Valuing People: a new strategy for learning disability for the 21st century

This White Paper, published 20 March 2001, is the first fundamental review of learning disability services for thirty years. The proposals are based on four key principles: civil rights, independence, choice and inclusion.

Valuing People takes a life-long integrated approach, beginning with services for disabled children and their families and explores how new opportunities can be offered for a full, purposeful adult life. It has cross-Government backing and its proposals aim to improve in education, social services, health, employment, housing and support for people with learning disabilities, their families and their carers.

The White Paper affirms the right of people with a learning disability to a fair deal from the NHS. The new strategy aims to:

- Ensure that all people from any background with learning disabilities, have the same access to mainstream health services as the rest of the population.
- Tackle health inequalities

People with learning disabilities will benefit from all the Government’s extra spending on the NHS. The National Service Frameworks (NSFs) apply to people with learning disabilities and the National Cancer Plan makes specific reference to their needs, particularly their inclusion in screening programmes. For people who have mental health problems in addition to their learning disabilities the Mental Health NSF will bring new benefits.

There will be a new role for specialist learning disability services; staff will give more time to facilitating the work of others in mainstream services.

Primary health care teams have key roles to play:

- All people with a learning disability to be registered with a GP by June 2004.
- Staff from local community learning disability teams will take on the role of health facilitator to help people with learning disabilities access the health care they need. Health facilitators will be identified by Spring 2003.
- Everyone with a learning disability will be offered a Health Action Plan by June 2005, completed by the health facilitator in partnership with primary care nurses and general practitioners.

The Government believes that effective partnership working is the key to achieving these aims. To promote this, Learning Disability Partnership Boards will be established in all local authority areas.

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For changes in address, please contact The Medical Mailing Company, PO Box 60, Loughborough LE11 0WP (or telephone Freephone 0800 626387).
Two documents were published recently which together describe a range of initiatives that help develop public health capacity and capability, and are essential to the implementation of the NHS Plan.

The Plan sets out a programme to modernise the NHS but also commits the latter to strengthening links with other partners.

The NHS Plan Technical Supplement signposts relevant Government initiatives and data sources, to assist in setting targets and monitoring progress. The Report of the Chief Medical Officer’s Project to Strengthen the Public Health Function identifies five major themes:

- a wider understanding of health and wellbeing.
- better co-ordination and communication within the public health function.
- effective joined-up working.
- sustained community development and public involvement.
- an increase in capacity and capabilities in the public health function.


For further information please contact: Technical Supplement – Sue Graves, 525 Wellington House, 133-155 Waterloo Road, London SE1 8UG. Tel: 0207 972 4648 e-mail: Sue.Graves@doh.gsi.gov.uk

Hard copies of publication can be obtained from: Department of Health Publications, PO Box 777, London SE1 6XH. Fax: 01623 724524 e-mail: doh@prolog.uk.com

For further information contact Elaine Cooper, SC6, Room 234, Wellington House, 133-155 Waterloo Road, London SE1 8UG. Tel: 0207 972 4499 e-mail Elaine.Coop@doh.gsi.gov.uk. Copies of Valuing People can be obtained online at www.doh.gov.uk/learningdisabilities or from The Stationery Office, PO Box 29, Norwich NR3 1GN, telephone 0807 6005522 (www.thestationeryoffice.com), Cm 5086 price £15.90.

Developing public health – the NHS Plan

Following a commitment in the NHS Plan, the national health inequality targets were announced in February by the Secretary of State, Alan Milburn. Local health communities will have a key role to play in delivering these targets, which are:

- starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between manual groups and the population as a whole.
- starting with HAs, by 2010 to reduce by at least 10 per cent the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.

These targets will:

- help focus action locally on areas of inequality.
- reinforce local inequality targets already in place across a broader spectrum of inequality issues.


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Report of the Chief Medical Officer’s Project to Strengthen the Public Health Function – Andrew Harvey Room 5E60 Quarry House, Quarry Hill, Leeds LS2 7UE. Tel: 0113 254 5933 e-mail: Andrew.Harvey@doh.gsi.gov.uk

Hard copies of publication can be obtained from: Department of Health Publications, PO Box 777, London SE1 6XH. Fax: 01623 724524 e-mail: doh@prolog.uk.com

Health inequalities targets

- raise standards across the board because the action to deliver the targets should improve services for all.
- be backed by a national health poverty index due in 2002.
- be delivered by a combination of specific health policies and broader Government policies.

A GP from Liverpool, Dr Katy Gardner, has already taken steps to identify patients whose health is most at risk and has found, for example, language barriers obstructing access. She explains that “the practice has now taken steps to address these problems as an integral part of the mainstream activity of the health centre.”

Further information is available on the health inequalities web-site at www.doh.gov.uk/healthinequalities.

Further advice from: Anne Griffin, room 646 Wellington House, 133-155 Waterloo Road, London, SE1 8UG, telephone 0207 972 4587, or e-mail: anne.griffin@doh.gsi.gov.uk
Progress on organ retention

The Retained Organs Commission, established on CMO’s advice to oversee the return of retained organs and tissues where families request it, since its inception at the end of January, has published comprehensive guidance to NHS Trusts, requiring:

- all Trusts involved to document relevant information systems.
- all Trusts involved to conduct a comprehensive physical search of premises where organs and tissue might be kept.
- all national or regional collections of organs and tissue to make arrangements to notify referring trusts of what is held.
- NHS regional offices to validate this process within the overall oversight of the commission.

This will enable Trusts to provide accurate and comprehensive information about retained organs and tissue to all those who have made enquiries since the Redfern Inquiry Report was published, as a necessary precursor to the return of organs and tissue for burial or cremation.

On 27 April, the Chair of the Commission, Professor Brazier, announced that one hundred Trusts could begin to release information to people who have made inquiries about organ retention. This has now been extended bringing the total to approximately 156 Trusts. There will be a further delay for some relatives, particularly where their relatives’ organs have been retained by the larger teaching hospitals who have a bigger task and it will take them longer to carry out the various checks and searches required by the Commission. The Commission is confident that the majority of Trusts will be giving out information in the next few weeks.

Copies of the guidance and information about the Commission can be found on www.nhs.uk/retainedorgans or by contacting Mrs Shehnaz Master at the Retained Organs Commission, room 705 Hannibal house, Elephant and Castle, London SE1 6TE, or telephone 0207 972 2051. e-mails to: retained-organs-commission@doh.gsi.gov.uk

Improving organ donation

Following the recent Organ and Tissue Donation Summit, one commitment from the Department of Health (DH) was to encourage more of its staff, the NHS, large organisations and society in general to join the NHS Organ Donor Register.

The Government has pledged to double the number of people on the Register from 8 million to 16 million by 2010. GPs can help by displaying Organ Donor Registration leaflets (posters also available) prominently in surgeries or hospital waiting areas. Joining the Register is a commitment that could ultimately save or dramatically improve someone’s life. More than 5,000 people in the UK are currently awaiting a transplant – unfortunately, many die each year before they can receive one.

DH encourages active participation in this year’s National Transplant Week, which runs from 15 to 22 July, with local community initiatives around the country; also the British Transplant Games will be held in Leeds this year from 25 July to 29 July.

For more details on how you can help please contact Ms Sue Johnstone at Transplants in Mind (TIME) – telephone: 0117 931 4638. To help encourage local initiatives United Kingdom Transplant (UKT) can supply you with figures on the number of people on the NHS Organ Donor Register. For details contact the Information Executive at UKT on 0117 975 7544.

Posters and leaflets for display in your surgery or hospital can be obtained from the Organ Donation Literature Line – telephone: 0845 6060 400.
Safety of Zyban as an aid to smoking cessation

The Committee on Safety of Medicines (CSM) recently reviewed the evidence concerning the safety of Zyban (bupropion hydrochloride) as an aid for smoking cessation.

Since Zyban was licensed in the UK in June 2000, an estimated 360,000 patients have received it up to 28 February this year. There have been 5,352 reports of suspected adverse reactions to it up to 25 April 2001.

• However, there were 113 reports of seizures. Approximately half of these occurred in patients who already had a history of seizures or were at risk of them.

• GPs were reminded by the CSM in March that Zyban is contra-indicated in people with a current or previous seizure disorder, and should be administered with extreme caution in those with predisposing factors for seizure.

• A small number of deaths were reported among people taking Zyban. These cases are being investigated further by the CSM. It is felt that in the majority of them the individual's underlying condition may be the cause of the death.

The CSM are continuing to monitor closely the safety of Zyban.

• Doctors are reminded to continue to report any suspected adverse reactions via the Yellow Card Scheme.

• They are also reminded that Zyban is contra-indicated for patients with a current or previous seizure disorder. Zyban should be administered with extreme caution to those with predisposing factors for seizure and those who are receiving medicinal products known to lower the seizure threshold (e.g., antipsychotics, antidepressants, theophylline, systemic steroids, antibiotics and antimalarial drugs).

For further information please contact either Dr D Milner Room 429 Wellington House, Waterloo Road, London SE1 8UG, telephone 0207 972 4026, or e-mail: dawn.milner@doh.gsi.gov.uk or tony.doole@doh.gsi.gov.uk. Alternatively, contact Dr J Williams at the Medicines Control Agency on 0207 273 0000. Further information on the CSM can also be found on the Medicines Control Agency website at www.open.gov.uk/mca/mcahome.htm

Availability of NRT on prescription

• Smoking kills 120,000 people a year in the UK, and is the major risk factor for cancer and heart disease.

• It is the leading single cause of avoidable ill health, premature death and the major contributor to health inequalities.

• Smoking cessation interventions are very cost effective and clinical effectiveness increases with support and the addition of pharmacotherapies.

• There is clear evidence that brief advice from a GP can produce a marked population health benefit. If that advice is coupled with treatment and referral to a trained smoking cessation adviser long term quit rates of 16% or more are achievable.

NHS smoking cessation services have been established in all Health Authorities to provide additional support and advice for smokers attempting to quit. It is vital that there is full co-ordination between all concerned to ensure that the seven out of ten smokers who wish to quit have access to support as and when they need it.

The NHS Plan announced the Government’s intention to make nicotine replacement therapy (NRT) available on prescription from GPs to complement the new smoking cessation treatment bupropion (Zyban). From 17 April this year, GPs have been able to prescribe NRT products, which have been shown to double the effectiveness of a quit attempt. NRT will continue to be available in pharmacies and will soon be available on general sale in some supermarkets. NICE is expected to provide an appraisal of NRT and Zyban later this year.

• Health Authorities are being asked to confirm that funding arrangements have been made/or are being made to enable GPs to prescribe smoking cessation aids to clinically suitable patients.

• From 1 May, nurse prescribers in England are able to prescribe NRT.

• All NRT products have been prescribable in Northern Ireland from 17 April, in Scotland from 30 April and in Wales from 1 May.

Information on smoking cessation guidelines and their cost effectiveness can be found on http://thorax.bmjournals.com/content/vol53/suppl5 and updated guidelines can be found on http://thorax.bmjournals.com/cgi/content/full/55/12/987

Smoking cessation co-ordinators are listed at http://nww.doh.nhsweb.nhs.uk/nhssmokingcessation

For further information please contact either Dr D Milner Room 429 Wellington House, Waterloo Road, London SE1 8UG, telephone 0207 972 4026 or Tony Doole Room 428 Wellington House (e-mail at dawn.milner@doh.gsi.gov.uk or tony.doole@doh.gsi.gov.uk).

References

4. SI No. 1178. The NHS (General Medical Services) Amendment (No.2) Regulations 2001.
National Clinical Assessment Authority – poor medical performance

- The National Clinical Assessment Authority (NCAA) was established in April 2001 to deal with cases where poor medical performance is suspected. The NCAA aims to remove the need for long suspensions.

- The NCAA will be the central point of advice for the NHS where concerns about a doctor’s performance arise.

- Employers, and – for GPs – Health Authorities (HAs), will be able to refer a doctor to the NCAA if concerns about his or her performance cannot be resolved locally. Initial concerns about possible poor performance should continue to be raised with the HA or the Trust medical manager.

- The NCAA will carry out rapid, objective assessments and make recommendations to the employer/HA. The emphasis is on finding a way back to satisfactory practice wherever possible – including further training, support, or if problems were intractable, dismissal or referral to the GMC.

- The NCAA complements the work of CHI, which addresses organisational rather than individual performance issues. The NCAA can refer a case to CHI if it finds that the problem is an organisational one rather than an issue about the performance of the doctor.

- On 8 January, DH published Assuring the Quality of Medical Practice, setting out a range of actions to safeguard against poor performance. The text is available at: www.doh.gov.uk/assuringquality.

The NCAA’s Medical Director and Chief Executive is Dr Alastair Scotland. The Chair is Mrs Jane Wesson. More information on the NCAA is available on its website at: www.ncaa.nhs.uk/

The NCAA can be contacted at: National Clinical Assessment Authority, 9th Floor, Market Towers, 1, Nine Elms Lane, London SW8 5NQ. Telephone: 0207 273 0850.

New guidance on consent

- Consent is fundamental to the doctor/patient relationship.

- New Departmental guidance aims to ensure that an accessible summary of the current law and good practice guidance on consent is readily available to all health professionals.

- The Reference guide to consent for examination or treatment is a comprehensive source of information on the current law and good practice concerning consent.

- The 12 key points on consent: the law in England summarises on one page key aspects of the law on consent which doctors are likely to need in their everyday practice.

- A copy of the 12 key points is included with this edition of CMO’s Update and both documents are available at www.doh.gov.uk/consent.

The Advisory Group assisting the Department with the development of these materials is now considering other aspects of consent practice, including the design of the standard consent form and the possibility of developing a model consent policy for NHS organisations.

Further details: Katharine Wright, 652C, Skipton House, 80 London Road, London SE1 6LH, telephone 0207 972 1435, or e-mail: katharine.wright@doh.gsi.gov.uk

Essence of care

- Essence of Care offers a practical toolkit for organisations to use as part of their quality improvement programmes.

- Developed by patients, consumer groups and professionals it provides best practice guidance in 8 fundamental aspects of care of relevance to all professionals involved in delivering direct care.

- Areas covered include: principles of self care; personal and oral hygiene; nutrition; continence and bladder and bowel care; pressure ulcers; safety of clients with mental health needs; record keeping; privacy and dignity.

- It can be an integral part of clinical governance at local level, helping practitioners to ensure that the basics of care are right.

The toolkit is available from the NHS Response Line 0541 555 455, also at www.doh.gov.uk/essenceofcare or via Regional Nurse Directors.

Further information can be obtained from Judith Ellis at room 4W43 Quarry House, Quarry Hill, Leeds LS2 7UE, telephone 0113 254 6062, or e-mail: judith.ellis@doh.gsi.gov.uk

from the Chief Medical Officer
Implementing An Organisation with a Memory

- A key priority of major health services around the world is promoting patient safety by reducing error.
- In the UK, the Chief Medical Officer chaired an expert group on learning from error and adverse events in the NHS. That group published its report An Organisation with a Memory last year.
- The Government agreed to implement all recommendations made in the report; implementation is underway.

It was announced on 17th April that the National Patient Safety Agency (NPSA) is to be set up to run a mandatory national reporting system for logging adverse health care events and near misses across the NHS. The Agency’s system of identifying, recording and analysing adverse events and harnessing the resulting learning will improve existing mechanisms for monitoring quality of care and promoting patient safety in a blame-free open environment.

- The Agency will be an independent body.
- It will collect and analyse information from the local level and assimilate other safety-related data from a variety of existing reporting systems.

Surveillance of healthcare associated infections

*Staphylococcus aureus* is an important cause of hospital and community infection. In hospitals it is particularly likely to cause wound and blood stream infections with significant attendant morbidity and mortality; the prevalence of methicillin-resistant *S. aureus* (MRSA) has increased markedly in the last decade, primarily associated with hospital acquired infection (HAI). It is sometimes difficult to distinguish between colonisation and true infection caused by MRSA, but culture of the bacterium from blood almost always represents significant infection.

It is reasonable to expect that hospitals with higher incidences of MRSA bacteraemia will also have higher rates of MRSA infection in general. Nationally co-ordinated surveillance of *S. aureus* bacteraemia rates (first stage surveillance) will allow comparison of *S. aureus* (and thus MRSA) infection rates between similar types of hospital.

The data set has been designed to allow simple extraction from laboratory systems with minimal subjective interpretation by microbiologists. The total number of blood cultures and the total of all positive blood cultures will provide further insight to where hospitals report unusually low or high MRSA bacteraemia rates as they may reflect different approaches to the indications for taking blood cultures.

- From 1 April, all acute Trusts are required to collect data on healthcare associated infections. This will focus on *Staphylococcus aureus* bacteraemias in the first instance.
- Data will be submitted to Regional Offices on a quarterly basis, and will be published from April 2002.

- Responsibility for collection lies with the Chief Executive of the Trust. Discussions will be needed with Regional Offices to agree the format for submission that best suits local needs.
- Regional Epidemiologists have been informed of this data collection requirement, and may already have been in touch with Trusts.

The collection of these data has been approved by the Review of Central Returns Steering Committee; the minimum data set and analysis will be:

- total number of blood cultures (sets taken: requests, not individual bottles).
- total number of positive blood cultures.
- total number of *S. aureus* positive blood cultures.
- MSRA positive blood cultures expressed as a proportion of all *S. aureus* positive blood cultures.

Each of these data to be expressed as a proportion of all hospital activity.

Further information, including the data that needs to be collected, can be found at [www.doh.gov.uk/hai/index.htm](http://www.doh.gov.uk/hai/index.htm)

For further details contact please contact David Howell at room 602A Skipton House, 80 London Road, London SE1 6LH, telephone 0207 972 5040, or e-mail: david.howell@doh.gsi.gov.uk

*Building a Safer NHS for Patients*, a document outlining progress and describing next steps was published on 17 April.

For further information please contact William Connan, Head of the Implementation Team in Room 609, Richmond House or telephone 0207 210 5603. Copies of Organisation with a Memory and *Building a Safer NHS for Patients* can be obtained on websites [www.doh.gov.uk/orgmemreport](http://www.doh.gov.uk/orgmemreport) and [www.doh.gov.uk/buildsafenhs](http://www.doh.gov.uk/buildsafenhs) respectively.
The NHS Plan sets out the main national priorities – patients should have fair access and high standards of care wherever they live.

National standards in priority areas are being set through National Service Frameworks (NSFs), drawn up by DH with the support of users of the service, clinicians, managers and staff.

NSFs define service models for a specific service or care group; put in place strategies to support implementation, and establish performance measures against which progress will be measured within an agreed time-scale.

Taking forward frameworks established for cancer and paediatric intensive care, the first phase of the rolling programme of NSFs included mental health, coronary heart disease (CHD), older people and diabetes. The mental health NSF, the CHD NSF and the National Cancer Plan have been published. The Older Peoples NSF was published on 27 March 2001. The next NSF will be for diabetes.

There will usually be only one new framework a year. The next phase of the NSF programme will include renal services, children’s services and long term health conditions, with particular focus on neurological disease and brain and spinal injury.

Older People: This NSF sets standards for the care of older people across health and social services. An accompanying booklet, Medicines and Older People, covers the use of medicines – a fundamental component of each standard.

The NSF specifically addresses those conditions which are particularly significant for older people and which have not been covered in other NSFs – stroke, falls and mental health problems associated with older age. But conditions such as stroke and dementia are not limited to older people, and the standards and service models will apply for all who need them, regardless of their age. The NSF contains eight standards in all:

- rooting out age discrimination.
- person-centred care.
- intermediate care.
- general hospital care.
- stroke.
- falls.
- mental health in older people.
- promoting an active healthy life.

The NSF is a ten year programme of improvement, supported by local action and national underpinning programmes for implementation. It sets out a series of milestones and performance measures to ensure progress. Regional Offices of the NHS Executive and the Social Services Inspectorate have been working together to prepare for implementation. They will continue to work closely with local health and social care partnerships to support implementation and to monitor progress.

Progress will be overseen by the NHS Modernisation Board and the Older People’s Taskforce, chaired by the National Director. Progress will be tracked through the performance assessment frameworks for health and social services. Initially, most measures of performance are related to inputs and process, however, the measures will be developed to focus more clearly on outcomes.

These data, and the Regional Office role in performance monitoring, will be complemented by surveys of users and carers, and by a systematic programme of reviews and inspections by the Social Services Inspectorate, the Commission for Health Improvement and the Audit Commission. From April 2002 the National Care Standards Commission will register and inspect all private and voluntary homes, the private health care sector and domiciliary care providers.

Renal Services: There is considerable potential for health improvement for people with end stage renal failure – this NSF will look at the patient pathway and will set service models to include:

- prevention;
- management of the condition;
- the alternative treatment modalities, bringing in kidney transplantation;
- conservative management or exit strategies for patients who opt not to begin treatment, or who decide to withdraw from treatment.

It will take account of the patient/carer experience and address the management of children and adults with end stage renal failure, especially how we respond to the healthcare needs of older people and of an increasingly multi-racial society more susceptible to kidney disease. It will draw on the targets set out in the NHS Plan for expanding haemodialysis provision.

Food the Chief Medical Officer
The climate of the UK is changing.

Predictions made by the UK Climate Impacts Programme (CIP) show that winters and summers will become warmer, that rainfall may well increase, as might the frequency of severe winter gales during the coming century.

In 1999 DH convened an Expert Group to look at the likely effects of such changes on health. The Group has produced a report and this has been published for comment; the report will soon be available on the DH web site.

The time-scale chosen by the Expert Group as its remit was for the next 50 years. Direct impacts such as of temperature change, and indirect impacts such as an increase in the mosquito population in the UK, were considered. Floods and gales were given special attention and original work was undertaken in this area.

The key messages are that:

- the numbers of deaths associated with cold weather are likely to fall, perhaps by 20,000 per year whilst hot weather associated deaths may rise by about 2,000 per year by 2050.
- it is likely that malaria, caused by Pl. vivax, may become established in localised parts of the UK and that the number of people returning to the UK with malaria will increase.

The NSF will deal with some important cross-cutting themes, especially:

- tackling inequalities and access problems;
- supporting children with disabilities and special needs;
- involving parents and children in choices about care;
- children growing up.

Climate change: effects on health in the UK

- The climate of the UK is changing.

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- the numbers of deaths associated with cold weather are likely to fall, perhaps by 20,000 per year whilst hot weather associated deaths may rise by about 2,000 per year by 2050.
- it is likely that malaria, caused by Pl. vivax, may become established in localised parts of the UK and that the number of people returning to the UK with malaria will increase.

- tick-borne diseases seem unlikely to rise.
- food poisoning is likely to increase in warmer summers.
- unless preventative action is taken skin cancer due to increased exposure to UV light is likely to increase.
- flooding and gales cause both direct and indirect effects on health and severe floods could place a heavy strain on the NHS.
- the effects of air pollutants are likely to decrease except in the case of those caused by ozone.
- drought can lead to an increase in disease associated with water supplies but the impact is expected to be small.

What does this mean for the doctor? Climate change is not a sudden process but is certainly taking place. Warning people about the effects of over-exposure to sunlight, the risks of food poisoning and of contracting diseases whilst on holidays abroad is important. Cold weather deaths, whilst predicted to decline, will remain a problem for many years and the Keep Warm Keep Well campaign should not be relaxed.

Further details can be obtained from: Dr R L Maynard, Department of Health, Skipton House, Room 661C, 80 London Road, London SE1 6LH, telephone 0207 972 5118, or e-mail: robert.maynard@doh.gsi.gov.uk
Modernising the SHO grade

In *The NHS Plan*, the Government committed itself to modernising the Senior House Officer (SHO) grade. Similar commitments have also been made in Scotland, Wales and Northern Ireland.

To take this forward, the Chief Medical Officer is chairing an SHO Modernisation Working Group; members have been invited separately in a personal capacity and have expertise in post-graduate medical and dental education, service, lay or relevant non-medical issues. The Group has been asked:

“to advise UK Health Ministers on a modern structure for basic specialist medical training throughout the UK and on the resulting consequences for workforce planning and service delivery”.

At its inaugural meeting on 31 January 2001, the Working Group came to four main conclusions:

• it should explore a move to programme-based training.

• careful consideration will need to be given to the particular needs of general practice and dentistry, and how these might link in to any new system.

• the interface and pathways between the training and the non-consultant career grades is an important consideration.

• any new arrangements need to be determined in context of broader workforce issues; for example, implementation of the Working Time Directive.

A smaller expert Technical Group, chaired by Professor John Temple (President of the Royal College of Surgeons of Edinburgh) has recently been gathering written and oral evidence from leading stakeholders on how a programme-based model might operate.

The Working Group has now met three times; it will hold one further meeting, following which CMO will present his report to Ministers.

Further information is available from: Andrew Matthewman, Medical Education Unit, Room 3N35A, Quarry House, Leeds LS2 7UE, telephone 0113 254 6588, or e-mail: andrew.matthewman@doh.gsi.gov.uk

Improving health in prisons

• As many as 65,000 people are in prison in England and Wales, and around 150,000 people pass through our prisons every year.

• The prison population displays high levels of morbidity, particularly in relation to mental health, substance misuse and infectious diseases – data shows the scale of the problem:
  
  – 90% of prisoners have a diagnosable mental health and/or substance misuse problem;
  
  – 24% of prisoners have injected drugs, and of this group around 20% are infected with Hepatitis B and 30% with Hepatitis C;
  
  – 80% of prisoners smoke;
  
  – 10% of female prisoners and 7% of male prisoners have a history of self-harm.

The Prison Health Policy Unit and Task Force, joint units established by the Prison Service and the Department of Health, are providing national leadership in the drive to improve prison health services and improve health in prisons. One important strand of this work is the development of a shared NHS and Prison Service “Healthy Prisons” strategy.

• Prisons clearly represent a significant opportunity to begin to improve the health of prisoners and also, indirectly, of their families. Key aims of the developing Healthy Prisons strategy are to:
  
  – promote health in prisons as being important to public health;
  
  – develop and promote the health and wellbeing of staff and prisoners;
  
  – prevent the deterioration of prisoners’ health during, or because of, custody; and
  
  – encourage prisoners as part of their rehabilitation to adopt healthy behaviours that can be carried back into the community.

With these aims, work is underway to assess the health and health promotion needs of prisoners and staff, to set out a vision of a healthy prison and to devise a plan of action. A strategy document will be published in the summer of 2001.

For further information on the Healthy Prisons work, or to register an interest in receiving a copy of the strategy when it is published, contact Paul Hayton, Head of Health Promotion, Prison Health Policy Unit, Room 7E60 Quarry House, Leeds LS2 7UE. e-mail paul.hayton@doh.gsi.gov.uk, tel. 0113 254 3611.

Details of the developmental work programme of the Policy Unit and Task Force, which at present comprises 14 specific policy and service development projects, can be found on the prison health website at: www.doh.gov.uk/prisonhealth/index.htm

Reference

The national five-a-day programme

- A key feature of the government’s prevention strategy to reduce early deaths from cancer and coronary heart disease is action to improve access to and increase consumption of fruit and vegetables.

- Evidence shows that eating at least five portions of fruit and vegetables a day could lead to estimated reductions of up to 20% in overall deaths from chronic diseases such as heart disease, stroke and cancer.

- Experts suggest that it is the second most effective strategy to reduce the risk of cancer, after reducing smoking.

However, the average consumption of fruit and vegetables among adults in England is only three portions per day, while children eat only two portions. These average figures mask wide variation between individuals:

- unskilled groups eat about 50% less than professional groups.

- one-fifth of children eat no fruit in a week.

The NHS Plan makes a commitment to the development of a national five-a-day programme to increase fruit and vegetable consumption, particularly in low-income groups.

Action by 2004 includes:

- the National School Fruit Scheme will entitle school children aged four to six to a free piece of fruit each school day. This is currently being piloted in over 500 infant schools across the country and over 80,000 children are receiving free fruit every day.

- Five-a-day Community Projects have been set up to test the feasibility and practicalities of evidence-based community approaches to improving access to and increasing awareness of fruit and vegetables. National roll out begins in 2002.

- working with industry – producers, caterers, retailers – to increase provision of and access to fruit and vegetables.

- a communications programme to increase awareness of fruit and vegetable consumption, particularly targeting those groups with the lowest intakes.

- evaluation and monitoring of the implementation and impact of the five-a-day programme.

Contact Danila Armstrong at Department of Health, Wellington House, 133-155 Waterloo Road, London SE1 8UG, telephone 0207 972 4294, or e-mail danila.armstrong@doh.gsi.gov.uk

A booklet and leaflet about the National School Fruit Scheme and the Five-a-day Community Projects are available from: Department of Health, PO Box 777, London, SE1 6XH. Tel: 0800 555 777; Fax 01623 724524; e-mail: doh@prolog.com

Further information can be found on the web-sites: www.doh.gov.uk/schoolfruitscheme, www.wiredforhealth.gov.uk, and www.doh.gov.uk/fiveaday

Clinical ethics support in the NHS

- Ethical dilemmas in clinical practice are increasingly recognised and subject to public and professional scrutiny.

- A range of mechanisms has been developed to provide support in resolving such dilemmas, which include the use of a clinical ethics committee or advice from an ethicist – these are well reviewed in a recent report1.

- Some 30 clinical ethics committees have now been set up in the UK.

- Ethox, based at the University of Oxford, have set up a network of clinical ethics committees to share existing good practice.

Those who are considering, developing, or providing ethics support services are encouraged to make contact with the network via their web-site at www.ethox.org.uk. At present there is no clear evidence of the best method of providing ethics support and therefore audit of existing work and further research should be encouraged.

For further information contact: Dr Elaine Gadd, 655C Skipton House, 80 London Road, London SE1 8UG, telephone 0207 972 1517, or e-mail: Elaine.Gadd@doh.gsi.gov.uk

References