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## **SUMMARY**

This consultation document is based on the recommendations of a Regional Advisory Group (RAG) which considered the advice of an expert group set up by GB Ministers in 2001 to assess the potential health risks posed to patients from new health care workers infected with serious communicable diseases, in particular TB, Hepatitis B, Hepatitis C and HIV. The RAG also took account of the recommendations of the Advisory Group on Hepatitis (AGH) for existing health care workers who may be infected with Hepatitis C.

All new health care workers will need to have standard health clearance for serious communicable diseases. Additional health clearance for blood borne viruses will be required for new health care workers who will perform exposure prone procedures. Existing health care workers who know that they have been infected with Hepatitis C and who perform exposure prone procedures should be tested for Hepatitis C virus RNA. Health care workers found to be carrying the virus should not perform exposure prone procedures. Those who respond successfully to antiviral therapy, in accordance with this guidance, may be cleared to perform exposure prone procedures.

These proposals are not intended to prevent those infected with blood borne viruses from working in the HPSS, but to restrict them from working in areas where their infection may pose a risk to patients.

This draft guidance has been made widely available for consultation to identify any major omissions or difficulties before the final guidance document is issued.

All responses to this guidance will be considered but we would especially welcome your comments on:

- The scope and content of the guidance
- Any obvious gaps in the information provided

- Issues relating to implementation, including information required by health professionals

Please note that all responses to this consultation, which is being conducted in accordance with the criteria for all national public consultations, (Annex E) may be made public unless a respondent requests that their views are kept confidential.

Comments should be sent to Mrs Caroline White, DHSSPS, Room C.4.22, Castle Buildings, Stormont, Belfast BT4 3SQ, Telephone: (028) 9052 2059 by 5<sup>th</sup> June 2003

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## **INTRODUCTION**

1. This guidance proposes additional health clearance measures for Hepatitis C and HIV for new health care workers in the Health and Personal Social Services (HPSS). It supplements existing guidance on health checks and immunisation for Tuberculosis and Hepatitis B [Ref. HSS(MD)8/2002, HSS(MD)4/94, HSS(MD)28/96, HSS(MD)17/00] . It also supplements the existing guidance on *The management of Aids/HIV infected healthcare workers and patient notification* [Ref. HSS(MD)29/98]. This new guidance includes recommendations of the Advisory Group on Hepatitis (AGH) to remind the various professional groups within health care of their responsibilities in relation to Hepatitis C. The guidance is not intended to prevent those infected with blood borne viruses from working within the HPSS, but to exclude them from working in clinical areas where their infection may pose a risk to patients in their care.

## **BACKGROUND**

### **Risk Assessment Expert Group**

- 2.1 In April 2001 an ad hoc risk assessment expert group was set up at the request of Ministers to assess the potential health risk posed to patients from new health care workers who were infected with serious communicable diseases (TB, Hepatitis B, Hepatitis C and HIV).
- 2.2 The expert group report recommended pre-admission/pre-employment health checks for serious communicable diseases for all new\* health care workers including health care related education and training.

\*See Paragraph 5 for definition

2.3 The **recommendations** of the ad hoc group in summary are:

To provide pre-appointment/pre-admission health checks for all new healthcare workers to include:

- **checks** for TB disease/immunity
- the **offer** of Hepatitis B immunisation (with post immunisation testing of response)
- the **offer** of testing for Hepatitis C and HIV, in addition to reminding them of their professional responsibilities in relation to serious communicable diseases.

The following health clearance checks will be required for new health care workers who will engage in exposure-prone procedures see **Annex A**.

- Hepatitis B surface antigen (HBsAg) testing, which indicates current Hepatitis B infection, and if positive, e-marker and Hepatitis B viral load testing in accordance with current guidelines [HSS(MD)4/94]. *Protecting Healthcare Workers and Patients from Hepatitis B* and its Addendum HSS(MD)28/96, also HSS(MD)17/00 *Hepatitis B Infected Health Care Workers*].
- Hepatitis C antibody (Anti-HCV) testing, and if positive, Hepatitis C RNA testing.
- HIV antibody (anti-HIV) testing.

## Advisory Group on Hepatitis

2.4.1 In 1995 the AGH had made recommendations in regard to Hepatitis C infected health care workers. Following this there were, however, a number of further incidents of workers transmitting infection to patients. The AGH has now assessed that the risk of transmission of Hepatitis C from a health care worker of unknown Hepatitis C status during exposure prone procedures is low. It does not, therefore, advise that all health care workers doing exposure prone procedures should be routinely tested for Hepatitis C. However, the AGH has made specific recommendations for existing health care workers who may know that they have been infected with Hepatitis C:

*Health care workers who know that they have been infected with Hepatitis C (i.e. who have antibodies to Hepatitis C virus) and who carry out exposure prone procedures, should be tested for the Hepatitis C virus RNA.*

2.4.2 Health care workers in this position should take account of their regulatory bodies statements on professional responsibilities in relation to communicable disease see **Annex B**. This testing is not necessary for health care workers who are already known to be Hepatitis C virus RNA positive. Those found to be carrying the virus (i.e. who are Hepatitis C virus RNA positive) should be restricted from carrying out exposure prone procedures in future, unless they have responded successfully to treatment (see Section 7.2.3. of this guidance). Occupational health departments will have a key role to play in identifying such health care workers and bringing this guidance to their attention. Health care workers who have antibodies to the Hepatitis C virus and are Hepatitis C virus RNA negative should be allowed to continue performing exposure prone procedures.

## Regional Advisory Group

2.5 Following receipt of the Expert Group's report and in the light of the advice coming from the AGH, the DHSSPS established a Regional Advisory Group, led by the Deputy Chief Medical Officer, Dr Ian Carson to consider the implications for the HPSS of the Expert Group's recommendations. The Regional Group included in its membership a wide range of health professionals representative of dentistry, nursing and midwifery, as well as a number of different branches of medicine eg occupational health, epidemiology, virology and public health. (Membership at Annex D). A project team was then appointed from within the Group to develop a consultation document. (Membership at Annex D). This paper reflects the working of these groups.

## RECOMMENDATIONS OF THE REGIONAL ADVISORY GROUP ON HEALTH CLEARANCE OF HEALTH CARE WORKERS FOR SERIOUS COMMUNICABLE DISEASES

### Key Recommendations

3.1 The key recommendations are as listed at 2.3 and 2.4 above to include:

- Pre-admission, pre-appointment health checks for serious communicable diseases for all health care workers new to the HPSS ie. those newly recruited to the HPSS or working in the HPSS for the first time. This will include **checks** for TB disease/immunity, **offer** of Hepatitis B immunisation (with post immunisation test of response) and the **offer** of testing for Hepatitis C and HIV.

- **Additional** health clearance for serious communicable disease will be **required** for new and re-entrant health care workers who engage in exposure-prone procedures to include testing for Hepatitis B, Hepatitis C and HIV as well as TB.
- **Existing health care workers who know that they have been infected with Hepatitis C (i.e. who have antibodies to Hepatitis C virus) and who carry out exposure prone procedures, should be tested for the Hepatitis C virus RNA.** Health care workers in this position should take account of their regulatory bodies statements on professional responsibilities in relation to communicable disease see **Annex B.** Those found to be carrying the virus (ie who are Hepatitis C virus RNA positive) should be restricted from carrying out exposure prone procedures in future, unless they have successfully responded to treatment (see section 7.2.3 of this guidance).

## **IMPLEMENTATION**

### **Putting the arrangements for checks in place**

4.2.1 Chief Executives of HSS Trusts, Principals in General Medical and Dental Services, Universities and Training Colleges will need to ensure arrangements are in place to carry out the standard checks for all health care workers and additional health clearance checks for all new and re-entrant health care workers in accordance with this guidance. This will require the services of a recognised occupational health department where accredited specialist advice, appropriate testing and follow up can be provided.

## **Publicising the new arrangements to prospective employees and students**

4.2.2 It is recommended that employers publicise these new health clearance requirements in job advertisements, job descriptions and application packs. Training establishments such as medical schools, dental schools and colleges of nursing and midwifery should include such information in their prospectuses and application packs. Publicity material should make it clear that health clearance will be required in accordance with this guidance.

## **Overseas recruitment**

4.2.3 Those health care workers from abroad applying for employment or a training place in the HPSS should have health checks for serious communicable diseases in their own country. The results of these health checks should be included by the applicant in their health declaration when applying for a post. The employing HSS Trust or training establishment should arrange for the tests to be repeated in this country to confirm the results before commencement of work or training. Where the employment or training will involve the performance of exposure prone procedures the additional health checks will be required.

## **Agency and locum recruitment**

4.2.4 HSS Trusts and other employers will need to ensure that locums and health care workers recruited through Agencies have appropriate health clearance to comply with this guidance. Those who will be involved in exposure prone procedures require the additional health checks.

## **Independent healthcare sector**

4.2.5 The independent health care sector will need to put procedures in place for health clearance of health care workers in accordance with this guidance. HSS Trusts arranging for patients to be treated in the independent sector will need to ensure this guidance is observed.

## **DEFINITIONS OF NEW AND RE-ENTRANT HEALTH CARE WORKER**

5.1 New entrants include:

- health care workers starting work or training in the HPSS for the first time, including students and visiting specialists/surgical teams.
- health care workers moving into training or taking up posts involving exposure prone procedures for the first time, eg junior doctors entering surgical specialties, nurses entering midwifery training.

5.2 Re-entrants include:

- health care workers returning to the HPSS after a period of absence such as voluntary service, research, sabbaticals, exchanges or periods of unemployment.
- medical/dental students returning from electives in countries where they may have been exposed to serious communicable diseases.
- locum/agency staff.

- 5.3 The need for health checks for health care workers returning to work in the HPSS should be determined on the basis of a risk assessment carried out by the occupational health department. The timing of any tests considered appropriate following risk assessment should take account of the natural history of the infections (i.e. window period )

## **STANDARD HEALTH CHECKS FOR ALL HEALTHCARE WORKERS NEW TO THE HPSS**

### **Tuberculosis(TB)**

6.1.1 The recommendations in relation to health clearance for TB are in accordance with the British Thoracic Society guidelines [ref. Circular HSS(MD)8/2002] and should include:

- Personal or family history of TB.
- Presence of symptoms compatible with TB (cough lasting longer than 3 weeks, fever, night sweats, weight loss, loss of energy, haemoptysis). If symptoms are compatible then further investigation should be carried out, which should include a chest X-ray.
- Check for BCG history/scar. (The presence of a BCG scar must be recorded only if the scar has been seen by a member of the occupational health department; a history of BCG vaccination and scar formation is helpful, but the presence of a BCG scar must not be recorded on the basis of history alone. Small scars may be difficult to identify and, if in doubt, in accordance with national guidelines, an experienced colleague should be asked for advice. The size of the scar is not relevant).

- If no or inconclusive evidence of a scar, a tuberculin skin test (Heaf or Mantoux) should be performed. It is recommended that all individuals who have spent time in areas of high TB prevalence, especially where HIV prevalence is also high, receive a tuberculin skin test regardless of BCG status.
- If skin test positive (Heaf test grade 3 or 4), assess clinically, including chest X-ray.
- If skin test negative (grade 0 or 1), consider risk of impaired immunity (e.g. due to HIV infection). Where relevant an HIV test should be recommended to exclude HIV infection as the underlying cause of a negative skin test and because BCG is contraindicated in HIV-infected individuals.
- Give BCG if skin test negative and no contra-indication.
- If skin test positive (Heaf grade 2-4) and no evidence of current TB, inform of TB risk and symptoms to be aware of.

6.1.2 In general, an individual who declines BCG, e.g. health care workers from abroad where BCG is not routinely used and protection against TB is based on serial skin testing and prophylactic chemotherapy, should not work with patients known to have, or at high risk of having infectious pulmonary TB. Occupational health advice should be sought.

6.1.3 BCG offers substantial but not complete protection against TB. All health care workers should be aware of this, and of the need to seek medical advice should they develop symptoms compatible with TB. Health care workers with previous contact with TB, including living in a country with high TB prevalence, are at increased risk.

## **Hepatitis B**

6.2 In accordance with Immunisation against Infectious Disease 1996 (Green Book - now available on the web at <http://www.doh.gov.uk/greenbook> ) it is recommended that all health care workers, including students and trainees who have direct contact with patients blood, blood-stained body fluids or patients tissues, are immunised and have their response to immunisation checked.

## **Hepatitis C**

6.3.1 All health care workers new to the HPSS should be offered a Hepatitis C antibody test (and if positive a Hepatitis C RNA test) in the context of their professional responsibilities in relation to hepatitis C. It would be helpful to remind them of the ways in which they might have been exposed to Hepatitis C. The major risk factors for Hepatitis C infection are:

- receipt of unscreened blood or untreated plasma products (in the UK prior to September 1991 and 1985 respectively);
- the sharing of injecting equipment whilst misusing drugs;
- having been occupationally exposed to the blood of patients known to be infected, or deemed to be at high risk of infection, with Hepatitis C by sharps or other injuries (and not subsequently screened and shown to be non-infectious);
- involvement as a healthcare worker or patient in invasive medical, surgical, dental or midwifery procedures in parts of the world where infection control precautions may have been

inadequate, or with populations with a high prevalence of Hepatitis C infection.

- Positive tests in themselves should not affect the employment or training of Hepatitis C infected health care workers who will not carry out exposure prone procedures.

6.3.2 There is no vaccine to protect against Hepatitis C infection. Therefore health care workers remain at risk of infection because of occupational injuries that may expose them to the blood of infected patients. It is therefore essential that employers provide staff with information and training about measures to reduce the risk of occupational exposure to Hepatitis C such as safe disposal of sharps, measures to reduce risks during surgical procedures, decontamination and waste disposal. The publication *Guidance for clinical healthcare workers; protection against infection with blood-borne viruses* [HSS(MD)7/98] provides relevant advice. For further guidance on management of blood exposure incidents **See Annex C.**

## **HIV**

6.4 All health care workers new to the HPSS will be offered an HIV antibody test in the context of discussing their professional responsibilities in relation to HIV. During this discussion, they should be given a copy of the guidance from their professional regulatory body **See Annex B.** It would be helpful to remind them of the ways in which they might have been exposed to HIV:

- shared injecting equipment whilst misusing drugs;

- had unprotected heterosexual intercourse in, or with a person who had been exposed in, a country where transmission of HIV through sexual intercourse between men and women is common;
- engaged in unprotected sexual intercourse between men;
- involvement in invasive medical, surgical, dental or midwifery procedures in parts of the world where infection control precautions may have been inadequate, or with populations with a high prevalence of HIV infection;
- had a significant occupational exposure to HIV infected material in any circumstances;
- engaged in unprotected sexual intercourse with someone in any of the above categories.

Positive tests in themselves should not affect the employment or training of health care workers who will not carry out exposure prone procedures, although HIV infected health care workers should remain under regular medical and occupational health supervision in accordance with good practice. Occupational health physicians should consider the impact of HIV positivity on the individual's resistance to infection when advising on suitability for particular posts, especially if the duties may involve exposure to known or undiagnosed TB.

## **ADDITIONAL HEALTH CHECKS FOR HEALTHCARE WORKERS NEW TO OR RE-ENTERING THE HPSS WHO WILL PERFORM EXPOSURE PRONE PROCEDURES**

### **Hepatitis B**

7.1.1 Previous guidelines assumed that a Hepatitis B antibody (anti-HBs) response measured after a course of vaccine could be taken as indicating non-infectivity. However, it is now recognised that on occasion this response may occur in individuals who have current infection. Where anti-HBs is present in such circumstances, it is usually in low titre, but levels of >100 mIU/ml have been documented in Hepatitis B infected health care workers, some of whom would be restricted from performing exposure prone procedures under current guidelines because of their relative infectivity. Hence relying on an anti-HBs response to vaccine to indicate non-infectivity may not be secure, since some infectious carriers of the virus could be missed. Therefore, health care workers who will carry out exposure prone procedures should:

- be tested for Hepatitis B surface antigen (HBsAg), which indicates current Hepatitis B infection;
- if negative for HBsAg, should be immunised (excluding those who have already received vaccine) and have their response to vaccine checked (anti-HBs);
- if positive for HBsAg, be tested for Hepatitis B e-markers. If they are e-antigen(HBeAg) positive, they should not be allowed to carry out exposure prone procedures. If they are e-antigen negative, they should have their Hepatitis B viral load (HBV DNA) tested. If the viral load is greater than  $10^3$  genome

equivalents per ml, they should not be allowed to carry out exposure prone procedures.

7.1.2 Health care workers should be asked about antiviral treatment when submitting a blood sample because special arrangements exist for health care workers who are receiving or have recently received interferon or antiviral therapy for Hepatitis B [see HSS(MD)17/00, Ref. Below]. Guidance on Hepatitis B infected health care workers is contained in the following documents:

- *Protecting health care workers and patients from Hepatitis B – Circular HSS(MD)4/94 and Addendum HSS(MD)28/96*
- *Hepatitis B infected health care workers- Circular HSS(MD)17/00.*

## **Hepatitis C**

7.2.1 New and re-entrant health care workers who are required to perform exposure prone procedures will be tested for Hepatitis C antibody. Those who are positive should be tested for Hepatitis C virus RNA to detect the presence of current infection. Those who are Hepatitis C virus RNA positive will not be allowed to carry out exposure prone virus procedures.

7.2.2 Health care workers should be asked about antiviral treatment when submitting a blood sample because special arrangements exist for health care workers who are receiving or have recently received interferon and/or antiviral therapy for Hepatitis C.

7.2.3 Hepatitis C infected health care workers who have responded successfully to treatment with antiviral therapy should be allowed to resume exposure prone procedures or to start professional training for a career that relies upon the performance of exposure prone procedures. Successful response to treatment is defined as remaining Hepatitis C virus RNA negative 6 months after cessation of treatment. Successfully treated health care workers will be allowed to return to performing exposure prone procedures at that time. As a further check, they should be shown to have remained Hepatitis C virus RNA negative after a further 6 months.

## **HIV**

7.3 New and re-entrant health care workers who are required to perform exposure prone procedures will be tested for HIV antibody. Those who are HIV antibody positive will not be allowed to carry out exposure prone procedures. Guidance on HIV infected healthcare workers is contained in the following document:

- *Guidance on the management of AIDS/HIV infected health care workers and patient notification* [Ref HSS(MD)29/98]

## **SPECIFIC CLEARANCE ARRANGEMENTS BY PROFESSIONAL GROUP**

### **Dental Students**

8.1.1 Health clearance for TB, Hep B, Hep C and HIV will be a criterion for admission to dental training. The tests will be carried out by the University occupational health service. It is envisaged that this will be done in the period following UCAS clearance when students are given

a firm offer of a place on the dental training course but before enrolment takes place.

- 8.1.2 Students returning from an elective where they may have been exposed to serious communicable diseases will require an assessment by the occupational health service to determine the need for further health checks.

### **Dentists**

- 8.2 New entrants to general dental practice, community dental services and hospital dental services will require the additional health clearance for serious communicable diseases.

### **Dental Hygienists / Therapists**

- 8.3 The additional health checks for serious communicable diseases will be required for students before admission to the dental hygiene or dental therapy courses.

### **Dental Nurses**

- 8.4.1 Dental nurses will require additional health checks for serious communicable diseases before they engage in exposure prone procedures.
- 8.4.2 Colleges running courses of training for dental nurses and general dental practices employing dental nurses will require an accredited occupational health service to arrange the additional health checks and provide specialist advice.

## **Medical Students**

8.5 Individual medical schools will need to assess the requirement for health clearance of medical students for serious communicable diseases. The recently published GMC Guidance “Tomorrows Doctors” (July 2002) clarified the practical skills required of medical students and this did not include exposure prone procedures. Some medical student clinical attachments, however do allow the student to engage in exposure prone procedures such as assisting in surgery. Where medical student training allows them to perform or assist in exposure prone procedures they will require the additional health checks for serious communicable diseases.

## **Pre-Registration House Officers**

8.6 Doctors may undertake exposure prone procedures during their pre-registration year but it is unlikely that this will form an essential part of their work. The practical skills required of pre-registration house officers do not include exposure prone procedures ref: “The New Doctor” (GMC, April 1997). However, some pre-registration house officers work in hospitals where they may be engaged in exposure prone procedures, for example assisting in theatre. Where this is the case they will require the additional health checks for serious communicable diseases.

## **Senior House Officers and Specialist Registrars**

8.7 All doctors commencing work or training in the specialist areas involving exposure prone procedures will require the additional health checks for serious communicable diseases eg. junior doctors entering surgical specialties.

## **Nursing Students/Nurses**

- 8.8.1 Student nurses are not required to engage in exposure prone procedures during their training.
- 8.8.2 Student nurses and new/re-entrant nurses to the HPSS will have the standard pre-admission health checks.
- 8.8.3 Nurses entering the specialties involving exposure-prone procedures such as A&E, theatre nursing or midwifery will require the additional health checks for serious communicable diseases.

## **Midwifery Students/Midwives**

- 8.9 Midwifery students and new entrant midwives who engage in exposure prone procedures will require the additional health checks for serious communicable diseases.

## **Podiatric Surgeons**

- 8.10.1 Podiatrists/chiropractors may undertake several years of further post-graduate training in order to become podiatric surgeons.
- 8.10.2 Those entering training in podiatric surgery or new/re-entrant podiatric surgeons will require the additional health checks for serious communicable diseases.

## **Emergency Medical Technicians/Paramedics**

- 8.11 Ambulance staff will require the additional health checks for serious communicable diseases before commencing training as emergency medical technicians/paramedics. New/re-entrant emergency medical technicians/paramedics will also require the additional health clearance.

*Those providing the health clearance and specialist advice to the above groups should take the opportunity to remind each individual of their professional responsibilities in relation to communicable diseases and patient care with reference to the guidance issued in this context by their professional governing bodies such as the General Dental Council, General Medical Council, Nursing and Midwifery Council etc. see **Annex B***

## **OTHER CONSIDERATIONS**

### **Health care workers who test positive for serious communicable diseases.**

- 9.1 Any health care worker who tests positive for any of these infections should be offered investigation and management of their condition to the same standard as would be expected for any patient with the disease. In the case of those diagnosed with Hepatitis B or Hepatitis C infections they should be referred to a Consultant Hepatologist . Those who are HIV positive should be referred to a consultant in Genito-urinary medicine or HIV medicine. Patients with TB should be referred to the appropriate Respiratory Physician in their area.
- 9.2 Positive tests for blood borne viruses should not affect the employment or training of health care workers who will not carry out exposure prone procedures. Occupational health should be involved in the supervision of infected workers and give advice on suitability for particular posts e.g. impact of HIV positivity on resistance to infection etc.

### **Role of Occupational Health Departments**

- 10.1 Occupational health departments, under the direction of an accredited occupational health care specialist, will undertake the pre-employment / pre-placement health checks. They should be able to explain the procedures and answer any questions which may arise. The

occupational health department will also inform health care workers of the results of their tests.

- 10.2 The pre-employment / pre-placement assessment provides the opportunity to emphasise local infection control policies and to remind the health care worker of the risk factors related to blood exposure incidents, measures to avoid incidents such as needlestick injuries and local procedures for reporting accidental exposures. Interventions for protection of health care workers should be explained e.g. post exposure prophylaxis after accidental exposure to HIV. The importance of reporting symptoms suggestive of serious communicable disease such as TB or blood borne virus infection should be stressed.
- 10.3 The occupational health departments will also carry out risk assessments to determine the need for further health checks eg dental students returning from electives abroad.
- 10.4 It is the responsibility of the occupational health unit sending blood samples to the laboratory for HIV, Hepatitis B and Hepatitis C testing to ensure that the samples are from the health care worker in question. Health care workers must not provide their own specimens.
- 10.5 Standards for occupational health data recording have been agreed by the Association of NHS Occupational Physicians (ANHOPS) and the Association of Occupational Health Nurse Advisors (ANHONA). These are as follows:
  - Laboratory results required for clearance to perform exposure prone procedures must be derived from an **identified, validated sample (IVS)**. Results should not be recorded in occupational health records if not derived from an **IVS**;

- An **IVS** is defined according to the following criteria:
  - a. the health care worker should show proof of identity with a photograph (eg driver's licence, identity card, passport)
  - b. the sample of blood should be taken in an occupational health department
  - c. samples should be transported to the laboratory in the usual manner, not delivered by the health care worker
  - d. when results are received by occupational health they should check that the sample was sent from their department

## **Confidentiality**

11.1 Occupational health services providing specialist advice, guidance, testing and follow-up will be required to have procedures in place to perform the health checks in an efficient manner with a confidential system for record-keeping. In the context of confidentiality, management only require to be advised of whether an employee is cleared for exposure-prone procedures or if a timescale exists for further testing before engaging in exposure prone procedures. Similar confidentiality restrictions would apply to notification of heads of departments following student/trainee health assessments. Occupational health departments, who work within strict guidelines on confidentiality, will have a key role to play in the setting up of procedures for testing health care staff new or re-entrant to the HPSS for serious communicable diseases.

11.2 Occupational health notes are separate from other hospital notes and occupational health staff are ethically and professionally bound not to release information without informed consent. An employer may need to be advised that a change of duties should take place but the infectious disease status will not normally be disclosed unless the health care worker gives consent to do so. Where patients are, or have

been at risk, however, it may be necessary in the public interest for the employer to have access to confidential information.

- 11.3 The introduction of **personal smart cards** would provide a means of accurately recording health clearance data electronically. Smart cards could then be used to transfer relevant data securely from one employer/occupational health unit to another as staff move within the HPSS. This may avoid duplication of activity within human resources and occupational health units.

### **Laboratories**

- 12.1 The laboratories performing the necessary tests to facilitate health clearance for serious communicable diseases, including blood borne viruses, should be accredited for these tests and participate in appropriate external quality assurance. The Regional Virus Laboratory based at the Royal Group Of Hospitals HSS Trust will meet these criteria.
- 12.2 Local arrangements need to be established between occupational health departments and the laboratories to ensure the effective transfer of identified and validated samples for testing and the subsequent confidential communication of results.

### **Monitoring and Audit**

13. DHSSPS will need to agree appropriate surveillance arrangements with occupational health departments. The arrangements for health clearance of health care workers new to the HPSS should be subject to local clinical audit.

## **EQUALITY CONSIDERATIONS**

14.1 Section 75 of and schedule 9 to the Northern Ireland (NI) Act 1998 place statutory obligations on Departments and other public bodies in carrying out their functions. Such bodies are to have due regard to the need to promote equality of opportunity:

- a. Between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- b. Between men and women generally;
- c. Between persons with a disability as defined in the Disability Act 1995 and persons without;
- d. Between persons with dependents and persons without.

14.2 Equality in the HPSS business area means that all people should:

- a. have equality of opportunity to access the public services, which the HPSS family provides;
- b. have services which are both relevant and sensitive to their needs;
- c. be able to use the services with the confidence that they will be treated with respect;
- d. have equal opportunities for membership on HSS Boards, Trusts, HSS Councils, Fire Authority and other agencies;
- e. have equality of opportunity both in service provision and in employment with the HPSS business area.

- 14.3 In the context of this consultation document, while patient safety is the paramount issue, the focus here is on “employment within the HPSS business area”. By seeking to ensure that health care workers involved in exposure prone procedures are free from serious communicable diseases, the risk of infection to all patients will thereby be reduced. In terms of the general public, therefore, all of those in each of the 9 groupings referred to in Section 75 of the N Ireland Act 1998 are likely to benefit from this guidance. There should be no adverse impact on any of them as a result of the implementation of this guidance.
- 14.4 In drawing up the proposals the Department, as stated in paragraph 2.5, has taken advice from a Regional Advisory Group. The Group considered how these proposals might impact on the health care workers falling into any one of the Section 75 groupings. While no hard data was available to the Group members, they felt nevertheless able to make a judgement, based on their own experiences, that the proposals herein, if implemented, were unlikely to impact more adversely on one grouping than on another.
- 14.5 With the benefit of the Group’s advice, the Department has thus considered its statutory obligation to have due regard to the need to promote equality of opportunity. In doing so the Department has also been conscious of other mitigating factors viz (a) the proposals, if implemented in regard to a positive test for eg HIV will not mean that a prospective employee will be barred from working in the HPSS, but only from those posts which would require involvement in exposure prone procedures (b) were an adverse impact to be identified, the effect of this has to be weighed against the overriding requirement to reduce the risk of infection to patients and (c) existing health care workers are already under a professional obligation to report possible exposure to infection, whether occupational or non-occupational, and to seek testing when appropriate.

14.6 Having, therefore, carefully considered the matter of equality in terms of the 1998 Act, the Department is satisfied that the proposals contained in the guidance will not impact more adversely on any one Section 75 grouping than another

### **Human Rights Considerations**

15.1 Justification for these policy proposals lies essentially on public health grounds. The Department has sought to balance the proposals in such a way as to protect patients against the risk of transmission of these infections, to recognise the right of individuals to respect for private and family life and to the prohibition of discrimination. There is nothing in the proposals, therefore, that contravenes articles 8 and 14 of the European Convention on Human Rights.

### EXPOSURE PRONE PROCEDURES

1. Exposure prone procedures are those invasive procedures where there is a risk that injury to the worker may result in the exposure of the patient's open tissues to the blood of the worker. These include procedures where the worker's gloved hands may be in contact with sharp instruments, needle tips or sharp tissues (e.g. spicules of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times. However, other situations, such as pre-hospital trauma care and care of patients where the risk of biting is regular and predictable, should be avoided by healthcare workers restricted from performing exposure prone procedures.
2. When there is any doubt about whether a procedure is exposure prone or not, expert advice should be sought in the first instance from a Consultant Occupational Health Physician who may in turn wish to consult the UK Advisory Panel for Healthcare Workers Infected with Blood-borne Viruses (UKAP)<sup>1</sup>. Some examples of advice given by UKAP are provided in *Guidance on the management of HIV/AIDS infected health care workers and patient notification* [ issued under cover of HSS(MD)29/98]
3. Procedures where the hands and fingertips of the worker are visible and outside the patient's body at all times, and internal examinations or procedures that do not involve possible injury to the worker's gloved hands from sharp instruments and/or tissues, are considered **not** to be exposure prone provided routine infection control procedures are adhered to at all times.

<sup>1</sup> UKAP may be contacted via its Secretariat: The Medical Secretary, UKAP, Room 635B Skipton House, 80 London Road, London SE1 6LH. Tel 020 7972 1533.

4. Examples of procedures that are **not** exposure prone:
- taking blood (venepuncture)
  - setting up and maintaining IV lines or central lines (provided any skin tunnelling procedure used for the latter is performed in a non-exposure prone manner i.e. without the operator's fingers being at any time concealed in the patient's tissues in the presence of a sharp instrument);
  - minor surface suturing;
  - the incision of external abscesses;
  - routine vaginal or rectal examination;
  - simple endoscopic procedures
5. The decision whether an HIV, hepatitis B or hepatitis C infected worker should continue to perform a procedure which itself is not exposure prone should take into account the risk of complications arising which necessitate the performance of an exposure prone procedure; only reasonably predictable complications need to be considered in this context.

### REGULATORY BODIES' STATEMENTS ON PROFESSIONAL RESPONSIBILITIES

#### 1. General Medical Council

The GMC Statement, *HIV Infection and AIDS: the Ethical Considerations*, was first sent to all registered medical practitioners in August 1988, and in April 1991 was sent to those who had obtained full registration since 1988. A revised version was sent in June 1993, and this was re-circulated to doctors as part of the series of booklets *Duties of a Doctor in 1995*.

In 1997, it was superseded by the booklet *Serious Communicable Diseases*. This term applies to any disease which may be transmitted from human to human and which may result in death or serious illness. It particularly concerns, but is not limited to, infections such as HIV, tuberculosis and hepatitis B and C.

#### **Relevant excerpts from *Serious Communicable Diseases* are as follows:**

Responsibilities of doctors who have been exposed to a serious communicable disease:

29. *If you have any reason to believe that you have been exposed to a serious communicable disease you must seek and follow professional advice without delay on whether you should undergo testing and, if so, which tests are appropriate. Further guidance on your responsibilities if your health may put patients at risk is included in our booklet Good Medical Practice.*
30. *If you acquire a serious communicable disease you must promptly seek and follow advice from a suitably qualified colleague – such as*

*a Consultant in Occupational Health, Infectious Diseases or Public Health on:*

- *whether, and in what ways, you should modify your professional practice;*
  - *whether you should inform your current employer, your previous employers or any prospective employer, about your condition.*
31. *You must not rely on your own assessment of the risks you pose to patients.*
32. *If you have a serious communicable disease and continue in professional practice you must have appropriate medical supervision.*
33. *If you apply for a new post you must complete health questionnaires honestly and fully.*

Treating colleagues with serious communicable diseases:

34. *If you are treating a doctor or other healthcare worker with a serious communicable disease you must provide the confidentiality and support to which every patient is entitled.*
35. *If you know, or have good reason to believe, that a medical colleague or healthcare worker who has, or may have, a serious communicable disease, is practising, or has practised, in a way which places patients at risk, you must inform an appropriate person in the healthcare worker's employing authority, for example an occupational health physician, or where appropriate the relevant regulatory body. Such cases are likely to arise very rarely. Wherever possible you should inform the healthcare worker*

*concerned before passing information to an employer or regulatory body.*

## **2. General Dental Council**

### **Extract from Maintaining Standards Guidance to dentists on professional and personal conduct (November 1997)**

This guidance was sent to all registered dental practitioners in December 1997 and replaces the guidance entitled *Professional Conduct and Fitness to Practise*.

#### Dealing with Cross-Infection

- 4.1 *There has always existed the risk of cross-infection in dental treatment. Therefore, a dentist has a duty to take appropriate precautions to protect patients and other members of the dental team from that risk. The publicity surrounding the spread of HIV infection has served to highlight the precautions which a dentist should already have been taking and which are now more important than ever. Detailed guidance on cross-infection control has been issued by the Health Departments and the British Dental Association, and is endorsed by the Council.*

*It is unethical for a dentist to refuse to treat a patient solely on the grounds that the person has a blood borne virus or any other transmissible disease or infection.*

*Failure to employ adequate methods of cross-infection control would almost certainly render a dentist liable to a charge of serious professional misconduct.*

## Dealing with Transmissible Disease

- 4.2 *A dentist who is aware of being infected with a blood borne virus or any other transmissible disease or infection which might jeopardise the wellbeing of patients and takes no action is behaving unethically. The Council would take the same view if a dentist took no action when having reason to believe that such infection may be present.*

*It is the responsibility of a dentist in either situation to obtain medical advice which may result in appropriate testing and, if a dentist is found to be infected, regular medical supervision. The medical advice may include the necessity to cease the practice of dentistry altogether, to exclude exposure prone procedures or to modify practice in some other way.*

*Failure to obtain such advice or to act upon it would almost certainly lead to a charge of serious professional misconduct.*

### **3. Nursing and Midwifery Council**

**Extract from: Registrar's letter 4/1994 Annex 1 *Acquired Immune Deficiency Syndrome and Human Immuno Deficiency Virus Infection (AIDS and HIV Infection)* The Council's Position Statement**

The Council's Code of Professional Conduct:

2. *The 'Code of Professional Conduct for the Nurse, Midwife and Health Visitor' is a statement to the profession of the primacy of the interests of patients and clients. Its introductory paragraph states the requirement that each registered nurse, midwife and health visitor safeguard the interest of individual patients and clients. It goes on to indicate to all persons on the register maintained by the*

*Council that, in the exercise of their personal professional accountability, they must 'act always in such a manner as to promote and safeguard the interests and well-being of patients and clients'.*

The Responsibility of Individual Practitioners with HIV Infection:

13. *Although the risk of transmission of HIV infection from a practitioner to a patient is remote, and, on the available evidence much less than the risk of patient to practitioner transmission, the risk must be taken seriously. The Department of Health in England have commissioned a study to evaluate this risk. It is incumbent on the person who is HIV positive to ensure that she or he is assessed regularly by her or his medical advisers and complies with the advice received.*
  
14. *Similarly, a nurse, midwife or health visitor who believes that she or he may have been exposed to infection with HIV, in whatever circumstances, should seek specialist medical advice and diagnostic testing, if applicable. She or he must then adhere to the specialist medical advice received. Each practitioner must consider very carefully their personal accountability as defined in the Code of Professional Conduct and remember that she or he has an overriding ethical duty of care to patients.*

### MANAGEMENT OF BLOOD EXPOSURE INCIDENTS IN RELATION TO HEPATITIS C

1. Each HSS Trust should designate one or more doctors to whom healthcare staff or any other person present in the healthcare setting may be referred immediately for advice if they have been exposed, or have exposed others, to potentially infected blood. Local policies should also specify who will be responsible for the follow up of any staff or patients who have been exposed. Dental and medical practitioners in primary care should also ensure that similar procedures are in place for themselves and their staff.
2. Guidance on the investigation and appropriate management of occupational exposure to blood has been published by Department of Health and Public Health Laboratory Service.<sup>1</sup> A summary of the Public Health Laboratory Service's recommendations about the investigation and follow up of healthcare workers in relation to hepatitis C, when they have been occupationally exposed to blood, is shown below:

#### **Known hepatitis C infected source**

- obtain baseline serum for storage from healthcare worker
- obtain serum/EDTA for HCV RNA testing at 6 and 12 weeks
- obtain serum for anti-HCV testing at 12 and 24 weeks

#### **Source known not to be infected with hepatitis C**

- obtain baseline serum for storage from healthcare worker

- obtain follow up serum if symptoms or signs of liver disease develop

### **Hepatitis C status of source unknown**

- obtain baseline serum for storage from health care worker
- designated doctor to perform risk assessment

### **High risk**

- manage as known infected source

### **Low risk**

- obtain serum for anti-HCV testing at 24 weeks

*Healthcare workers found to have acquired Hepatitis C infection following occupational exposure should be referred as soon as possible for specialist assessment.*

3. There is currently no post-exposure prophylaxis for Hepatitis C. However, a recent study suggests that early treatment of acute Hepatitis C infection may prevent chronic Hepatitis C infection.<sup>2</sup> This underlines the need for careful management and follow-up of occupational exposures and early referral for specialist occupational medicine and gastroenterology/hepatology/infectious diseases assessment if infection has been transmitted.

4. This guidance is directed mainly at healthcare workers, but patients who are exposed to blood should be managed in the same way as exposed healthcare workers. There may be occasions when a patient is accidentally exposed to the blood of a healthcare worker who may be infected with Hepatitis C in circumstances which may or may not involve exposure prone procedures. Healthcare workers are under ethical and legal obligations to take all proper steps to safeguard the interests of their patients. This would include ensuring that, in the event of a patient being exposed to the infected healthcare worker's blood, information about the latter's status is reported to the appropriate person to consider what action might be necessary for the well-being of the patient. The General Medical Council's guidance documents *Good Medical Practice and Serious Communicable Diseases* state that doctors who have a serious communicable disease and continue in professional practice must have appropriate medical supervision and should not rely upon their own assessment of the risks they pose to patients. Statements from the General Dental Council and Nursing and Midwifery Council also emphasise the duties of healthcare workers to safeguard the well-being of their patients.

#### **Patient notification exercises**

5. Whenever a transmission of Hepatitis C from an infected healthcare worker to a patient is detected, other patients, who have undergone exposure prone procedures by that health care worker should normally be notified and offered serological testing. Most new infections with Hepatitis C are asymptomatic. It has yet to be determined whether there is a need for automatic patient notification exercises when a Hepatitis C virus RNA positive healthcare worker is identified in the absence of evidence of transmission. Until more precise indications for patient notification in this situation can be defined, the UK Advisory Panel for Healthcare Workers Infected with Blood-borne Viruses (UKAP) should be approached for advice

whenever patient notification is being considered, and before preparations for such an exercise are put in train.

<sup>1</sup>*“Guidance for clinical healthcare workers: protection against infection with blood-borne viruses”* [ref. Health Service Circular HSS(MD)7/98] contains advice on the management of blood exposure incidents. The Public Health Laboratory Service has published guidance on the management of occupational exposure to hepatitis C – Ramsay ME. *Guidance on the investigation and management of occupational exposure to hepatitis C. Commun Dis Public Health* 1999; 2:258-262. [http://www.phls.co.uk/topics\\_az/hepatitis\\_c/HepCguidelines.pdf](http://www.phls.co.uk/topics_az/hepatitis_c/HepCguidelines.pdf)

<sup>2</sup>Jaeckel E, Cornberg M, Wedemeyer H, Santantonio T, Mayer J, Zankel M, Pastore G, Dietrich M, Trautwein C and Manns M, for the German Acute Hepatitis C Therapy Group. Treatment of acute hepatitis C with interferon alfa-2b. *N Engl J Med* 2001; 345: 1452-1457. <http://content.nejm.org/cgi/content/full/345/20/1452>

## ANNEX D

### **REGIONAL ADVISORY GROUP ON HEALTH CLEARANCE OF HEALTH CARE WORKERS FOR SERIOUS COMMUNICABLE DISEASES**

Dr Ian Carson, Deputy Chief medical Officer, DHSSPS [Chairman]

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Dr Gordon Patterson, Medical Officer, DHSSPS

Mr Robert Saulters, DHSSPS

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Mr Donncha O'Carolan, Dental Officer, DHSSPS

Dr Carolyn Mason, Nursing Officer, DHSSPS

Ms Ruth Clarke, Midwifery Adviser, DHSSPS

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Dr Richard Smithson, CCDC [WHSSB]

Dr Vinod Tohani, CCDC [SHSSB]

Dr Clive Burgess, Occupational Health [Altnagelvin]

Dr Lorna Rodgers, Occupational Health [BCH]

Dr Tony Stevens, Occupational Health [RGH]

Dr Dennis Todd, Occupational Health [QUB]

Dr Delia Skan, [Director of Employment Medical Advisory Services]

Mr Paul McCormick, NIAS

Dr Sloan Harper, GP Adviser, NHSSB

Dr David Stewart, Director of Public Health, EHSSB

Dr Maureen McCartney, Public Health Consultant, EHSSB

Ms Breedagh Hughes, RCM

Ms Mary Kerins, RCM

Ms Isobel King, Greenpark Healthcare Trust

Ms Eleanor Hayes, Greenpark Healthcare Trust

Dr Will Coulter, School of Dentistry [RGH]  
Ms Caroline Parkes, Medical Director, RGH HSS Trust  
Mr Ian Doherty, Staff Side [MSF/Amicus]  
Dr Michael McBride, RGH  
Dr Conal McCaughey, Consultant Virologist [RVH]  
Prof Rod Hay, QUB  
Prof Hugh McKenna, UUU  
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Ms A Gaughran, [DHSSPS] Information Office  
Mr G Dorrian, [DHSSPS] – Secretary

### THE CONSULTATION CRITERIA

The criteria for all UK national public consultations is set out in the Code of Practice for Written Consultations\* published by the Cabinet Office. This requires that:

1. Timing of consultation should be built into the planning process for a policy (including legislation) or service from the start, so that it has the best prospect of improving the proposals concerned, and so that sufficient time is left for it at each stage.
2. It should be clear who is being consulted, about what question, in what timescale and for what purpose.
3. A consultation document should be as simple and concise as possible. It should include a summary, in two pages at most, of the main questions it seeks views on. It should make it as easy as possible for readers to respond, make contact or complain.
4. Documents should be made widely available, with the fullest use of electronic means (through not to the exclusion of others), and effectively drawn to the attention of all interested groups and individuals.
5. Sufficient time should be allowed for considered responses from all groups with an interest. Twelve weeks should be the standard minimum period for a consultation.
6. Responses should be carefully and open-mindedly analysed, and the results made widely available, with an account of the views expressed, and reasons for decisions finally taken.

7. Departments should monitor and evaluate consultations, designating a consultation co-ordinator who will ensure the lessons are disseminated.

We confirm that these criteria have been, and will continue to be followed.

**CONSULTATION CIRCULATION LIST**

Board Chief Executives

Board DPHs

Board Nursing Directors

Board Dental Directors

Board CCDCs

Trust Chief Executives

Trust Medical Directors)

Trust Nursing Directors

Trust Clinical Dental Directors

Heads of Trust Occupational Health Departments

HSS Councils

RACCDC

Hospital Laboratories

School of Dentistry RGH Trust

General Dental Council

British Dental Association (NI)

NI Council for Post-Graduate Medical & Dental Education

British Medical Association

Royal College of General Practitioners (NI)

Royal College of Obstetricians & Gynaecologists

Royal College of Nursing

Royal College Of Midwives

Faculty of General Dental Practitioners, London

Faculty of Occupational Medicine (London)

Joint Tuberculosis Committee, The Royal Hospital of St Bartholemews

Dental Nurses Association Society of Chiropody/Podiatry

Chinese Welfare Association

Indian Community Centre

Multicultural Resource Centre

Northern Ireland African Cultural Centre

Northern Ireland Council for Ethnic Minorities

NIPSA

UNISON  
NUS/USI  
NIC/ICTU  
Cara-Friend  
Gay & Lesbian Youth Northern Ireland  
Rainbow Project  
Queer Space  
Northern Ireland Gay Rights Association  
Body Positive Northern Ireland  
Coalition on Sexual Orientation (COSO)  
Foyle Friend  
AIDS Helpline  
Hep Cats Support Group  
Transfusion C Positive  
Communicable Disease Surveillance Centre (NI)  
Department of Epidemiology & Public Health Royal Group of Hospitals HSS Trust  
NI Public Health Laboratory Belfast City Hospital  
General Consumer Council for NI  
Equality Commission  
NI Human Rights Commission  
RCN Treatment Room & Practice Nurses Forum  
Vice Chancellor's Office, QUB  
Vice Chancellor's Office, University of Ulster at Coleraine  
School of Nursing QUB  
School of Nursing UUU  
Faculty of Medicine & Health Sciences, QUB  
Department of General Practice  
School of Applied Medical Sciences  
Department of Microbiology & Immunobiology  
Faculty of Social & Health Sciences and Education UUC  
Faculty of Social & Health Sciences and Education UUU  
Society of Occupational Medicine (Belfast)  
Society of Occupational Medicine (Dublin)  
Association of National Health Occupational Physicians  
Occupational Health Nurses (NI)

