Volume 2;Issue 3

OCTOBER 1998

ANHOPS NEWS

ASSOCIATION OF NHS OCCUPATIONAL PHYSICIANS

Working Together

Securing a quality workforce for the NHS

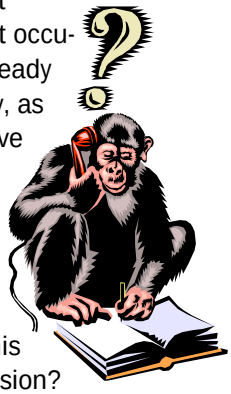
Special points of interest:

- The NEW HR Strategy – out at last.
- Peter Verow gives his first impressions
- There are new targets for sickness absence, accidents at work, OH services and counselling
- Download the document from the internet at:
- Http://www.open.gov.uk.doh/newnhs/hrstrat.htm

Inside this issue:

THE BLUE FOLDER: WHY, HOW AND WHERE NEXT ?

Ours is not to reason why, ours is but to do and make the best use of resources! We are often the last to hear about new initiatives in the NHS. It is not unknown for decisions to be made that affect occupational health practice, without "the experts" being consulted. It was unfortunate, therefore, that the latest Health Services Circular about occupational health, which has already become known, affectionately, as "the blue folder" seems to have continued this trend. Whilst it is true that the Dean of the Faculty of Occupational Medicine **WAS** consulted and indeed wrote the foreword, ANHOPS was overlooked. Was this oversight omission or commission?



Turn to pages 4 & 5 and judge for yourself. *ANHOPS NEWS* visited Quarry House on your behalf to talk to Mr Robin Heron, Head of Employment services at the NHSE. We were able to ask about the process leading to publication and to glean some up to date information about the role of occupational health in the NHS.

The ANHOPS executive committee has arranged to have two meetings per year at the Faculty of Occupational Medicine, to which other key personnel will be invited. Ideally this will include representatives from the FOM, SOM, DOH and NHSE. The aim will be to improve communication and to obtain endorsement of literature/ advice by all involved.

ANHOPS

M.R.S.A. – NEW GUIDELINES..... NEW EVIDENCE ?

Methicillin Resistant Staphylococcus aureus (M.R.S.A.) is a European currency for hospitals, according to a recent editorial in the Quarterly Journal of Medicine. The prevalence of M.R.S.A. varies from country to country, being most prevalent in the southern European member States. New U.K. guidelines on the control of M.R.S.A. have been published which are likely to rekindle the debate about what should be done to try to contain the spread of this organism. There is an expectation that occupational health departments will be able to treat staff colonised with M.R.S.A., but what are the issues? Is it really so straightforward? Turn to page 3 and read on.

FROM THE CHAIRMAN OF ANHOPS: Dr Peter Verow

The Human Resource Strategy for the NHS has finally been released. Entitled "Working Together" it gives further support for occupational health services within the NHS. For Human Resource directors to meet the core targets that they have been set, will require them to work closely with ourselves and other Health and Safety colleagues. To some of us this may present an opportunity - to others it may be a threat!!. The key targets within the strategy are:

Sickness Absence, Workplace Accidents and Occupational Health and Counselling services.

Sickness absence targets - (with measurement towards a national minimum benchmark.) As we are aware, the occupational service should be closely involved in setting any local sickness absence procedures. Without this involvement, it is likely that the occupational health service will be faced with the longstanding problem of being used as a back-up (or even a replacement!) for managers own disciplinary processes. Hopefully the enlightened employer will see us as a pro-active resource which is capable of supporting employees in their efforts to return to work. It will be interesting to see what the benchmarking criteria for sickness absence are. To be comparable there will have to be some national agreement on the way sickness absence is measured and the reasons for absence.

WORKING TOGETHER: THE NEW HUMAN RESOURCE STRATEGY

Through joint working we hope to produce guidelines that are concise and based on recognised, even evidence-based, occupational health principles

Workplace accidents - (with particular emphasis on violence at work.) All occupational health services should be actively involved with incident reporting systems, however past audits of accident reporting within the West Midlands indicated that the occupational health service was frequently unaware of what incidents had been reported, and many of those who did, only obtained the information weeks or even months following the event!!

Occupational Health and Counselling services: I suspect that delivery of these services will be based upon "the NHS executives, blue book". Whilst ANHOPS was not involved in this production, the NHS Executive recognises this was an oversight and are keen to work more closely with us in the future. Hopefully through joint working we will be able to persuade the powers to be that this document should be a little more concise and wherever possible, be based upon recognised and even evidence based, occupational health principles.

Occupational Health Benchmarking Club – First Meeting

The Nuffield Trust report has highlighted the need for Trusts to address Organisational factors in addition to the more common health promotion solutions which are being emphasised by the Health Education Authority. The report has outlined a number of activities for which there is reasonable evidence for taking action and provides a good opportunity for Trusts to agree a combined H/R and Occupational health strategy for the next year.

Are you confident that your Trust has effective procedures and systems in place to deal with high risk needlestick injuries, especially those which occur at weekends? The possible need for triple therapy and the relevant advice that has to go with it is not easy to arrange at such times. Recent guidance from the Expert Advisory Groups on AIDS and Hepatitis suggests that the source patient should be tested for HIV Hepatitis B and C. I am unaware of any service that is currently routinely testing for HIV following a needlestick injury, and many do not do so for hepatitis C. I suspect that many Trusts operate a risk assessment process, following which appropriate action is decide. If this is the approach that is to be used, it is necessary to establish who is competent to undertake the risk assessment when the injury occurs in the middle of the night or at a weekend. Perhaps it should be the manager who has been trained, or an A/E doctor, or perhaps an occupational physician who is on call. The last option would require more than one occupational physician, and then, if more than one Trust was being advised, would require all Trusts to agree on standard procedures etc. This type of arrangement appears to be in place in some areas - should it become common practice?

The first meeting of the occupational health benchmarking club was recently held in London. Many of the 30 Trusts who had participated were present. Not surprisingly, the results confirmed the wide variation in practice between occupational health services. Costs for services ranged from £9 to £75 per head and also demonstrated that many Trusts were actually selling their services to external clients at a price which was cheaper than it was costing their own Trust!! It was clear that comparisons were difficult when commercial activities were included and as a result the group agreed to continue with the programme but to concentrate purely on NHS activities. For those interested in the exercise, further details are available from the NHS National Performance Advisory Group. Telephone No: 0161 718 5653.

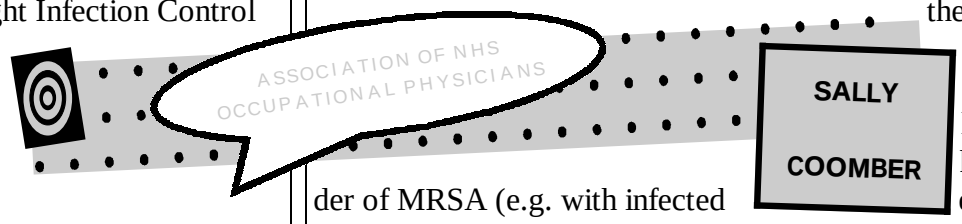
We are still awaiting the distribution of our Ill Health Retirement guidelines. These have been in the hands of the NHS Superannuation Division for the past six months. However my understanding is that they are very near to being finalised. (There has been much discussion about their contents and the possibility of including information relating to injury benefits.) Guidance on immunisation practice for NHS employees is also in draft. This is likely to be discussed in depth at our Winter meeting in Birmingham. We are also involved in the produc-

(Continued on page 7)

M.R.S.A.

There must only be a lucky few occupational physicians working in the NHS who are not involved in dealing with MRSA in staff, writes Dr Sally Coomber.

When a hospital outbreak occurs, or where MRSA is endemic, we can be dealing with distressed, confused or angry staff, differing policies between hospitals and trying to liase with sometimes fraught Infection Control Teams. The ANHOPS Spring Meeting, earlier this year, that was held in conjunction with the Hospital Infection Society produced a valuable sharing of experiences and viewpoints.



M.R.S.A. IN HOSPITALS

Since then, the new Guidelines "On the Control Of MRSA In Hospitals" has been published. This useful, if rather lengthy, document advocates a more flexible and targeted approach to the management of MRSA in hospitals based on clinical risk. As I had been given access to an earlier draft version, several months ago, updating out local infection control policy for staff was relatively straight forward.

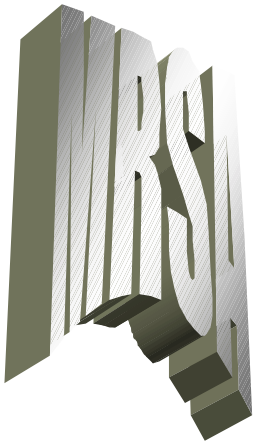
tion. The second section gives clear, practical guidance, based on the definition of four levels of clinical risk to patients. (See Table below) Each hospital's approach to an outbreak is still likely to vary, however, depending on specific risk factors. These will include the virulence and potential transmissibility of the strain, whether the individual is likely to be a heavy shedder of MRSA (e.g. with infected eczema), the type and design of the wards or units involved, local facilities for patient isolation and the hospital's experience of managing MRSA outbreaks.
I would recommend strongly that all NHS occupational physicians read the new guidelines.

Definitive advice is still lacking e.g. the management of recurrent skin or throat carriage and the use of mupiricin in pregnant workers

Discussion of the issues with the Infection Control Team in advance of an outbreak is advisable, particularly where definitive advice is lacking: the management of recurrent skin or throat carriage, when to prescribe systemic antibiotics for otherwise healthy staff, the use of mupiricin in pregnant workers and the risk from junior doctors or clinical students who may visit different wards and patients every day. Actions taken should be documented in the notes.

NHS Occupational Physicians should read the new guidelines

The guidance covers both patients and staff in two sections. The first section contains a comprehensive background to the MRSA problem, which includes the dramatic rise in the incidence of epidemic strains EMRSA-15 and EMRSA-16 and the emergence of multiple antibiotic resistance. There is concern about the increasing resistance to mupiricin (Bactroban) as this is used frequently to treat MRSA colonisa-



CATEGORY	EXAMPLES
High risk clinical areas i.e. specialist areas where consequences most serious	ICU, SCBU, burns unit, transplantation etc.
Moderate risk areas Local factors may alter grouping	Surgery (Orthopaedic, vascular, general) O&G, dermatology
Low risk areas	Medical wards, Paediatrics (non-neonates)
Minimal risk areas Community-based guidelines apply	Long stay wards: elderly, psychiatry.

POSITIVELY

AN INTERVIEW WITH

Suspicion, mistrust, paranoia: None of these words seem particularly out of place when used in connection with the management of the NHS. As occupational physicians our perceptions of "the management" are likely to be coloured by our continual exposure to the victims of organisational change and by the status of occupational health. However, most of us who have been around the NHS block several times have come to accept that problems usually arise as a result of omission , rather than commission. This is the explanation for the lack of consultation with ANHOPS prior to the launch of the "Blue Folder". How credible is this? *ANHOPS NEWS* was given an opportunity to talk to Mr Robin Heron, Head of Employment Issues at the NHSE.

We all know that change is inevitable. There has been an on-going period of transition within the NHS for many years. However, the way in which change will be directed appears to have evolved from a hands off to a hands on, participative approach. The new administration in Wellington House has set out its stall to make the NHS a better place to work in and to be more pro-active. There is no doubt that occupational health will have a key role in assisting the implementation of a new strategic framework which will be launched by Mr Alan Milburn, in October. This will be the start of a 10 year plan to modernise the NHS and it will be based on the results of a consultation exercise that has taken place during the last year. A new H-R strategy will address a number of issues that affect not only the NHS, but also the Public Sector generally. It will include:

- Existing patchiness of H-R management
- Equal opportunities
- Violence to NHS staff
- Sickness Absence
- Major causes of work-related morbidity, such as musculoskeletal disorders and stress at work

None of these issues are new but there appears to be a new intention to take them seriously. Talks are being held to underpin some of these initiatives with changes to the criminal justice system. In addition, a recent report from the Cabinet Office entitled "Working Well Together, Managing Attendance in the Public Sector" has underscored the Government's desire to introduce an inter-departmental approach to this issue. The need to consider introducing progressively earlier or wider referrals to occupational health services to address cases of workplace injury or sickness, by June 1999, is one out twenty-seven recommendations. It is also encouraging that the report from the Partnership for the Health of the NHS Workforce, sponsored by the Nuffield Trust, has been received sympathetically by the Minister.

We all know how easy it is to pay lip service to them and how skilled Trusts are at creating façades that give the impression that policies have been implemented. The next step will be to educate Chief Executives of Trusts (and of Health Authorities!) about the importance of Human Resource management and to hold them accountable. It is tempting to add that most of them also need educating about occupational medicine and occupational health.

The new approach can be illustrated by comparing the development of occupational health guidelines in the NHS HSG(94)51 produced as a reaction to the Clothier Report on the case of Beverly Allitt. The process, which took about one year, involved a small core of people. The "Blue Folder", which was a reaction to the Bullock Report, took only four and a half months to produce and there was a much wider involvement of people in the field. Why, then, no ANHOPS?

Whether we care to acknowledge this or not, we have a problem in occupational medicine and occupational health. There are TOO MANY GROUPS. Who is the voice of occupational medicine: The Faculty of Occupational Medicine? The Society of Occupational Medicine? ANHOPS? ALAMA?…… and so on. It is even more confusing when the same occupational physician might sit on committees within the different groups. It is very difficult for people outside the specialty to know who to speak to or to be confident that the opinions that have been sought are representative of "occupational health".

There can be little doubt that when the "Blue Folder" was produced, the NHSE genuinely thought that they had consulted with the relevant occupational physician groups. That this was a misunderstanding has been a learning exercise for both the NHSE, ANHOPS and the Faculty of Occupational Medicine. The potential for improving communications between the respective organisations has been recognised and it is to be hoped that they have established a basis for effective consultation, in the future. This will build on good work that has been done already, with examples of collaboration between NHSE and ANHOPS on issues such as a drug and alcohol policy for the NHS and, currently, occupational health in the Primary Care Sector.

Although it was necessary to respond to the Bullock Report, it is clear that there was some difficulty in taking all the recommendations at face value. Reference to some of the recommendations in the "Blue Folder" gives an indication of which could be translated into practical guidance for occupational health services. It seems likely that the Bullock Report will become less relevant as new examples of good practice are incorporated into the "Blue Folder". In addition, a national H-R strategy may make issues, such as the transfer of occupational health records, easier to manage.

SPEAKING

It is clear that the NHSE views the current provision of occupational health services within the NHS as not bad, but thin in places. There is an appreciation that most occupational health services are nurse-led, in that they do not employ specialist occupational physicians and the responsibility for the management and the development of the service resides with a nurse. There are 59 consultant occupational physicians, based on a recent survey, not all of whom work full-time. Consequently, there are about 50 W.T.E. consultant occupational physicians. It is also clear that there is a realisation that the status quo is insufficient, in terms of specialist resources, to deliver the goals of the new strategy, particularly given the emphasis on being pro-active.

ROBIN HERON

Agreement that there are insufficient specialist occupational physicians and occupational health nurses is welcome, but finding new people is not going to be easy. Training the specialists of tomorrow has become a key issue because of the difficulty in filling doctor training posts and because of the national shortages of nurses. Only about half the nationally agreed specialist registrar posts in occupational medicine have been filled, due in no small part because of a reluctance of Trusts to fund them. Alternative models for training occupational physicians are being considered. However, it seems that, once again, there is a need to educate directors of Trusts that the concept that, in occupational health, a doctor is a doctor is a doctor is incorrect. The new H-R strategy should give us an opportunity to show how trained occupational physicians benefit the organisation and to demonstrate the "added value" of employing consultant occupational physicians.

Clinical governance and quality of clinical services are two other initiatives which will have a significant impact on occupational health services. There is an expectation that occupational health will not be treated any differently from other clinical services and that clinical effectiveness and clinical audit will have to be addressed. There will be a requirement for the setting, delivering and monitoring of professional standards, which will be evidence-based. The Research and Development programme of the NHS will underpin the new strategy by encouraging practical outcome research. The NHSE will drive an H-R research and development programme which should provide long-awaited access to research funds for occupational health. At present, the investment in occupational health is, in the main, an act of faith. The key question that has to be addressed is what are the links between good occupational health and an efficient workforce?

ANHOPS, with its extensive communication network with occupational physicians working in the NHS throughout the U.K., is arguably the voice of occupational medicine in the NHS. It is also well-placed to facilitate research to address questions that may be difficult to answer using studies based in single Trusts. There is an opportunity to consider how ANHOPS can work more closely with the NHSE for mutual benefit. The message is that the NHSE is keen to talk, but is unclear about the best way to do this. We need to establish means of communication that enable the passage of information that allows both quick responses to specific problems and the consideration of issues in a strategic manner.

Year 2000 targets for the NHS are reductions in sickness absence, reductions in accidents rates, improved occupational health and counselling. There have not been better prospects for occupational health services in the NHS. However, it is still possible that this is just another false dawn. We have to be aware that the political winds of change blow inconsistently and are often short-lived. Investment in occupational health means diverting funds from other areas in the Health Service. How stable will the new strategy be in the advent of another "Jennifer's ear" or "Ben's liver"? Spending money on public sector employees will always mean walking a political tightrope unless it can be demonstrated that it is cost-effective to do so. It is encouraging that the new strategy has been given a high priority and will emerge early in the life of the Parliament. There is a lot of political credibility riding on the back of occupational health such that this initiative has to be seen to work. The impression is that NHS staff will be given the opportunity to make it work. The next few years will be about partnership. ANHOPS can be a member of the partnership.

John Harrison.

EDUCATION & DEBATE

A New Service for Addicted Healthcare Professionals

Dr Jennifer Bearn, Cons. Psychiatrist/Snr Lect. (1)
Dr E. Jane Marshall, Cons. Psychiatrist/Snr. Lect. (2)
Carol Suffers, Addictions Directorate Manager (3)

(1) Wickham Park House
(2) Alexandra House
The Bethlem Royal Hospital
*(3) The Bethlem Royal & Maudsley NHS Trust**

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Traditionally in the NHS little is done to provide specific services to assist staff who become ill. Such professionals are particularly slow to access services for drug and alcohol problems. Although these individuals have access to NHS services, as well as occupational health departments, factors such as potential loss of employment, professional isolation, guilt and fears of recrimination, or even work pressures and lack of time, may disadvantage them from seeking help.

Healthcare professional groups are at special risk of developing drug and alcohol problems, not least through their privileged access to controlled drugs. The recent "British Medical Association Working Group on the Misuse of Alcohol and Other Drugs by Doctors" estimated that one in fifteen doctors in the U.K. might suffer from some form of dependence (1). Prevalence rates for nurses and other healthcare professionals are not known, but evidence from the nursing U.K. C.C. Healthcare Committee suggests that rates of dependence are similar to those for doctors. In 1996-97 83 out of 121 cases considered by the committee were drug or alcohol-related (3).

Such drug and alcohol problems may constitute a risk to the general public. Professional judgement and standards of care for patients can become impaired, as both physical and psychological health is affected. There is a need, therefore, for a special service for doctors.

The need for such a service was highlighted recently in the British Medical Journal. (2) A large personal and public investment is devoted to training these professionals and so it is important that a sympathetic and supportive approach is given to help "sick" doctors overcome their drug and alcohol problems. The BMA guidelines "The Misuse of Alcohol and Other Drugs by Doctors" (1) make specific recommendations for the early identification of drug or alcohol misuse, as well as for preventative education. Where serious problems have developed it may be necessary to remove sufferers from the workplace because of concerns about fitness to practice and to remove access to opiates or benzodiazepines. Professional regulatory bodies must make every effort to assist doctors to obtain medical treatment, whilst also ensuring that the public are protected.

The Bethlem and Maudsley Trust recently introduced a new Addicted Healthcare Professional service. This was a response, in part, to continuing requests from bodies such as the General Medical Council for assistance in the treatment of affected doctors. There had also been an increase in referrals from general practitioners, psychiatrists and general physicians. There was a perceived need for a comprehensive service to overcome the stigma, collusion, and denial typical of these illnesses in doctors. And others.

The NHS service differs from other private facilities in that it is comprehensive. It offers immediate emergency admission for crisis intervention, assessment followed by detoxification and stabilisation. Psychiatric and physical assessments are an integral part plus professional support and monitoring. The latter usually continues for a year after in-patient admission. Individual support is balanced with appropriate supervision by the relevant professional body.

Healthcare professionals find it difficult to adopt the "patient" role. In addition ward staff may have false expectations of them, treating them as colleagues and holding higher expectations for compliance with treatment and for their recovery. Nonetheless, there is evidence that comprehensive treatment leads to good outcomes (4). The service is delivered by a small team of two consultant psychiatrists and a specialist nurse practitioner. They are supported by other professionals on the dedicated in-patient units. Withdrawal and treatment lasts 2 weeks initially, but may be extended. It is abstinence-based and includes both individualised and group sessions. The latter incorporate peer evaluation, health education, relapse prevention and stress management strategies. A full physical and psychological assessment leads to the development of individually-tailored care plans.

Denial is a major factor preventing healthcare professionals from accessing help and the immediate access to our highly confidential in-patient treatment facilitates self-referral when it is needed. Referrals have come from a variety of sources including doctors or nurses in crisis at work, distraught colleagues, friends or family. The confidential nature of the service means that we do not disclose personal details to the relevant Health Authority. They have been notified regarding our intention to set up this service, but unfortunately only 7 have responded. They insist that they approve the referrals before admission.
We believe that the service should be available on an extra-contractual basis because:

1. Specialist skills are required to meet the needs of addicted healthcare professionals
2. It is often preferable to remove the individual from the local community
3. The problem has often progressed to requiring emergency treatment.

It is only 6 months since the service commenced, so our experience to date is limited. A prospective evaluation is being carried out, the results of which will be made available to professional bodies.

1. The Misuse of Alcohol and other drugs by doctors. London: BMA, 1998.
2. Strang J et al. Missed problems and missed opportunities for addicted doctors. BMJ 1998;316:405-6
3. United Kingdom Central Council. Annual Report 1997
4. Brooke D et al. Doctors and substance misuse: types of doctor, types of problem. Addiction 1993;88:655-63

From the REGIONS

(Continued from page 2)

tion of guidance by the NHS Executive on Occupational health services in primary care. (Particularly for General Practitioners and their staff). The guidance has deliberately not yet addressed the funding issues which will arise from such guidance, however it is clear, that there is growing recognition of their need and therefore there will be future opportunities for those wanting to expand their services to this group., If you are interested, it would be advisable to make contact with those involved in the new primary care groups.

Finally, thanks to John Harrison for producing his first edition of the Newsletter. The Executive team frequently communicate by e-mail (with hard copies for Alison Rimmer!!) and it is likely this will become a more popular form of communication in the future. John has raised the possibility of distributing the Newsletter on the internet, (as well as in hard copy). This would make it available to non-members as well as members, however this may also help to promote the presence of ANHOPS as a body. If you have strong

REGION	Name
Wales	H Rees
Scotland	S Elder
N Ireland	L Rodgers
North/Yorks	C English
North-West	J McNamara
Trent	A de Bono
Anglia	N Irish
West Midlands	A Robertson
North Thames	R Copeman
South Thames	N Mitchell-Heggs & J Carruthers
Oxford	A Ross & M Robertson
Wessex	A Harrington
South West	A Rossiter

IMPORTANT HAZARD DATA SHEETS

Element: Human Male. **Symbol:** MAn
Discoverer: Not known, possibly generic creator
Atomic Mass: unstable, increases with age
Occurrence: Ubiquitous, senior management.
Physical Properties:

- When newly classified, can be covered in fuzz (especially upper lip)
- Appearance improves with time
- Prone to ironising dermatitis

Chemical Properties:

- Miscible with alcohol (all proportions)
- Seasonal affinity for WO_2
- Does not mix with household detergents

Functional Tests:
"Would you blow into this bag, sir?"
"My headache's gone, dear……."

Element: Human Female **Symbol:** WO_2
Discoverer: Adam
Atomic Mass: Accepted as 55Kg, known to vary
Occurrence: Large quantities in urban areas
Physical Properties:

- Surface normally covered in powder and paint
- Boils at nothing, freezes for no apparent reason
- Bitter if used incorrectly

Chemical Properties:

- Affinity for gold, silver and platinum
- Softens with rosy glow when in hot water
- Powerful money reducing agent

Functional Tests:
Turns pink when discovered in natural state
Turns green when placed alongside a superior specimen.

Internet discussions amongst ANHOPS members usually produce a reaction of some kind. There are two schools: people who are keen to embrace the new technology (without necessarily knowing much about it, and people who wouldn't touch with a barge pole. Communication by e-mail has real advantages and is easy to set up. An ANHOPS web page would also help us to spread the occupational health word. The Newsletter could be distributed via e-mail or the web. We could set up a discussion group or make use of an existing one. **Any views?**

EXECUTIVE COMMITTEE MEMBERS

NAME	TITLE	ADDRESS
Peter Verow	Chairman	Sandwell 01216073417
Alison Rimmer	Secretary	Sheffield 01142714161
B Graneek	Treasurer	Royal Brompton 01713528171
A Robertson	Education	Birmingham 01212233762
J Harrison	Newsletter	Newcastle 01912228748

"Notes for Your Diary"

THE 4TH ICOH INTERNATIONAL CONFERENCE ON OCCUPATIONAL HEALTH FOR HEALTH CARE WORKERS	MONTREAL, CANADA. SEPT. 28 – OCT 1, 1999 Contact Dr I Symington 01412874422, or Conference Secretariat, 5100 Sherbrooke St. East, Suite 950, Montreal Canada H1V3R9 Tel: (514)2536871 Fax: (514)2531443
ANHOPS MEETINGS AUTUMN SPRING (London)	 November 12, 1998 March 3, 1999

ANHOPS REVIEW

QUALITY CARE IN OCCUPATIONAL MEDICINE

Few doctors in the United Kingdom have not been made aware of the medical tragedies in Exeter, Canterbury and, more recently, Bristol – writes Kit Harling, President of the Faculty of Occupational Medicine.
These events have given rise to a genuine and understandable concern in the general public about the quality of medical care and, more particularly, in the medical profession's ability to self-regulate. You will also have seen in the press, reports of the Government's determination to put quality at the heart of the NHS. White Papers and other publications have outlined the structure the NHS will use to reassure the public they are receiving quality medical care.

The GMC has recently published "Good Medical Practice" and "Maintaining Good Medical Practice". These pamphlets set out the steps they believe are necessary for all doctors to undertake to ensure the highest professional standards. The essence of this approach is the use of local peer review combined with an evidence-based approach to decision making. These processes will be combined into personal development plans. It is the intention that all doctors, whether in the NHS or the private sector, will take part in these arrangements. They will apply to occupational physicians wherever they work.

What then is the role of the Medical Royal Colleges and Faculties? We will have input at various levels. For me, the most important is around the area of standard setting. The FOM has already seen this as a major area for development. In addition to setting standards for specialist training, we must now develop standards to cover the period after training: the so-called "30 years".

However, the FOM alone cannot set these standards. The exercise must include all our members. After all, these standards are merely an expression of the views of occupational physicians, based on evidence and clinical experience. Indeed, I would argue that no-one other than our members can do this task. Standards must be reasonable and attainable in practice. At the end of the day, however, they must protect the public from poor or incompetent practice.

This article is based on a similar article written for the FOM Newsletter, November 1998 and has been produced with the permission of Dr Kit Harling

GET SMART

After a considerable number of meetings with medical staff from the North West Regional Office and also Directors of the Software Company, the Smart Card Pilot Scheme was set up at Halton General Hospital

Progress report in respect of the SMART CARD system in the Mersey Deanery (North West Region)

NHS Trust, Runcorn from April 1st 1998. The cards are currently issued , in the main, to Specialist Registrars in the Mersey Deanery area and include a recent photograph of the holder, brief personal details and the current GMC registration. In addition, it carries a vaccination history which includes hepatitis B status and records of TB testing/BCG vaccination, Rubella and varicella immunity. It is hoped that eventually cards will be used that include relevant details from the person's medical history. The "fitness" for employment of medical staff can be determined by passing the card through a "reader" device located at a few specially designated sites within the Mersey Deanery area. Confidential details are very carefully protected however, and would never be accessible to, for example, managers.

The scheme has got off to a slow start because of problems with the software and the hard drive. We have solved the main problems and are producing cards for the new entry of trainees.

JOHN McNAMARA

ANHOPS

ASSOCIATION OF NHS OCCUPATIONAL PHYSICIANS

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