

# CMO

SPRING 2008

ISSUE 47

## UPDATE

### Foreword



Lord Darzi's NHS Next Stage Review, *Our NHS, Our Future*, is being published shortly to coincide with

the 60th anniversary of the NHS. The work that took place as part of the Review has provided a unique opportunity for clinicians to set out their vision for the next decade of the health service.

Prior to the report's publication, each strategic health authority will be publishing a document setting out their own vision for improving local health and healthcare. To assist with this, last October strategic health authorities formed working groups of local clinicians and others to consider the evidence for improved models of care across eight broad areas:

- maternity and newborn care
- children's health
- planned care
- mental health
- staying healthy
- long-term conditions
- acute care
- end-of-life care.

Local events were held to ensure that the views and experiences of staff, as well as stakeholders, patients and the public, informed the thinking of each clinical

(continued page 4)

### REINVIGORATING CLINICAL AUDIT

Effective clinical audit can be a rich source of information to support service improvement, provide better information for patients and assist in activities such as revalidation of clinicians. In 2006, *Good Doctors, Safer Patients* called for the reinvigoration of clinical audit, partly because it has a chequered reputation amongst health service managers and commentators, and partly because it falls short of its potential due to the lack of visibility of its benefits.

To support this reinvigoration, an additional £3.2 million per year has been allocated to the National Clinical Audit and Patients' Outcomes Programme. Its role as a commissioner of clinical audits will be expanded to include wider support activities and increase the use of this valuable service improvement tool. The Programme was previously managed by the Healthcare Commission. As of 1 April 2008, a consortium comprised of the Academy of Royal Colleges, the Royal College of Nursing and the Long Term Conditions Alliance began hosting the expanded programme. It is now known as the Healthcare Quality Improvement Partnership.

At present, the Programme commissions national audits across a range of specialties, and there are currently over 20 active audits. The expanded role of the Programme will include:

- prioritising topics for audit. The Programme will also incorporate two national audits that currently sit outside the programme – the National Joint Registry and the Paediatric Intensive Care audit

- increasing stakeholder engagement. Consultation with clinicians, professional organisations, users of audit and others will be an essential part of reinvigorating audit and building consensus about how to develop audit in the future. A stakeholder forum will be established to enable discussion and debate
- developing materials and resources. This support for practitioners carrying out both local and national audit might include training materials, guidance, and an electronic library of validated audits that practitioners can download for use locally.

Additionally, a National Clinical Audit Advisory Group has been created to drive the reinvigoration programme and provide a national focus for discussion and advice on matters relating to clinical audit. Chaired by Nick Black, Professor of Health Services Research at the London School of Hygiene and Tropical Medicine, the Group will provide advice and guidance to the expanded National Clinical Audit and Patients' Outcomes Programme. It will advise on the overall programme of work, in particular it will consider proposals for new audits or for discontinuing existing audits.

The challenges ahead for the clinical audit programme include investigating how clinical audit can be linked to wider professional revalidation work and its link to local clinical governance processes.

Policy contact: [helen.lovell@dh.gsi.gov.uk](mailto:helen.lovell@dh.gsi.gov.uk)

For more information: [www.hqip.org.uk](http://www.hqip.org.uk)

Guidelines aid identification of community-associated MRSA

PAGE 2

Reforming the process of death certification

PAGE 3

Increasing diagnosis of hepatitis C

PAGE 4

Priority treatment for war veterans

PAGE 5

Identifying barriers to organ donation

PAGE 6

# IMPROVING THE QUALITY OF MEDICAL EXPERT EVIDENCE

The report, *Bearing Good Witness: Proposals for reforming the delivery of medical expert evidence in family law cases*, was launched for public consultation in October 2006. Its publication followed some very high-profile court cases that called into question the quality of medical expert witnesses in certain types of cases.

The report made 16 proposals, the key being that the NHS should establish teams of specialist doctors and other professionals within local NHS organisations. This would help to improve the quality of the medical expert witness service by introducing mentoring, supervision and peer review. The report proposed that each team should be led by a named medical consultant, who would take responsibility for coordinating the initial response to instructions and for ensuring that the appropriate health expert was available to contribute to the report and give oral evidence as required.

The report also proposed that a commissioning body should be identified to strategically plan and directly commission expert medical witnesses for public law Children Act proceedings.

A summary of responses to the public consultation was published in July 2007. The Legal Services Commission (LSC) has now committed, in principle, to working with the Department of Health to pilot the proposed new commissioning arrangements. The pilot is likely to last 12 months, and will begin in summer 2008.

A programme of pre-pilot design work, led by the LSC, has recently got under way. This work will include developing model specifications and contracts, as well as establishing the arrangements for evaluating the new commissioning model. Several existing teams of expert witnesses in NHS Trusts have indicated their interest in participating in

the piloting process. As this work progresses, a timetable setting out the full piloting process will be published by the LSC.

As part of the *Bearing Good Witness* programme, a knowledge, skills and competences framework is being developed for expert witnesses who are members of the healthcare professions. Key elements of the framework include knowledge of the expert's role and its scope, skills in report writing (and knowledge of the format and style of reports preferred by the courts), and skills in oral presentation and response to cross-examination. The intention is to provide this to the teams involved in the piloting process, as well as to prospective teams.

---

**Policy contact:**  
[ruth.benjamin@dh.gsi.gov.uk](mailto:ruth.benjamin@dh.gsi.gov.uk)

**For more information:**  
[www.dh.gov.uk/consultations](http://www.dh.gov.uk/consultations)

## GUIDELINES AID IDENTIFICATION OF COMMUNITY-ASSOCIATED MRSA

The British Society for Antimicrobial Chemotherapy, jointly with the Health Protection Agency, has produced guidelines for general practitioners that cover the management of serious infection caused by MRSA (meticillin-resistant *Staphylococcus aureus*) arising in the community. These guidelines complement existing guidance on MRSA and were published in the *Journal of Antimicrobial Chemotherapy*.

Most MRSA infections that appear to have a community onset currently occur in patients who have had direct or indirect contact with hospitals, care homes or other healthcare facilities. These MRSA strains are typical of the local healthcare-associated MRSA (HA-MRSA), and may be carried asymptotically by patients for months after discharge.

However, new strains of MRSA have recently emerged which cause infections in patients who have no previous history of direct or indirect healthcare contact. These strains, designated community associated (CA-MRSA), are genetically and phenotypically distinct from HA-MRSA and frequently cause skin and soft tissue infections.

CA-MRSA often produce Panton-Valentine leucocidin, a toxin that destroys white blood cells, and appear to be associated with increased risk of transmission, complications and hospitalisation.

Although such infections are rare at present, they usually affect young, previously healthy people and may have a rapid and devastating course. The new guidelines cover management of staphylococcal pneumonia, although other serious manifestations of these infections are emerging.

Serious *S. aureus* infections can be caused by strains that are meticillin-resistant or susceptible and which may or may not express the Panton-Valentine leucocidin toxin. The guidelines recommend that suspected serious and deep-seated MRSA infections, including suspected bacteraemia and staphylococcal pneumonia, are assessed and treated in hospital.

---

**Policy contact:** [sally.wellsted@dh.gsi.gov.uk](mailto:sally.wellsted@dh.gsi.gov.uk)

**For more information:**  
<http://jac.oxfordjournals.org/cgi/reprint/dkn096v1>

# REFORMING THE PROCESS OF DEATH CERTIFICATION

Death certification is an important source of information about the mortality associated with different diseases for clinicians, for those responsible for planning and managing health services, and for the general public. There is particular public concern about the recording of healthcare-associated infections as the cause of, or as a contributory factor to, death.

Recently, far-reaching proposals for reforming the process of death certification in England and Wales were put out for consultation. The proposals form part of the Government's action programme in response to the recommendations of the Shipman Inquiry. As well as improving the quality and accuracy of death certification, the reformed process will introduce a single system of effective medical scrutiny applicable to all deaths that are not reportable to the coroner. It will also provide improved information on cause of death to strengthen local clinical governance and public health surveillance.

The key proposals are that:

- Medical Certificates of Cause of Death (MCCDs), for burials and cremations alike, would be subject to scrutiny by an independent medical examiner appointed by a primary care trust and with strong links to NHS clinical governance teams

- if the medical examiner was satisfied that all was in order, they would issue an authorisation to the family of the deceased to enable them to register the death and proceed to burial or cremation
- where the medical examiner was not satisfied that the MCCD told the full story or felt that there were other unusual circumstances, they would refer the case to the coroner for further investigation, along with their reasons for doing so
- the medical examiner would have full access to medical records and would be empowered to discuss the circumstances of the death with the doctor signing the MCCD and with the family of the deceased
- NHS clinical governance teams would collate information from MCCDs and would use this to analyse trends and patterns, looking out for unusual features, such as those revealed by Shipman's pattern of deaths.

The vast majority of responses have been supportive, and the proposed role of the medical examiner in a

reformed system has been welcomed. Many respondents also support the proposal that medical examiners should be the main source of general medical advice to coroners, and that a line of professional accountability to the National Medical Adviser to the Chief Coroner (when appointed by the Ministry of Justice) should be established.

The main concerns are over ensuring that the scrutiny process does not cause significant delays to funerals and that medical examiners are able to carry out their duties with the necessary degree of independence from NHS and other public authorities. A formal response to the consultation will be published shortly.

Implementation of the reforms is being coordinated by a Department of Health Steering Group. Membership includes clinicians and representatives from professional and regulatory bodies in the NHS, as well as funeral industry representatives and colleagues from other government departments.

The reforms will be piloted in a number of locations during 2008/09, beginning with a 'pathfinder pilot' in Sheffield. Implementation, which will be subject to the parliamentary timetable for introducing new legislation, will be completed by 2011.

---

**Policy contact:** [simon.bennett@dh.gsi.gov.uk](mailto:simon.bennett@dh.gsi.gov.uk)

**For more information:** [www.dh.gov.uk/consultations](http://www.dh.gov.uk/consultations)

---

## REDUCING ANTIBIOTIC PRESCRIBING

The overuse of antibiotics poses a major public health challenge, with antibiotic resistance becoming more common. Prudent prescribing can help tackle healthcare-associated infections including MRSA. A national advertising campaign was launched recently to help clinicians make clear to patients, such as mothers with young children, that antibiotics are not effective for common conditions such as most

coughs, colds and sore throats. General practices and most pharmacists received a poster for display, and more can be requested, free of charge. A leaflet is also available that explains to patients the need to get the right treatment for common illnesses such as coughs and colds, without encouraging antibiotic resistance. It can be downloaded in 10 languages, and specially ordered in Braille and audio.

The free campaign materials can be ordered at [www.nhs.uk/antibiotics](http://www.nhs.uk/antibiotics). Alternatively, material can be ordered from the DH Publications Orderline (telephone 08701 555 455 or email [dh@prolog.uk.com](mailto:dh@prolog.uk.com)).

---

**Policy contact:** [sunita.rutherford@dh.gsi.gov.uk](mailto:sunita.rutherford@dh.gsi.gov.uk)

**For more information:** [www.nhs.uk/antibiotics](http://www.nhs.uk/antibiotics)

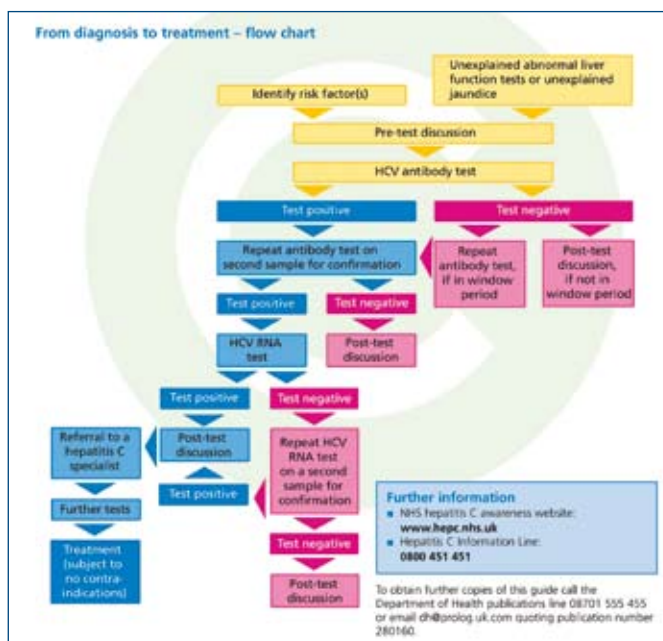
# INCREASING DIAGNOSIS OF HEPATITIS C

A recent audit by the All-Party Parliamentary Hepatology Group indicates that nearly nine out of 10 primary care trusts are taking steps to implement the *Hepatitis C: Action Plan for England*. The audit assesses nearly four out of 10 primary care trusts as implementing the action plan effectively. This represents a significant improvement compared with the first audit in 2006, but it is clear that more needs to be done.

Diagnoses of hepatitis C have increased by 10% over the past year. There were 8,346 cases reported in 2006, according to the Health Protection Agency's latest annual report on hepatitis C, which was published in December 2007. It is estimated that there could be about 100,000 people with chronic hepatitis C yet to be diagnosed, so efforts need to be sustained and improved. This is particularly important as untreated hepatitis C can lead to cirrhosis and primary liver cancer. There is effective drug therapy recommended by the National Institute for Health and Clinical Excellence.

At the heart of the problem is the very nature of the disease – most people who have hepatitis C experience no symptoms for many years, which means it is unlikely that people will actively seek a test. Therefore, unless a patient has unexplained abnormal liver function tests or unexplained jaundice, the only indications for offering testing will be risk factors for hepatitis C infection.

As a blood-borne virus, hepatitis C is mainly spread through direct blood-to-blood contact. In this



country, patients who may have injected drugs (even if only once, a long time ago) are most at risk. Other transmission routes include through a blood transfusion (before September 1991), or through blood products (before 1986) in the United Kingdom. Hepatitis C can also be transmitted through tattooing or piercing with unsterile equipment or by sharing razors or toothbrushes with someone infected with the virus.

There is a small risk of contamination from mother to child during pregnancy or childbirth and through unprotected sex with someone who has the virus. Medical or dental treatment abroad in countries where hepatitis C is common (e.g. parts of the Middle East, Asia and Africa), and where infection control may be poor, is also a risk.

To help increase diagnosis by clinicians, *Hepatitis C – Quick reference guide for primary care*, is available. It forms part of the Department of Health's national campaign – FaCe It – which aims to raise awareness of hepatitis C among healthcare professionals and the public, and encourages people to find out if they could be at risk. The guide includes information about hepatitis C and at-risk groups, and details of how patients with hepatitis C should be managed through testing, diagnosis and referral for specialist assessment. Copies are free and can be ordered from the DH Publications Orderline (telephone 08701 555 455 or email [dh@prolog.uk.com](mailto:dh@prolog.uk.com), quoting publication number 280160). Copies can also be downloaded from [www.hepc.nhs.uk/resources](http://www.hepc.nhs.uk/resources).

**Policy contact:** [gerry.robbs@dh.gsi.gov.uk](mailto:gerry.robbs@dh.gsi.gov.uk)

**For more information:** [www.hepc.nhs.uk](http://www.hepc.nhs.uk)

## Foreword (continued)

working group. Each group has now set out their proposed models of care to their strategic health authority. The groups have also detailed what could enable them to make, or is preventing them from making, the improvements they believe are necessary.

From this work, strategic health authorities are developing their own

visions of world-class healthcare in their region for the next decade. The visions will be published from May. In the light of these, primary care trusts will develop their commissioning plans in conjunction with local partners.

As part of my contribution to the Review, I have been working to ensure that quality and safety are

right at the heart of every patient's care and have made a submission to the Review through my national leadership of this workstream.

*Liam Donaldson*

Sir Liam Donaldson  
Chief Medical Officer

# PRIORITY TREATMENT FOR WAR VETERANS

From 1 January 2008, all veterans are eligible to receive priority access to NHS secondary care for any conditions likely to be causally related to their service, subject to the clinical needs of other patients. A veteran is someone who has served in the Armed Forces for at least one day.

The types of care that veterans are most likely to need for service-related conditions are:

- audiology services. Noise-induced hearing loss resulting from a person's time in the Armed Forces may begin to present problems after discharge, while hearing aids or appliances may need ongoing maintenance. In addition, there may be future groups of veterans for whom hearing loss is an issue
- mental health services. Veterans sometimes do not seek treatment for service-related mental health problems until some years after discharge, making it particularly difficult to establish whether a condition is due to service and its implication for treatment. Information about the veterans' mental health pilots and the Ministry of Defence Medical Assessment Programme at St Thomas' Hospital in London, which provides a free assessment for veterans with operational experience since 1982, can be found at [www.veterans-uk.info](http://www.veterans-uk.info)
- orthopaedic/prosthetics services. Injuries during a person's time in

the Armed Forces may begin to present problems or need ongoing maintenance after discharge.

General practitioners should make clear in referrals of veterans to secondary care that the condition may be, in their clinical opinion, related to military service. If secondary care clinicians agree with this opinion, veterans should be prioritised over other patients with the same level of clinical need. However, veterans should not be given priority over other patients with more urgent clinical needs.

Where patients are already receiving secondary care, staff should not systematically ask them whether they are veterans suffering from a condition that they believe is related to their military service. Veterans may, however, raise with clinicians the fact that they believe that their condition is related to service. It will then be for the clinician to decide whether this is likely and that priority should be given to their case.

It is important to note and make clear to patients that a veteran who has a disorder recognised as qualifying for priority treatment does not necessarily fulfil the criteria for award of a war pension. If a

general practitioner considers that a condition is likely to be due to service and is significantly disabling, they can suggest that the individual applies for a war pension. If an award is made, they may also be entitled to other benefits. The Service Personnel and Veterans Agency can provide details of other help associated with the accepted disablement. For details, go to [www.veterans-uk.com/pensions/medical\\_treat.html](http://www.veterans-uk.com/pensions/medical_treat.html) or telephone 0800 169 2277.

On discharge, members of the Armed Forces are given a summary of their medical records to give to a general practitioner when they register, along with contact details for the clinician if fuller records are needed. On occasion, the new patient may not have to hand the summary or the contact details. The contact details to obtain summary or full records are as follows:

- Royal Navy, MDG(N) Medical Records Section, Institute of Naval Medicine, Alverstoke, Hampshire PO12 2DL.
- British Army, Secretariat Disclosure 3 (Medical), Mail Point 525, Army Personnel Centre, Kentigern House, 65 Brown Street, Glasgow G2 9EX.
- Royal Air Force, ACOS Manning, Medical Casework, Room 1, Building 22, RAF High Wycombe, Buckinghamshire HP14 4UE.

**Policy contact:**  
[karen.todd@dh.gsi.gov.uk](mailto:karen.todd@dh.gsi.gov.uk)

**For more information:** [www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH\\_081171](http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_081171)

## CMO Update online

Would you like to be notified when the new edition of *CMO Update* is available online? We offer an email alert service that will let recipients know when the newest edition is available on the CMO website. This alert has a link that will take you directly to the website, where you can view or print the new edition.

If you would like to subscribe to this service, please complete an online subscription form, available at:

[www.info.doh.gov.uk/cmo/cmoupdate.nsf/registrationmenu?openform](http://www.info.doh.gov.uk/cmo/cmoupdate.nsf/registrationmenu?openform)

# IDENTIFYING BARRIERS TO ORGAN DONATION

Over the last 10 years, United Kingdom organ donor rates have remained steady at best, while the number of people needing an organ transplant has risen by 8% per annum. In 2006/07, over 3,000 patients received a transplant (600 from live donors) but another 1,000 people died, either while on the transplant waiting list or after having been removed because their condition deteriorated. More worryingly, the national transplant list does not reflect the true extent of need. Approximately 8,000 people are on the list at any one time. An additional 4,000 people need a transplant but do not get on the list, as clinicians are reluctant to list more people than are realistically likely to receive organs.

In December 2006, an Organ Donation Taskforce was established to identify the barriers to organ donation and to recommend what action should be taken within existing legal frameworks. Its work highlighted three key areas within the NHS to be resolved – donor identification and referral, donor coordination and organ retrieval arrangements.

In January 2008, all four United Kingdom health departments accepted the 14 recommendations of the Organ Donation Taskforce. The recommendations focus particularly on the need to invest in the infrastructure of organ donation and to make donation a usual, not unusual, event. These include:

- the establishment of a United Kingdom-wide organ donor organisation as part of NHS Blood and Transplant
- a strengthened network of dedicated organ retrieval teams, available 24 hours a day, working closely with critical care teams
- a doubling of the number of front-line donor coordinators (about an extra 100 donor transplant coordinators)
- clinical donation champions and donation committees in every Trust
- mandatory training for all clinical and nursing staff likely to be involved in the treatment of

potential organ donors with regular update training

- removal of financial disincentives in hospitals to organ donation

The Taskforce believes that its recommendations could increase cadaveric organ donation rates by at least 50% over five years – a potential 1,200 extra transplants each year, of which around 700 will be kidney transplants. The increase will see United Kingdom rates rise to match some of the more successful countries in Europe and elsewhere. Significant additional funding is being made available to support implementation of the recommendations.

The Taskforce will continue its work and is examining the impact of moving to an opt-out system of organ donation across the United Kingdom, as recommended in last year's Chief Medical Officer's Annual Report. It will be reporting on this to Ministers in summer 2008.

---

**Policy contact:** [triona.norman@dh.gsi.gov.uk](mailto:triona.norman@dh.gsi.gov.uk)

**For more information:**

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_082122](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082122)

## ONLINE CHECKS TO ASSESS BABIES' HEALTH

The NHS Early Years LifeCheck is an online health assessment questionnaire for parents and carers with babies aged between five and eight months. Currently being piloted, it provides personalised feedback and useful advice about what parents can do to help keep their baby healthy and safe.

NHS Early Years LifeCheck presents a series of questions and information on topics such as growth and development; playing and learning; safety; sleeping; teething; feeding; and protecting against diseases. It then feeds back personalised advice to the parent or carer, for example on how to find an NHS dentist,

the importance of ensuring that immunisations are up to date or how to reduce household accidents.

The tool has been designed with input from parents and a wide range of health professionals, including paediatricians, health visitors and the British Medical Association so that, where appropriate, information is provided to reassure parents whilst directing only those at highest need to seek advice from a health visitor or general practitioner. The content of the tool is based upon the Department of Health's *Birth to Five* publication.

The tool is available online at [www.nhs.uk/lifecheck](http://www.nhs.uk/lifecheck) and is being promoted to selected Sure Start Children's Centres within the NHS Choices Learning Network areas of North and North-east Lincolnshire, Coventry, Warwickshire, Derbyshire and Hull. The pilot sites all have

trained facilitators to help parents use the tool and ensure equitable access for families who have difficulty reading, or whose first language is not English.

An evaluation of the NHS Early Years LifeCheck pilot has been commissioned, which will involve parents and health professionals. National roll-out of the tool is expected to commence in late summer 2008 and will initially focus on ensuring that the tool is available and promoted in deprived communities. Data confidentiality and privacy issues have been addressed and LifeCheck is fully compliant with respective legislation and best practice.

---

**Policy contact:**

[chris.lovitt@dh.gsi.gov.uk](mailto:chris.lovitt@dh.gsi.gov.uk)

**For more information:**

[www.dh.gov.uk/lifecheck](http://www.dh.gov.uk/lifecheck)

# SAFER PATIENT CARE THROUGH TECHNOLOGY

Automatic identification and data capture (AIDC) involves the use of bar codes, radio-frequency identification and other machine-readable codes to identify or process an item quickly and accurately. Though used for decades in other sectors of industry such as retail, its use in healthcare has been limited.

Errors, many caused by getting patient identity wrong, currently cost the NHS about £2 billion a year in extra hospital days. Studies have shown that, when coding systems are used to verify a patient's identity and ensure that the right patient is receiving the right care, there are fewer medication errors; a reduced risk of wrong-site surgery; more accurate tracking and tracing of surgical instruments, equipment and other devices; and better record keeping. Widespread use of bar codes and other AIDC technologies could make a significant impact on the number of patient safety incidents.

The guidance document, *Coding for Success: Simple technology for safer patient care*, shows how widespread the potential benefits are and encourages the wider adoption of AIDC technologies in hospitals and healthcare settings to increase patient safety and improve efficiency. The case for coding is compelling, but commonly agreed standards are needed for benefits to be realised fully.

The Department of Health recommends that the GS1 System (a global coding standard developed and managed by the GS1 organisation) be adopted throughout the healthcare system in England. This applies to both manufactured products (medicines and devices) and coding systems used within healthcare settings, such as patient identification codes on wristbands.



Connecting for Health has coordinated the main development and implementation of AIDC across the NHS. The key to this has been to enable NHS organisations to become members of GS1 and to use its global coding standards. To date, 65 hospitals have joined the programme and been assigned a GS1UK organisational identifier.

Since the guidance was issued, Connecting for Health has focused on three priority areas: the decontamination of sterile surgical instruments, medicines manufacturing and patient identification. The project looking at developing coding standards to use on surgical instruments is vital to ensure appropriate tracking and tracing of an instrument tray through the decontamination process and linking it to patients. The National Decontamination Team has been working with GS1 to develop national guidelines. The team is developing decontamination regional super-centres that will be designed to handle the decontamination of equipment across a number of hospital Trusts. All Trusts need to work to commonly agreed standards to achieve effective tracking and tracing.

Progress will be reviewed at the end of 2008 by the Department of Health. It will work with stakeholders to determine where AIDC technology has been implemented and its benefits for patient safety. It will also review what gaps, if any, still exist and how to increase uptake of the technology.

**Policy contact:** [cfh.aidcenquiries@nhs.net](mailto:cfh.aidcenquiries@nhs.net)

**For more information:** [www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/PatientSafety/PatientSafety/GeneralInformation/fs/en](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/PatientSafety/PatientSafety/GeneralInformation/fs/en)

## HEALTH TRAINERS HELP TACKLE INEQUALITIES

Since April 2006, health trainers have been working in communities in highest need of action to tackle health deprivation and reduce inequalities. Their function is to help people make positive behavioural changes to improve their health, and to help them access health information and/or services. Currently more than 1,200 health trainers have been trained and are in post.

The scheme is organised locally through primary care trusts. Trainers are recruited from the community and are knowledgeable about what is available in that area. Health trainers follow the mandatory procedures in place for the NHS with regard to confidentiality and quality assurance. Two national awards based on health trainer competences have been developed: City & Guilds (Level 3) and the Royal Institute of Public Health (Level 2).

There has been considerable enthusiasm for the project among third-party organisations. There are currently in the region of 80 health trainers in prisons working on peer-to-peer education. The Army has trained 450 physical training instructors with a view to training a further 2,000 in subsequent years, while Royal Mail has trained two cohorts of first aid staff to Royal Institute of Public Health Level 2 as workplace health trainers.

The programme is building an evidence base through the activity report compiled by University College London with the British Psychological Society. The 2007 *National Health Trainer Activity Report* collates and assesses all the 2006/07 end-of-year reports from the different health trainer partnerships across the country.

**Policy contact:**  
[rachel.carse@dh.gsi.gov.uk](mailto:rachel.carse@dh.gsi.gov.uk)

**For more information:**  
[www.dh.gov.uk/en/PublicHealth/Healthinequalities/HealthTrainers/usefullinks/index.htm](http://www.dh.gov.uk/en/PublicHealth/Healthinequalities/HealthTrainers/usefullinks/index.htm)

# NEWS IN BRIEF

---

## Electronic drug safety bulletin

*Drug Safety Update* is a new monthly electronic bulletin from the Medicines and Healthcare products Regulatory Agency and the Commission on Human Medicines. Replacing *Current Problems in Pharmacovigilance*, which was previously mailed to doctors and pharmacists, *Drug Safety Update* aims to bring all healthcare professionals the latest information and clinical advice to ensure the safe use of medicines. Healthcare professionals can quickly find the information that is relevant to their practice. Keywords on main articles enable items of particular relevance or interest to be identified and, where possible, margin notes indicate how to access additional information. The bulletin will include regular updates on the Yellow Card scheme. To view the bulletin, go to: [www.mhra.gov.uk/mhra/drugsafetyupdate](http://www.mhra.gov.uk/mhra/drugsafetyupdate). To receive a monthly email alert when a new issue is published, go to: [registration@mhradrugsafety.org.uk](mailto:registration@mhradrugsafety.org.uk)

---

## Improving care of transgender people

The Department of Health has produced information for healthcare professionals to help improve care of transgender people. *Transgender experiences – Information and support*, provides information to help healthcare staff to understand their role when caring for transgender people. There is also a new leaflet, *A guide to hormone therapy for trans people*, which provides information about the benefits, risks and side effects of currently available hormone treatments. Both publications can be viewed or downloaded at: [www.dh.gov.uk/sogi](http://www.dh.gov.uk/sogi). Hard copies of the publications can be ordered free of charge from the DH Publications Orderline on 08701 555 455 or by email from [dh@prolog.uk.com](mailto:dh@prolog.uk.com) (order numbers 284892 and 284887).

---

## Easier access to clinical knowledge

Clinicians are now able to access the National Library for Health and its database resources through a single interface. Previously access was via separate websites and databases, such as Dialog, Ovid or MyiLibrary, for different aspects of clinical knowledge. The National Library for Health Search 2.0 enables users to log in to one site to get to the most up-to-date clinical and health knowledge. To find out more about the National Library for Health Search 2.0, go to: [www.library.nhs.uk/CommsPage.aspx](http://www.library.nhs.uk/CommsPage.aspx)

---

## Support for smoking cessation

Research shows that around 70% of smokers want to stop, and they are up to four times more likely to succeed with NHS support. Resources and information are available for general practitioners and other healthcare professionals to help patients and clients give up smoking, including free leaflets, a support guide and a DVD. The *Get Support* DVD provides a closer look for patients at the various types of help available through the NHS. This includes local NHS Stop Smoking Services, which offer group and one-to-one support, and the Together Programme, which sends support materials and messages to the person at home and provides advice from expert staff on the NHS Smoking Helpline. The DVD also includes advice on all nicotine replacement therapy options, along with non-nicotine medicines to help reduce cravings. To order any of the material, telephone 0800 917 6699 or go to: [www.nhs.uk/gosmokefree](http://www.nhs.uk/gosmokefree)

---

## Online ethical guidance launched

The General Medical Council has launched an interactive web zone for doctors to highlight important issues addressed in its guidance booklet, *Good Medical Practice*. The web zone allows users to explore a series of ethical dilemmas and case studies, including issues such as conscientious objection, advertising, and reporting concerns about colleagues. The zone, 'Good Medical Practice in Action', allows users to click on one of the patients to watch and listen to their consultation with a doctor. As each dilemma reveals itself, the user is called on to decide which option is the best match to the General Medical Council's guidance. Feedback on the user's decision is given, and there are links to the General Medical Council's website where the relevant guidance can be viewed. Patients can also access the web zone to give them an insight into the types of issues regularly faced by doctors. For more information, go to: [www.gmc-uk.org/online/gmp\\_in\\_action/AppLoader.asp](http://www.gmc-uk.org/online/gmp_in_action/AppLoader.asp)

For changes in address, please contact The Medical Mailing Company, PO Box 60, Loughborough LE11 0BR (Freephone 0800 626 387).

*CMO Update* is a newsletter sent by the Chief Medical Officer of the Department of Health to all doctors in England. It incorporates topics that might otherwise have required an individual letter or progress report, as well as other information from the Department of Health that is of interest to practising doctors. *CMO Update* is also available at: [www.dh.gov.uk/cmo](http://www.dh.gov.uk/cmo)

© Crown copyright 2008.

Editorial address: Room 101, Richmond House, 79 Whitehall, London SW1A 2NS

Editor: Ricki Ostrov. Email: [cmoupdate@dh.gsi.gov.uk](mailto:cmoupdate@dh.gsi.gov.uk)