Scottish Executive Health Department logo! The revised guidelines on hepatitis B do not exist in a Scottish version (as of August 14th) The differences between the NHS in England and Scotland must be considered by NHS consultants in Occupational Medicine when networking and promoting services to healthcare workers. Membership of ANHOPS provides a useful channel for information to receive guidance.

ANHOPS MAY MEETING Control of Infection Issues.

INFORMATION & EDUCATION

HEPATITIS B AND HEALTHCARE WORKERS -

Dr Elizabeth Boxall PHLS

This is a sensitive, but important issue. The risk of infection depends on:

The infectivity of sources, blood being the most infectious fluid, the virulence, the viral load, the route of infection, the volume of fluid involved, and the procedure involved.

The status of the exposed person, whether they are immunised, their general health, medication, or whether they are immunocompromised.

In 1976-1990, twelve outbreaks of transferred infection from Healthcare workers, mainly surgeons to patients giving 5-10% infectivity rate. Other historical landmarks:

1972, the Rosenheim Report

1981 – The CMO stated surface antigen positive Healthcare workers could continue working doing EPP's providing no transmission had occurred.

In 1994, e antigen carriers were not to perform EPP's.

Since then, seven cases of transmission from s antigen positive surgeons. Guidance has now been published and should be available to you. If Hbs Ag positive Healthcare Worker, is involved in a needlestick injury, and this is a surgeon operating in a deep cavity, the patient needs to be vaccinated - Please remember.

HEPATITIS C – Dr

Anne Cockcroft, Royal Free Hospital

- more transmissible than HIV
- no vaccine available
- no effective PEP
- definite occupational health risk
- risk of transmission approximately 3% after needlesticks. If PCR positive up to 10%, if PCR negative negligible risk.
- December 1999 there was a revision guidance and more guidance on Hepatitis C positive healthcare workers is due in the near future.

After needlestick injuries, it is recommended that:

- test source patients for HBC infection
- store baseline blood sample from healthcare worker
- if donor source HBC positive, test healthcare worker for RNA at six weeks and twelve weeks and for hepatitis C antibodies at twelve weeks and twenty-four weeks
- refer for consideration for early treatment if RNA and antibodies for hep C virus are positive
- HCV is the commonest blood borne virus infection in source patients found as a result of testing. Approximately five cases where there have been known transmission of hepatitis C from a healthcare worker to patients. If we consider there are 60,000–70,000 healthcare workers undertaking EPP's – estimate 200 will be hepatitis C positive. The new Guidance should give information on how to look after these healthcare workers. Actions are likely to be based on an estimate of viral load similar to those now suggested with hepatits B.
- prevention and safety practices are to be encouraged

POST EXPOSURE PROPHYLAXIS - Dr Paul Grimes, King's Occupational Health Department

In a study looking at post exposure prophylaxis in seventy-one NHS Trusts –

- risk of transmission 0.3% after percutaneous exposure – after zidovudine post exposure treatment there appears to be an 80% reduction in risk. EAGA Guidelines 1997 are important. It is suggested we keep to these, giving post exposure prophylaxis only if donor is HIV positive or strongly suspected to be.
- ideal time for prophylaxis is within the hour but it can be given up to two weeks after exposure.
- post prophylaxis - there should be follow up for six months of the healthcare worker

We need to document incidents very carefully. This study showed a considerable lack of documentation and details. Treatment of the episode needs to be coordinated through one department. Strategies need to be considered to prevent and reduce needlestick injuries. Source patients – there should be routine HIV testing after pre-test discussion.

Anne Ross and Ian Murphy

Inside this issue:

STOP PRESS

The new Hepatitis B guidelines are taking time to bed in. Recent messages posted to *occenvmed* indicate that the laboratories in Birmingham and Glasgow are not quite as prepared as they might be to carry out tests on viral loads. In the interim it is probably advisable to liase with local departments of virology.

Care of Healthcare workers from Abroad ?

Increasingly it seems Health Care Workers are being recruited from abroad to fill the nursing vacancies in our hospitals. Many come from countries where Tuberculosis is endemic, Hepatitis B very common and HIV positive patients common. This must be taken into consideration when screening such applicants.

The following process is suggested:

Ideally a recent reported chest X-ray, and Hepatitis B (and C) status should be obtained by the recruiting agency and passed to the Occupational Health Service with a completed Health questionnaire prior to acceptance, and before the Health Care Worker leaves their native country.

All Health Care Workers from abroad for a face to face interview in the Occupational Health Department.

If the Health Care Worker is going to do exposure prone procedures, and comes form a country with a high incidence of HIV infection, careful consideration should be given to asking for an HIV test. In fact, it has been noticed that some Health Care Workers coming from such countries will actually ask for an HIV test on coming to this country to satisfy themselves that they have not contracted HIV during the course of their duties in their native country.

Many Health Care Workers in countries when TB is endemic will have had BCG. Even in the presence of a scar, it is wise to do a Heaf Test. Many will show a Grade 4 reaction suggesting a primary tuberculous infection in spite of having had BCG. Such people can then be warned to react quickly to symptoms. It is well known that cases of tuberculosis can reactivate under stress, the most common time being twelve to eighteen months from taking up residence in a foreign country. Some trusts may consider giving chemoprophylaxis. Others will feel that a chest X-ray should be repeated at two to three months after arriving in this country to make sure that they were not actually incubating the disease prior to their arrival This does not of course protect against any later relapse and this is why these people need to be seen and the situation talked through.

A Grade 0 Heaf result in a Health Care Worker from a country where TB is endemic, especially if a BCG scar is present, should be noted carefully, and checked by a Mantoux Test. If this is negative, it may well be indicative that the Health-Care Worker is HIV positive. It would be advantageous to the Health Care Worker to have an HIV test so that treatment can be instituted if necessary, and it is wise that this is done, before consideration is given to giving BCG, if there has been no previous history of such vaccination .

Hepatitis B status should be carefully determined. There will be an increased incidence of natural immunity showing core antibodies and also of the carrier state in Health Care Workers, in particular from the Middle and Far East. If there is any doubt about the results we suggest you repeat hepatits B and C screening in this country especially if the Health Care Worker is to do EPP's. If the blood is taken in the Occupational Health Department we can be sure of the results we obtain.

All Health Care workers from abroad need considerable support to adapt, not only to different conditions within the hospital, but also in their living environment. Occupational Health Services are well placed to work with Management to make sure that they are well supported.

The above precautions are recommended, as we are well aware that several cases of active tuberculosis have been found in recently recruited Health Care Workers. Some of these have also been HIV positive. It is, therefore, vital that all such Health Care Workers have a health interview once in this country, when details can be checked and the active support of the Occupational Health Service reinforced.

Anne Ross.

ACCESS TO O.H.

OPPORTUNITIES FOR NHS OCCUPATIONAL HEALTH

PETER VEROW
CONSULTANT

Http://www.hse.gov.uk/noframes/access.html

This is an essential document for any NHS Occupational Health Physician. The 80 pages highlight the increasing awareness both by government and other agencies of the need to improve health at work. Together with the HSE's 10 year strategy, the documentation should support any NHS Consultant wishing to develop their Occupational Health service in line with a wider public health agenda.

The OHAC Working Group (CBI, EMAS, TUC, NHSE, DOH, and Federation of Small Business.) was chaired by an HSE representative, Other individuals with experience in health promotion, regional health authorities, and ergonomics were also co-opted onto the group. The Occupational Health Physician input was provided by Dr Susan Robson who was representing the BMA/ SOM/FOM, Dr David Snashall and Dr Nerys Williams representing the HSE and EMAS, and Dr Olivia Carlton representing the DOH.

The document highlights that there is a need for local partnerships and that there should be a mandatory requirement for Occupational Health to form one of the core issues to be covered by Health Improvement Programmes (HIMPS). Health Action Zones (HAZ) initiatives should also develop Occupational Health provision.

Comments:

It may be beneficial for Consultant Occupational Health Physicians to arrange a meeting with their director of public health to debate how HIMPS / HAZ may incorporate the future need for occupational health as recommended by the document and the government's apparent intention to pursue NHS plus.

There is a need to undertake further research into the economic benefits of occupational health interventions and to develop guidance on good practice on occupational health solutions.

Comments:

Perhaps an opportunity for those departments with an interest in research particularly if they have links with academic OH units.

GPs and practice nurses should be encouraged to train in occupational health and be encouraged to network with services, including NHS Occupational Health Units. PCG's should be encouraged to take onboard OH needs.

Comments:

Owing to the shortage of qualified OHP and OHN it is inevitable that a large agenda such as that being recommended here will need the support of and delivery by, primary care practitioners. It may be advisable to discuss these issues with PCGs to ensure that they are planning for these developments in the future.

DOH/NHSE should examine the feasibility of developing and extending the provision of OH units within the NHS without prejudicing the OH support for NHS staff.
Consideration to be given to the benefit of recognising of OH as an NHS speciality to which primary care patients can be referred.
More time should be given in undergraduate medical training to promote the awareness of OH issues and the control of work related risks.

A regional NHS group OH service should be piloted and evaluated in at least one geographically defined locality.

Appendix 9 outlines "how the NHS fits in". It gives an indication of NHS manpower levels and the ability of the NHS to tackle rehabilitation issues, and how PCGs could be influenced to include occupational health issues.

There are unlimited opportunities for NHS Occupational Health. Local resources may influence our response, which in turn are likely to be dependant upon the views of local multi-disciplinary teams. Such teams will need to include the OH service, the Director of Public Health, and the health authority, PCGs and local businesses.

Over to you! As a minimum I would suggest you read the full document!

Peter Verow

REVITALISING HEALTH AND SAFETY

Following a consultation exercise, the HSE has launched its 10-year strategy for taking health and safety forward in the U.K.. A 10-point Strategy Statement sets the framework for further action for the early part of the twenty-first century. There is a recognition that mere prevention of work-related harm is insufficient and that there must be a promotion of better working environments. Occupational health has been identified as a top priority and this has been underlined by the launch of an **OCCUPATIONAL HEALTH STRATEGY** for Great Britain in July 2000. (See below)

The buzz phrases from the strategy document include "positive engagement of small firms", "motivate employers", "culture of self-regulation", "Partnership on health and safety issues", "Government must lead by example", "Education", "Design it in". A change in culture appears to be being sought, but how to achieve this will be the challenge. There is a recognition that the benefits of self-regulation need to be promoted and these are likely to be a combination of incentives and the avoidance of penalties. In a world where the Government is increasingly less able to influence business operating in a global economy, the business case for health and safety is to be emphasised. Financial incentives to encourage good practice and changes in the law to deter bad practice will be sought. Changes in the employers' liability insurance might be anticipated. There is a clear need to ensure that all businesses, large or small, are appraised of what constitutes good practice and it seems possible that health and safety issues will become key components of education, starting at the primary school stage and continuing throughout secondary and higher education.

The rehabilitation of disabled workers is seen as an important role for occupational health. Action points 28, 29 and 30 are concerned with the full implementation of the Occupational health Strategy, encouragement of better access to occupational health support and promoting coverage of OH in local HIMPs and Primary Care Group strategies, (See article by Peter Verow) and the strengthening of retention and rehabilitation services for people in work who become disabled or have persistent sickness. Action point 31 considers whether organisations will be required to set out their approach to rehabilitation within their health and safety policy. JH

AN OCCUPATIONAL HEALTH STRATEGY FOR GREAT BRITAIN

The Occupational Health Strategy, referred to in the *REVITALISING HEALTH AND SAFETY* document, was launched in July, 2000. There are clear goals to reduce ill health both in workers and the public caused, or made worse by, work; to help people who have been ill, whether caused by work or not, to return to work; to improve work opportunities for people currently not in employment due to ill health or disability; and to use the work environment to help people maintain or improve their health.

By 2010, it is hoped that the following targets will have been achieved:

- 20% reduction in the incidence of work-related ill health
- 20% reduction in ill health to members of the public caused by work activity
- 30% reduction in the number of work days lost due to work-related ill health.

Opportunities for rehabilitation should be communicated to workers AND to people not in work due to disability.

The aspirational goals will be supported by work carried out in 5 programme areas. Within each programme there will be priorities for action, targets and set projects. The implementation of the strategy will be overseen by a PARTNERSHIP BOARD, chaired by the Chairman of HSC. There will be Programme Action Groups (PAG) to oversee the work of each programme.

Programme One is "to improve the law in relation to occupational health and compliance with it." COMPLIANCE This will look at involving H&S reps, increasing fines and securing consistent enforcement. Programme Two is "striving for excellence through continuous improvement in OH." CONTINUOUS IMPROVEMENT The focus is on culture, partnerships and health promotion. KNOWLEDGE is programme 3. Systems for collecting data, commissioning and co-ordinating research and sharing knowledge will be developed. Programme 4 (SKILLS) is concerned with ensuring that all parties have the relevant competences and skills to perform their roles effectively. This will target ALL professionals involved in OH. Last, but not least, programme 5 focuses on ensuring "that appropriate mechanisms are in place to deliver information, advice and other support on occupational health. SUPPORT

Helplines, information centres OR providers of occupational health support will be made available, with competent individuals or organisations. The need to recognise when to call on the expertise of others to find solutions to problems is emphasised. Development of IT will be essential.

There is a strategy web site, which is still awaiting development.
Http://www.ohstrategy.net JH