NEWS

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Ministers use veto to stop publication of risk register

MHRA is told to improve its safety monitoring after breast implant debacle

Ingrid Torjesen LONDON

A government review has concluded that the UK regulator of medical devices, the Medicines and Healthcare Products Regulatory Agency (MHRA), acted "reasonably" in communicating to the public safety issues related to breast implants made by the French company Poly Implant Prothèse (PIP).

The review was ordered by the health secretary for England, Andrew Lansley, in January, when it became clear that more than 40 000 UK women had been fitted with the defective implants, which had fraudulently been filled with non-medical grade silicone.[1]

Although the review, conducted by the health minister Earl Howe, exonerates the actions of the MHRA and the Department of Health, it says that both organisations need to learn lessons, particularly in how to communicate information promptly and appropriately to patients, the medical profession, the public, and the press.[2]

Although the MHRA was found to have followed clinical and scientific advice, the minister said, "There is room for improvement in the operation of the MHRA and the regulation of medical devices."

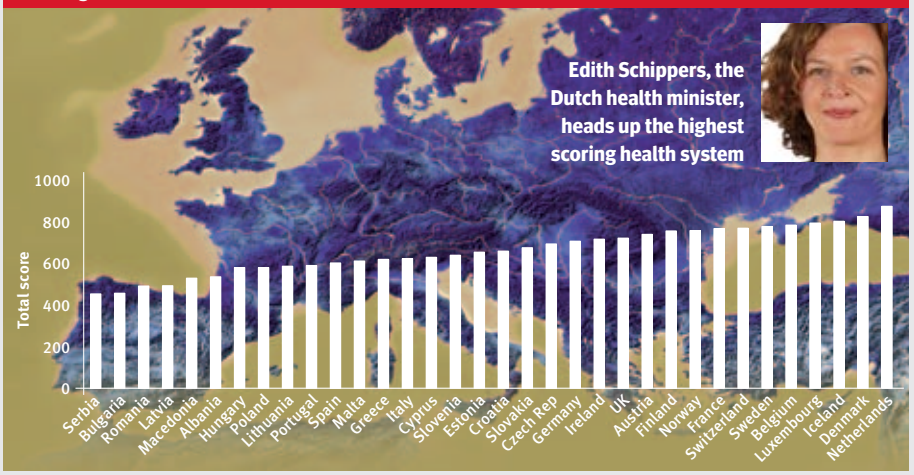
The role of the MHRA is to monitor all incidents reported to it, investigate them, and take action where necessary. The review says that improvements are needed in the gathering and analysis of data at national (the MHRA) and European levels. Better post-marketing surveillance needs to be implemented across Europe, and European regulators need to work together more closely and share information.

The review recommends that the MHRA should identify ways to gather better evidence on the safety of devices from a wider set of sources, including robust data from clinicians, and should routinely review information about specific high risk medical devices so that any safety problems are identified promptly. It should also review and develop its communications capability to ensure that it can communicate proactively with patients, professionals, the press, and the public.

Earl Howe said, "Regulation alone cannot prevent fraudulent activity such as this, but serious lessons must be learnt from this scandal."

Cite this as: *BMJ* 2012;344:e3456

Rankings in the Euro Health Consumer Index



UK comes 12th out of 34 in European healthcare league

Rory Watson BRUSSELS

For the third time in a row the Netherlands has come top in an exercise to gauge which country's residents are most satisfied with their healthcare system, have the best outcomes, and have the best access to healthcare and drugs.

The Netherlands came top of the Euro Health Consumer Index, which is produced by the Swedish think tank Health Consumer Powerhouse.[1] With 872 points out of a possible 1000, the country emerged well ahead of Denmark (822), Iceland (799), Luxembourg (791), and Belgium (783).

The United Kingdom, with 721 points, was placed equal 12th with Ireland and Austria among the 34 countries surveyed—two places higher than its ranking in the index produced in 2009.

Overall, the index points to continuous improvement in European healthcare, with better outcomes and conditions. The report says that fears of the economic downturn resulting in worse standards and services may have been somewhat exaggerated but points to three areas of concern. There is a tendency towards longer waiting times for expensive surgery in the countries most affected by the economic crisis. The share of private payment for healthcare is increasing; and there has been no improvement in access to new drugs.

Johan Hjertqvist, president of Health Consumer Powerhouse, notes that since the first index in 2005 healthcare users' influence has gradually grown: the gap between the health profession and patients is closing, as second opinions and medical records become tools of empowerment.

This can be seen in the Netherlands, which, according to the 2012 report, has arguably the best and most structured arrangement for the participation of patients' organisations in healthcare decision and policy making in Europe. The country also has many health insurance providers acting in competition and separate from hospitals and care givers.

The Dutch health system has dealt with one of its weak areas, accessibility, by establishing 160 primary care centres with surgeries open every day around the clock.

The report concludes that the large resources invested in the UK's health services have largely had the desired effect by reducing waiting times and tackling resistant hospital infections. The UK is among the best in Europe in terms of access to healthcare information and use of services such as electronic prescriptions and health records. Its health services also score well on the range and reach of public healthcare services, as measured by factors such as kidney transplantations, rate of mammography, and equity of healthcare.

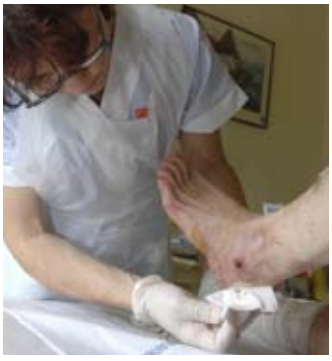
Cite this as: *BMJ* 2012;344:e3430

Lack of specialist diabetes teams in hospitals is "absolutely disgraceful," says NHS clinical lead

Ingrid Torjesen LONDON

The long term health and quality of life of patients with diabetes is being put at risk by the poor standard of care they receive in primary and secondary care, two reports have warned this week.

State of the Nation 2012: England, published by the charity Diabetes UK on Monday 14 May,[1] found that less than half of patients are receiving the basic standard regular care that they need: nine simple regular checks recommended by the national service framework for diabetes and the National Institute for Health and Clinical Excellence (NICE). Then on Thursday 17 May the national diabetes inpatient audit (NaDIA) showed that a third of patients with diabetes who are admitted to hospital in England and Wales are being put at risk of dangerously high or low blood glucose concentrations, with potentially fatal consequences, because of errors made in their treatment.[2]



JOSE OTO/SPL

Foot problems often lead to hospitalisation of diabetic people, yet access to podiatry has worsened

The audit, by the NHS Information Centre in partnership with Diabetes UK, looked at the care of 12 800 patients on the wards of 212 English and 18 Welsh hospitals during one week in October 2011. In the case of 3700 of the patients it identified at least one medication error. Where medication errors were made, patients had more than double the number of severe hypoglycaemic episodes. A further 65 patients developed the potentially fatal diabetic ketoacidosis.

Medication errors consisted of prescribing errors—the most common of which was failing to sign off on the patient's bedside chart that insulin had been given—and medication management errors, such as failing to adjust treatment for high blood sugar. Although medication errors improved slightly since the last audit in 2010, the number of cases of diabetic ketoacidosis rose by almost 50%: from 44 cases in 2010 to 65 in 2011.

The audit's clinical lead, Gerry Rayman, a consultant physician at Ipswich Hospital and an NHS clinical lead on diabetes, said that the performance of hospitals was "pretty poor." He described the finding of one in five diabetes inpatients having a hypoglycaemic event as "quite disturbing" and said that diabetic ketoacidosis "shouldn't occur at all, that's a disaster," and that there is "harm to patients in terms of not having their feet examined."

The most common diabetes complication responsible for hospital admission was a foot complication, yet access to podiatry worsened over the past year: the proportion of hospitals with no podiatry services rose from 27% in 2010 to 31% in 2011, the audit showed. Furthermore a third of hospitals did not have an inpatient diabetes nurse specialist.

Overall just over half of patients admitted to hospital needing referral to the specialist diabetes team were seen. Rayman said it was "absolutely disgraceful" that one in six people in hospital had diabetes but that, unlike for conditions such as stroke, hospitals did not appoint specific specialist teams of podiatrists, diabetes specialist nurses, and consultants to look after them.

Cite this as: *BMJ* 2012;344:e3449

UK doctors vote on industrial action over pensions

Helen Jaques BMJ

More than 100 000 doctors across the United Kingdom are being asked to vote on whether they are prepared to provide only urgent and emergency care for 24 hours in protest at the government's changes to the NHS pension scheme.

Should the BMA call for industrial action at the end of the month, doctors will have to attend their usual places of work as scheduled on the day of action but will undertake only treatments that cannot safely be postponed to another day.

Outpatient and GP appointments, non-urgent elective surgery, management meetings, and non-urgent administrative work would all be cancelled during the day of action.

The BMA says that the government's plans to alter the NHS pension scheme would mean that healthcare staff would have to work longer and contribute up to 14.5% of their pay into their pensions—almost twice as much as some other public sector workers on similar pay.

Under the changes the current final salary NHS pension scheme will be replaced by a career average scheme; the normal pension age for NHS staff will increase in line with the state pension age, due to rise to 68; and healthcare staff will have to pay more into the scheme.

The NHS pension scheme underwent a major overhaul only four years ago, the BMA says, and currently delivers a positive cash flow to the Treasury of £2.5bn (€3.1bn; $4bn) a year, so is "far from being a drain on taxpayers."

Read more about the pensions dispute and the planned industrial action in BMJ Careers (http://bit.ly/KK1eYo).

Cite this as: *BMJ* 2012;344:e3457

Cheap alcohol is to be outlawed in Scotland

Bryan Christie EDINBURGH

The days of cheap alcohol being sold in Scotland may soon be over as a minimum price of 50p a unit is set to be approved later this month.

It will mean that the cheapest bottle of spirits will rise in price from just under £9 to over £13 and cheap cider will more than double from £1.69 for two litres to £4.20. The aim is to reduce harmful drinking, and it has been estimated that the policy will save 300 lives a year in the first 10 years, result in 6500 fewer admissions to hospital, and produce overall savings of £942m.

Scotland's chief medical officer, Harry Burns, said, "For too long too many Scots have drunk too much, and now it's time for tough action to address this. Alcohol related disease and violence are costing the NHS millions of pounds every year, and this cannot be allowed to continue."

The Scottish parliament is certain to approve minimum pricing on 24 May, as there is support from all parties, with the exception of Labour. Implementation may not be straightforward, however, as the policy could face a challenge under European Union competition laws. Rules on free trade generally do not allow price fixing, which is seen as anticompetitive.

Cosmetic laser and light treatment is dangerously unregulated, warn experts

Jacqui Wise LONDON

Experts have called for cosmetic laser treatment to be regulated, warning that its misuse can result in skin burns, blistering, scarring, and permanent blindness.

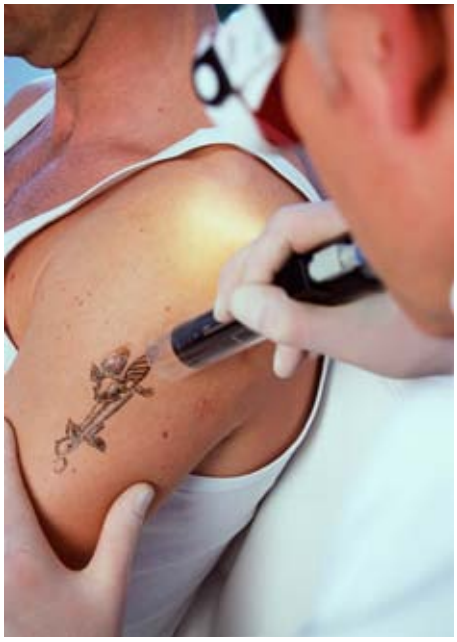
Laser and intense pulse light cosmetic treatments are becoming increasingly popular for the removal of hair, tattoos, and birthmarks as well as for skin "rejuvenation" or "resurfacing." These treatments are offered at an estimated 10 000 beauty salons and clinics in England, and there is no requirement that the practitioner is trained or registered.

Experts from the Society for Radiological Protection expressed their concerns at a press conference in London on 9 May ahead of the International Radiation Protection Association Congress in Glasgow later this month.

"Lasers, by their nature, are dangerous pieces of equipment," warned Harry Moseley, consultant clinical scientist and head of a dermatological laser clinic at Ninewells Hospital in Dundee. He said he knew of many cases where patients had been burned or scarred because of operator negligence. "We need to make sure the operators are properly trained and competent," he said.

Between 2000 and 2010 the Healthcare Commission and then the Care Quality Commission had responsibility for regulating premises that used lasers and intense pulse light cosmetic treatments under the Private and Voluntary Healthcare Act. But in October 2010 the Department of Health deregulated the use of such equipment in non-surgical settings, despite widespread opposition.

A Department of Health assessment in 2008 concluded that deregulation carried "minimal risk" to the public although it also estimated that there would be an extra 1700-3400 adverse incidents per year, which could cost an extra £900 000 to £1.8 million.



Training is the key to the safe use of lasers; in the wrong hands they can burn, blister, and scar

Moseley thought this figure was likely to be an underestimate because the lack of a central registration system means that there are no figures about adverse events. It is only if a clinic is taken to court that such information comes to light. Moseley said: "I suspect that nine out of 10 cases are settled out of court."

Graham Hart, chairman of the Society for Radiological Protection and an independent laser protection adviser, acknowledged that there were problems with the old system under the Care Quality Commission (CQC): "It was costly, bureaucratic, and difficult to run. Beauty salons had to register in the same way as independent hospitals." As a result only about 20% of premises were ever registered with the CQC, he said. But Hart added: "What we need is a simple, centrally regulated system in place."

Stanley Batchelor, head of radiation and laser safety at Guy's and St Thomas NHS Foundation Trust hospital, agreed: "It was over-regulation, to be honest, but now we have gone full swing."

Cite this as: *BMJ* 2012;344:e3346

Plans have also been announced to set a minimum price in England, but the minister for universities and sciences, David Willets, has warned in a letter of the possible dangers of "complex and costly" legal challenges.

The BMA in Scotland believes that the public health benefits of the policy are so great that these will counter any free trade arguments.

DANNY LAWSON/PA

Harry Burns: "For too long too many Scots have drunk too much"

Brian Keighley, chairman of BMA Scotland, said, "The trend for cheap alcohol and excessive consumption has a human cost. Alcohol related illness causes one death every three hours in Scotland."

The policy has wide support in Scotland, including from the Scottish Licensed Trade Association and some drink manufacturers.

Cite this as: *BMJ* 2012;344:e3425

Dying remains a taboo subject for patients and GPs, finds survey

Jacqui Wise LONDON

Many GPs are failing to discuss dying and end of life wishes with patients, says a survey commissioned by the Dying Matters Coalition, a group led by the National Council for Palliative Care.

The online survey of 2028 adults and 1000 GPs found that discussing dying and end of life plans remains a taboo for most people in Britain. The survey, carried out by the polling agency ComRes, found that only 27% of the public have asked a family member about their end of life wishes and less than a third (31%) have talked to someone about their own wishes. Just 37% of the public have written a will, 31% have registered to become an organ donor, and only 8% have written down their end of life wishes.

The survey also found that a third (35%) of GPs have not initiated a discussion with a patient about their end of life wishes or talked to a family member about end of life wishes (33%). The survey found that just 56% of GPs have written a will themselves and only 7% have written down their own end of life care preferences.

The coalition says that many people currently miss out on having their end of life wishes met. Although 70% of people in England would prefer to die at home, more than half of deaths take place in hospital.

The survey found that 71% of the public and 79% of GPs agree that people in Britain are uncomfortable discussing dying, death, and bereavement. Most people surveyed could see the benefits of more open discussion about dying.

Mayur Lakhani, a Loughborough GP and chairman of the Dying Matters Coalition, said: "Until we have a more open approach to discussing dying we risk continuing to see people die without their wishes being met. By raising the issue of end of life care earlier with people who have advancing disease, doctors can also play a key role in ensuring people get the type of end of life care and support they need and want."

Eve Richardson, chief executive of the Dying Matters Coalition and the National Council for Palliative Care, commented: "Every minute someone in England dies, but many people, including GPs, still feel uncomfortable discussing end of life issues. Talking about dying is in everyone's interests. That's why we want as many people as possible to discuss their end of life wishes and to take small actions such as registering to become an organ donor or making an effort to speak to anyone they know who is nearing the end of their life or who has been bereaved."

Cite this as: *BMJ* 2012;344:e3356

IN BRIEF

Dutch mobile euthanasia team received 200 requests in two months: The "life's end" clinic launched by the Dutch Right to Die Society in March[1] has received 200 euthanasia requests in its first two months. Only three requests have been carried out. Other people either died naturally or failed the clinic's criteria, which include first discussing their request with their own doctor (www.levenseindekliniek.nl).

Mortality from cancer in people in their 50s fell by 40% in past 40 years: Cancer Research UK reports a reduction in deaths from cancer from 310 per 100 000 people in their 50s in 1971 to around 185 per 100 000 in 2010, which it attributes to a fall in the number of smokers, better diagnostic techniques, and more effective treatments.

FDA cautions against experimental "liberation therapy": The US Food and Drug Administration has issued warnings about an experimental procedure used to treat chronic cerebrospinal venous insufficiency, a condition thought, though not proved, to be associated with multiple sclerosis. "Liberation therapy," which uses balloon angioplasty to widen narrowed veins in the neck and chest, has not been approved by the FDA. The agency has been alerted to incidents of death, stroke, bleeding, and clots after the treatment.

Nurses' leaders criticise cutbacks to community care: The Royal College of Nursing has described as a "façade" the UK coalition government's plans to transfer care of patients from hospitals to the community while implementing policies that cut nursing jobs. The college has warned that NHS reforms are putting up to 60 000 nursing posts at risk, including those of community nurses.

Adverse effects of alternative therapies are under-reported: Studies assessing the effectiveness of alternative therapies may be neglecting to mention adverse effects. A systematic review conducted by Edzard Ernst, professor of complementary medicine at the University of Exeter, found that 29 of the 60 randomised controlled trials of chiropractic had failed to cite side effects of the therapy.[2] "Alternative medicines might be safe, but we simply cannot be sure that this assumption is correct," said Ernst.

Cite this as: *BMJ* 2012;344:e3432

EU law forces UK ministers to rethink advice on food labelling

Zosia Kmietowicz LONDON

Health ministers from the four countries of the UK have launched a consultation on what system food manufacturers should use to show consumers the nutritional content of products.

The move comes after the European Union passed legislation last July designed to improve the clarity and degree of information provided on food packaging across the EU.[1]

The new rules make it compulsory for the first time for food labels to include details of the energy, protein, fat, saturated fat, carbohydrate, sugar, and salt levels. They come into force in 2016.

John Dalli, the EU health and consumer commissioner, said at the time that the new measures would empower consumers and "help them to make more informed decisions when buying food." They would also contribute to efforts to tackle obesity and chronic diseases.

Around 80% of food products sold in the UK already have some form of labelling on the front of the packaging, says the Department of Health for England. But different retailers and manufacturers use different labelling systems, which can be confusing for consumers.

Some use labels with guideline daily amounts (GDAs), which give approximate amounts of particular nutrients and energy needed for a healthy diet; some use traffic light colour coding (red, amber, green) to highlight high fat, sugar, or salt content; and some use both.

PA

Sainsbury's uses the traffic light colour coding system on its products

The British Heart Foundation is backing labelling that uses traffic light colours combined with GDAs and the words "high," "medium," and "low."

Julia Waltham, the foundation's advocacy manager, said, "This isn't about telling people what should or shouldn't be in their baskets. This is about making healthy choices easy for busy shoppers.

More psychiatrists attack plans for *DSM-5*

Geoff Watts LONDON

The authors of the 5th edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*), due to be published in May 2013, have responded to previous criticisms of their text by announcing a further series of changes.[1]

But far from mollifying their critics, these concessions have served to ignite a further and still more vituperative barrage of dissent.

The list of topics under reconsideration or already subject to change can be found on the *DSM-5* website.[2] It includes the proposed "attenuated psychosis syndrome," which is slated for further study, and also major depressive disorder. Here the authors have added a footnote "to clarify the difference between normal bereavement associated with a significant loss and a diagnosis of a mental disorder." One criticism of *DSM-5* has been its propensity for medicalising normal human behaviour.

"It is a great relief that the APA [American Psychiatric Association] is dropping the attenuated psychosis syndrome," said Robin Murray of London's Institute of Psychiatry. "It was always a mystery why this was being proposed since all the research evidence demonstrates that the vast majority of people who meet the proposed criteria will never develop psychosis.

"Three cheers—even the APA can be persuaded by evidence to change its mind."

But not to change it sufficiently, according to the fiercest critics. While commending the *DSM-5* authors for "reconsidering some of their most unfortunate mistakes," the clinical psychologist Peter Kinderman of the University of Liverpool added that the manual remains, fundamentally, a bad system.

"The very minor revisions recently announced do not constitute the wholesale revision that is called for," he said. "It would be very unfortunate if these minor changes were to be used to suggest that the task force has listened in any meaningful way to critics."

Allen Frances, an emeritus professor of psychiatry at Duke University, North Carolina, and chairman of the *DSM-4* steering committee, shares this view. "This is only a first small step toward desperately needed *DSM-5* reform," he said. "In my view, *DSM-5* needs to be kept back

"Front of pack labels using traffic light colours, GDAs, and the words 'high,' 'medium,' and 'low' will help everyone make more informed choices at a glance, before they head to the till."

Until now the UK government has been relying on "responsibility deals" with the food industry to try to make healthier food options available, but these deals have been widely criticised.

In March England's health secretary, Andrew Lansley, launched a scheme whose goal was to cut five billion calories from the national diet, with 17 companies signing up. Coca-Cola Great Britain, for example, said that it would reduce the energy content of some of its soft drink brands by at least 30% by 2014.[2]

At the time Lindsey Davies, president of the Faculty of Public Health, welcomed attempts to cut food products' energy content but said that more companies needed to be involved.

The faculty supports the Food Standards Agency's "traffic light labelling," which it says helps people compare products rapidly and is particularly useful for ready meals, cereals, and processed meat, which often have unexpectedly high levels of concealed fat, sugars, and salt.

"We want all food labels to use this system so that customers can make informed choices about the food they buy," said Davies.

Officials in all the UK countries intend to share the responses from the consultation, which runs until 6 August.

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for an additional year to allow for independent review, to clean up its obscure writing, and for retesting to ensure that adequate reliability has finally been achieved."

The most stinging rebuff came from another clinical psychologist, Mark Rapley of the University of East London. "The APA insists that psychiatry is a science," he said, before posing some barbed questions. "Why, I wonder, does the Royal College of Physicians not seek website comments from the public on the diagnosis of breast cancer . . . When, oh, when will the Geological Society finally solicit 'views from the general public' on the appropriateness of diagnosing granite as an igneous rock?"

Responding to his own questions he went on: "Real sciences do not decide on the existence and nature of the phenomena they are dealing with via a show of hands with a vested interest and pharmaceutical industry sponsorship."

Lucy Johnstone, a south Wales consultant clinical psychologist, was another expert who voiced her unhappiness. She accused the authors of ignoring "many of the most fundamental criticisms about the reliability and validity of psychiatric diagnostic categories."

Cite this as: *BMJ* 2012;344:e3357

Abbott pays $1.6bn for promoting off-label use of valproic acid

Bob Roehr WASHINGTON, DC

The drug company Abbott Laboratories has agreed to pay $1.6bn (£0.9bn) in penalties for improper promotion of the drug Depakote (valproic acid) in the US. The settlement is the second largest by a drug manufacturer and ends a four year investigation by federal and state officials.

The company acknowledged training a workforce to promote off-label use of the drug to nursing homes to control agitation and aggression in older schizophrenia patients and in patients with dementia. The judgment says that Abbott also made illegal payments to doctors and pharmacists to encourage them to promote or prescribe valproic acid outside its licensed indications.

"Not only did Abbott engage in off-label promotion, but it targeted elderly dementia patients and downplayed the risks apparent from its own clinical trials," said Tony West, acting associate attorney general at a news conference in Washington, DC, on 7 May.

Abbott closed a trial of Depakote in patients with dementia in 1999 because of increased incidents of adverse events.

The Justice Department said Abbott waited nearly two years to tell its sales force that a schizophrenia trial that looked at adding Depakote to another drug failed to show any statistically significant benefit beyond the initial drug. And it waited four years before publishing the trial results. It continued to promote combination use of Depakote to treat schizophrenia throughout the entire period.

"As this criminal and civil resolution demonstrates, those who put profits ahead of patients will pay a hefty price," said West.

TIM BOYLE/GETTY IMAGES

Abbott targeted elderly patients and downplayed the risks from its own trials, said West

The settlement consists of $800m in civil charges and $700m in criminal charges that will go to the federal government and states. States will receive an additional $100m to resolve consumer protection claims.

Abbott will be on probation for five years, having to regularly report its compliance activities to the court. It also has entered into a corporate integrity agreement with the Department of Health and Human Services Office of the Inspector General, which holds the company's board of directors responsible for compliance.

Former Abbott sales representatives turned whistleblowers will share $84m for helping to uncover and prove the illegal activity, as the law allows.

James Cole, deputy attorney general, said the settlement is important for what it says about the Obama administration's "efforts to protect the integrity of programs like Medicare and Medicaid." A special antifraud unit formed in May 2009 has recovered $8.85bn through settlements and other legal actions.

Cite this as: *BMJ* 2012;344:e3343

Payment to help quit smoking "works," says study

Bryan Christie, EDINBURGH

A scheme that offers a payment of £12.50 (€15; $20) a week in food vouchers to encourage people living in deprived circumstances to give up smoking is being hailed a success.

A two year evaluation of the quit4u programme in Dundee concludes that it "offers an effective model for engaging and supporting smokers in deprived areas to quit."

When the scheme was launched in 2009, it was hoped that half of those who took part would give up.[1] At one month, the quit rate was 50%, compared with 33.7% for other smoking cessation programmes in Scotland that do not offer a financial incentive. At three months, it was 30.7 % against 14.2 % for other services.

However, at 12 months only 9% of those on quit4u were still not smoking, just above the 6.5% rate for other services. The evaluation, carried out by NHS Health Scotland, also acknowledges that there is some uncertainty about the exact size of these 12 month differences because of difficulties in comparing people who were lost to follow-up.

Despite this, the evaluation says the programme is highly cost effective, and Scotland's public health minister, Michael Matheson, has recommended it to other Scottish health boards.

Recruitment to quit4u exceeded expectations with just over 2000 people signing up to the programme in the two years from March 2009.

The full evaluation report is available at www.healthscotland.com/documents/5827.aspx.

Cite this as: *BMJ* 2012;344:e3327

Insecticide resistance threatens malaria control

WHO

Insecticide resistance could wipe out much of the progress made on malaria control, said Newman

Peter Moszynski LONDON

Concerned by the emerging threat that resistance to insecticides poses to programmes to control malaria vectors, the World Health Organization this week launched a new global plan for insecticide resistance management.

WHO says, "Vector control is a central, critical component of all malaria control strategies." Control relies primarily on two interventions: long lasting insecticidal nets and indoor residual spraying. Use of both has increased significantly over the past decade as part of a drive towards universal coverage of all populations at risk, "saving hundreds of thousands of lives."

WHO says that resistance is now reported in nearly two third of countries with ongoing malaria transmission and affects all major vector species and all classes of insecticide.

Currently only four classes of insecticide are recommended for vector control: pyrethroids, organochlorines (such as dichlorodiphenyltrichloroethane (DDT)), organophosphates, and carbamates.

Most sprays and all net formulations use pyrethroids as their active ingredient. Robert Newman, director of WHO's global malaria programme, says that, from the point of view "of both safety and effectiveness, pyrethroids are the best insecticides ever developed for public health use."

Newman said that the main factor driving resistance has been this heavy reliance on a single class of insecticides, the pyrethroids, for which it was essential to find a replacement. Although there were alternatives available for spraying, another insecticide that could survive the manufacturing process for making bed nets had not yet been found.

Although he emphasised that, for the time being, "existing malaria prevention tools remain highly effective in all endemic countries," he said that, if nothing were done and insecticide resistance eventually led to widespread failure of pyrethroids, "the public health consequences would be devastating: much of the progress achieved in reducing the burden of malaria would be lost."

WHO's new global plan has a five point strategy, which will cost $200m (£125m) a year:

- Plan and implement insecticide resistance management strategies in malaria endemic countries
- Ensure proper, timely entomological and resistance monitoring and effective data management
- Develop new, innovative vector control tools
- Fill gaps in knowledge on mechanisms of insecticide resistance and the effects of current insecticide resistance management approaches, and
- Ensure that enabling mechanisms (advocacy, personnel, and funding) are in place.

Newman said, "We currently have a lot of eggs in one basket. We don't want to repeat the mistakes of the past by just relying on one compound. We need to find alternatives."

To this end the Innovative Vector Control Consortium is currently researching new products, including nets without pyrethroids and nets treated with two classes of insecticides, which may become available in 3-5 years.

More information is at www.who.int/malaria/en.

Cite this as: *BMJ* 2012;344:e3416Z

Hospitals in Wales need to reconfigure to improve patient outcomes, says report

Matthew Limb LONDON

Hospital services in Wales need to be reorganised urgently, as some are close to "collapse" despite a decade of improved NHS performance, says an independent review.

The report highlights increasing demand for care and acute pressure on medical staffing in some specialties.[1]

It says that patients' lives may be at risk and argues that there is a "strong case" for centralising some services, such as trauma, orthopaedics, and paediatrics, to improve safety and the quality of care.

The review was carried out by Marcus Longley, a professor at the Welsh Institute for Health and Social Care, University of Glamorgan.

He says in the report, "There is now convincing evidence that hospital services in Wales are not always configured optimally, and that patient care may suffer.

"Some services will collapse because of shortages of key staff, if changes are not made proactively."

The independent research paper was drawn up to help patients assess the plans being developed by Welsh health boards to determine the future of services.

He said that the evidence was not always unequivocal but that it was clear that the current configuration of hospital services was not delivering the best outcomes uniformly across Wales.

In some specialties—notably major trauma, general trauma and emergency care, stroke care, maternity and newborn care, and paediatrics—the way services are organised "probably falls well short of what the evidence suggests is optimal," the review found.

It highlights acute pressure on medical staff in paediatrics, emergency medicine, core surgical training, and psychiatry, and more generally in remote areas of the country.

The report says, "A perfect storm has developed, with more doctors in our hospitals, but actually less availability in comparison with demand."

The review does not name hospital units or particular services that should be closed. But it says that the evidence points to a need for fewer inpatient paediatric units and for centralising major trauma services to improve survival rates.

Cite this as: *BMJ* 2012;344:e3413