NEWS

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Head of private firm who brokered first deal to run NHS hospital steps down

Clinical networks for cancer and cardiac care report big funding cuts

Susan Mayor LONDON

The clinical networks that coordinate care of NHS patients with cancer and those with heart disease and stroke are reporting major cuts in their budgets, show figures collected in a survey by the Labour Party, published this week.[1]

The survey asked the 28 cancer networks and 28 stroke and heart networks in England to provide information on their funding, under the Freedom of Information Act; more than three quarters responded.

Cancer networks reported that their funding had been cut by around 25% and that 73 staff posts (a fifth of the total) had been lost since 2009-10. Stroke and heart networks said that their funding had been cut by 12% and that 38 staff posts (16% of the total) had gone over the same period.

"Ministers have repeatedly promised to protect the funding for clinical networks," said Liz Kendall, Labour's shadow minister for care and older people. "Doctors, nurses, and other experts brought together by cancer and cardiac networks are crucial to improving patient care for Britain's biggest killers. The government should be working to support these local specialists."

The Department of Health said in a statement that funding for clinical networks had not been cut and that £33m (€41m; $53m) had been invested each year since 2009 to fund cancer, cardiac, and stroke networks. It said that the NHS Commissioning Board planned to extend the range of clinical networks and to increase funding next year.

New clinical networks in maternity and children's services and in mental health will be introduced in April 2013,[2] but the number of networks will be cut from 28 to 12 both in cancer and in heart disease and stroke.

Labour's survey said that the budget cuts and reduced staffing being reported by networks meant that they were having to reduce existing and future projects to improve patient care and to reject additional grants from charities.

"The government's NHS reorganisation is causing huge uncertainty and confusion about the future of clinical networks," said Kendall.

Cite this as: *BMJ* 2012;345:e8422

End hospital care for people with learning disabilities by 2014

Ingrid Torjesen LONDON

The Department of Health for England has pledged to move as many people as possible with a learning disability or autism out of inpatient hospital care and into care in a community setting.

The commitment was made in the department's final report into the neglect and abuse of people with learning disabilities at Winterbourne View Hospital in Bristol, which was published on Monday 10 December.[1] The abuse at the hospital was uncovered last year by the BBC's *Panorama* programme.[2]

The minister for care and support services, Norman Lamb, told a press conference: "I thought we had addressed the problem of institutionalised care some time ago, then you discover that it is quietly going up again."

A "complete culture change" in society was needed, he said. "Would we ever tolerate someone with cancer getting the wrong sort of treatment or the wrong sort of care? No, we wouldn't. Yet we have for too long tolerated people with learning disabilities put into the wrong settings."

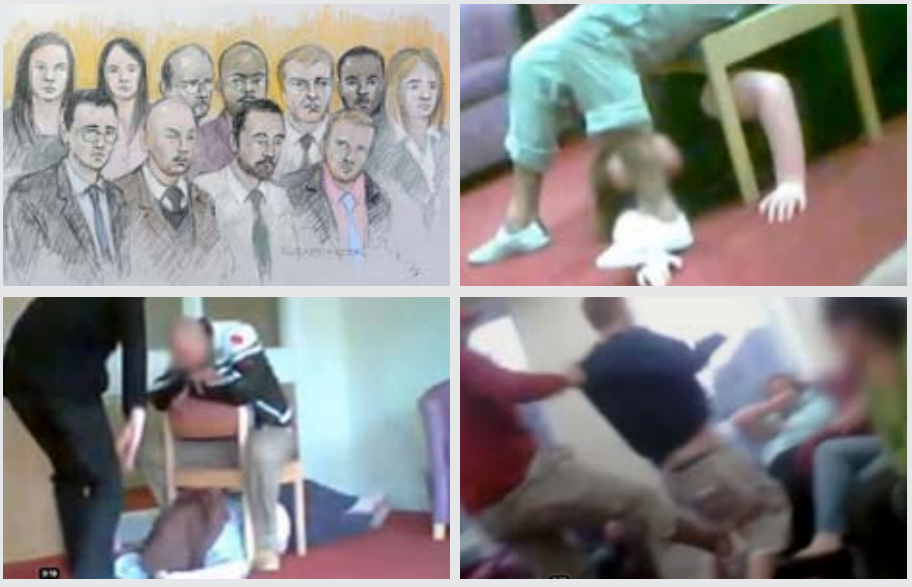
The report outlines the steps that should be taken to bring about this cultural shift. By April next year primary care trusts must have produced a register of all people with learning disabilities or autism in NHS funded care who have mental health conditions and who exhibit challenging behaviour. The cases of these people who live in hospitals or large scale residential care must be reviewed by June, and anyone considered to be in hospital inappropriately must be moved to a community based setting by June 2014.

Jo Webber, interim director of policy at the NHS Confederation, which represents most NHS organisations, said that the six month deadline was "highly ambitious."

An estimated 3400 people are in NHS funded learning disability inpatient beds in England. Around 1200 of these are in assessment and treatment units; these are supposed to be short stay facilities, but an investigation by the Care Quality Commission found that some people were there for years.[3] Lamb said that no more than 400 people should be within assessment and treatment centres at one time and that the large ones were "inappropriate settings" and must close.

Rather than sending people to residential units far from home, every area will be required to provide high quality care and support services by April 2014.

Cite this as: *BMJ* 2012;345:e8431



Winterbourne View: care home workers (top left) who were caught on camera abusing patients

PA

IN BRIEF

Doctor held in UAE may soon be released: The lawyers for Cyril Karabus, the South African doctor accused of manslaughter over the death of a patient in the United Arab Emirates,[1] are hopeful that he may soon be released. A hearing on 6 December was adjourned when the prosecution was still unable to produce the medical files relevant to the case, weeks after the defence requested them. The judge ordered another hearing on 13 December and told the prosecution that the situation "could not carry on" if the documents weren't found.

Needlestick injuries are still a problem in NHS: The number of reports of needlestick injuries that exposed healthcare staff to bloodborne viruses was 541 in 2011, twice as many as in 2002, when 271 were reported, says a report from the Health Protection Agency.[2] But these reports were only a fraction of needlestick injuries that would have occurred, it says. Between 2008 and 2011 there were five transmissions from patient to healthcare worker of hepatitis C virus in the United Kingdom, bringing the total number of these cases to 20.

GMC provides new helpline for advice on patient safety: The General Medical Council has launched a confidential helpline for doctors who want advice on patient safety issues and to raise serious concerns that they feel unable to report at a local level (0161 923 6399). It has also set up an online decision aid (www.gmc-uk.org/guidance/ethical_guidance/decision_tool.asp) to help doctors report concerns about patient safety. The services follow the publication of new GMC guidance earlier this year, *Raising and Acting on Concerns about Patient Safety*.[3]

Cut price vaccines should be available to more agencies, says MSF: Médecins Sans Frontières has called for the GAVI Alliance to systematically extend the prices it gets for vaccines to other agencies, such as MSF, that are often well placed to reach unvaccinated children. In 2011 estimates indicated that 22.4 million babies were unvaccinated. But at the moment MSF has to negotiate access to vaccines on a cumbersome case by case basis, which can take months or fail altogether, it says.

Cite this as: *BMJ* 2012;345:e8417

NICE to look again at basis for approving oseltamivir

BMJ OPEN DATA CAMPAIGN

REX

Michael Rawlins and Fiona Godlee exchanged letters about how NICE approved oseltamivir

Zosia Kmietowicz BMJ

The chairman of the UK National Institute for Health and Clinical Excellence has said that if Roche were found to have withheld relevant data on its drug oseltamivir (Tamiflu) the company's medical director at the time could be reported to the General Medical Council.

Michael Rawlins was responding to a letter from the *BMJ*'s editor in chief, Fiona Godlee, in which she asked NICE to withdraw its guidance on oseltamivir until it "has received and reviewed the full clinical trial data." The request was part of the *BMJ*'s open data campaign (bmj.com/tamiflu) to persuade Roche to make key trial data on oseltamivir available for independent scrutiny.

In her letter (Observations, p 27) Godlee said that she was perplexed that NICE did not require all clinical trial data when it was deciding whether a drug should be purchased by the NHS.[1]

She pointed out that although Roche could claim in Europe that oseltamivir reduced the rate of complications, such as bronchitis and pneumonia, it could not do so in the United States because the US Food and Drug Administration "performed a more thorough assessment of the trial data and found no good evidence of an effect on rates of complications."

Rawlins said that he was making further inquiries about NICE's appraisal of oseltamivir. But for now, he said it would be inappropriate

AstraZeneca must pay €52.5m fine for anticompetitive tactics over ulcer drug, European court rules

Nigel Hawkes LONDON

The drug company AstraZeneca will have to pay a fine of €52.5m (£42.4m; $68m) for trying to prevent the marketing of cheaper generic versions of its blockbuster ulcer treatment omeprazole (marketed in the UK as Losec) after its appeal against a ruling made by the European Commission was rejected in the European Court of Justice.

The commission welcomed the decision, saying that it showed that misuse of drug regulatory procedures could amount to an abuse of antitrust rules. AstraZeneca said that it was disappointed and that it was committed to doing business in an ethical and proper manner.

The dispute between the company and the commission is long standing and relates to activities undertaken by AstraZeneca between 1993 and 2000. After a complaint by two manufacturers of generic drugs, the commission launched an investigation in 1999 into two allegations: that AstraZeneca had lied to patent lawyers, patent offices, and courts in several member states over the date at which omeprazole had originally been given marketing authorisation; and that by replacing a capsule formulation of the drug with tablets and asking for the capsule authorisation to be withdrawn it had made it impossible for manufacturers of generic drugs to market the capsules.

In 2005 the commission found the case proved and imposed a fine of €60m. On appeal, the General Court of the European Union upheld the finding but reduced the fine to €52.5m. AstraZeneca then appealed to the EU's highest court, the European Court of Justice, which dismissed the appeal in a ruling on 6 December. Contrary to what the company claimed, the General Court had not made any errors in law and was entitled to rule that AstraZeneca's actions were an abuse of its dominant market position, the Court of Justice concluded.

At its peak in 2000 omeprazole was the world's best selling drug, with sales in the United States worth $6bn a year. Although the patent expired in 2001, AstraZeneca was able to delay competition from generic versions by using methods some of which have now been found to be illegal in Europe.

FINN BARR WEBSTER/ALAMY

AstraZeneca was found to have lied about the date of authorisation

The London law firm Linklaters said that the judgment was significant because it meant that companies with a dominant position in the market could not delay generic competition by tinkering with marketing authorisations.

Cite this as: *BMJ* 2012;345:e8396

for NICE to withdraw its guidance on oseltamivir for the treatment of influenza because "the additional clinical trial data might, for example, support the use of oseltamivir under the circumstance we have already proposed."[2]

He said that NICE requires "full access to all the information that is available to marketing authorisation holders of medicines when they are subject to a NICE technology appraisal." In this case the authorisation holder is the European Medicines Agency. He added, "Pharmaceutical physicians are very well aware of their obligations and if a medical director were knowingly to withhold relevant data the Institute would report the matter to the General Medical Council."

Cochrane researchers have said that at least 123 trials on oseltamivir were unpublished. They needed Roche to release the data from these trials because the company had not supplied them to the European Medicines Agency.[3]

In a statement the company said, "Roche has provided the relevant information pertinent to the Tamiflu appraisal as per NICE's requirements, and we follow their processes."

Cite this as: *BMJ* 2012;345:e8408

Performance data on surgeons will be published

Gareth Iacobucci BMJ

League tables showing the results of individual surgeons working in the NHS in England are to be published within two years, the NHS's medical director has announced.

Bruce Keogh said that the move, backed by the health secretary, Jeremy Hunt, would drive improvements in standards by forcing surgeons to deal with performance problems in an open and transparent manner.

The BMA cautiously lent its backing to the move but warned that surgeons might be deterred from taking on complex and high risk procedures if they were judged solely by "simplistic league tables."

The NHS mandate, published last month by the Department of Health,[1] pledged to expose "variation and unacceptable practice" in the health service by publishing the results of "consultant-led teams."

Discussing the plans in an interview for BBC Radio 4's *The Report*,[2] Keogh, charged with implementing the mandate as national medical director of the NHS Commissioning Board, said that they would include publishing the results of individual surgeons.

The proposal to publish individual surgeon data was first floated in 2001 by Ian Kennedy, who led an inquiry into the high number of deaths of babies from heart surgery at Bristol Royal Infirmary. Individual results of heart surgeons are now published, but the policy has yet to be implemented for all surgeons.

The case of Rob Jones, an obstetrician and gynaecologist from Cornwall who was suspended in May 2012 after a review by the Royal College of Obstetricians and Gynaecologists, has raised the profile of the issue, after it emerged that Jones was able to continue operating despite numerous inquiries into his clinical competence over 12 years.[3]

Keogh, himself a former cardiothoracic surgeon, said that the Jones case showed that the current system was not working.

Cite this as: *BMJ* 2012;345:e8377

NHS

Sally Davies said genetic information offers huge potential to target and develop new treatments

Cameron announces £100m for "unlocking the power of DNA data"

Nigel Hawkes LONDON

Up to 100 000 patients in England with cancer or rare diseases are to have their entire genome sequenced over the next three to five years, the prime minister announced on 10 December. And £100m of new money will be earmarked for sequencing, for training geneticists, and for improving NHS systems to make best use of the new data.

"By unlocking the power of DNA data, the NHS will lead the global race for better tests, better drugs, and, above all, better care," David Cameron said. "If we get this right, we could transform how we diagnose and treat our most complex diseases, not only here but across the world, while enabling our best scientists to discover the next wonder drug or breakthrough technology."

Sally Davies, the chief medical officer, said, "Understanding and harnessing genetic information offers huge potential to target effective treatments and develop new treatments and cures. Single gene testing is already available across the NHS, ranging from diagnosing cancers to assessing patients' risk of suffering side effects from treatment.

"At the moment these tests focus on diseases caused by changes in a single gene. This funding opens up the possibility of being able to look at the three billion DNA pieces in each of us so we can get a greater understanding of the complex relationship between our genes and lifestyle."

To the relief of some geneticists, the plan falls short of the national DNA database recommended a year ago by the Human Genomics Strategy Group.[1] Its chairman, John Bell, said at the time that it would be almost impossible to go forward with personalised medicine without such a database, but critics warned that it would be a waste of money.

The government's plan involves smaller numbers and focuses on cancer and rare diseases. "I think geneticists will welcome this focus as a good place to start," said Frances Flinter, professor of clinical genetics at King's College London and chairwoman of the National Clinical Reference Group for Medical Genetics, which reports to the NHS Commissioning Board. "It's hugely aspirational, rather light on detail, and it looks as if the work will be led by the NHS Commissioning Board, which is right because it leads commissioning for specialised services and has an oversight of the whole NHS.

"Research is needed to fully interpret the findings and understand their implications in order to maximise the potential benefit to patients," she added. "It is sensible to start with DNA from patients who have rare genetic diseases or cancer, but it is important that patients are confident that their personal data will be protected."

Cite this as: *BMJ* 2012;345:e8413

Hospital cannot withhold "futile" treatment if man's condition worsens

Clare Dyer BMJ

A High Court judge has refused to give a hospital trust caring for a man deemed minimally conscious by clinicians a declaration that it need not offer him "futile and burdensome" treatment if his condition deteriorated.

The unnamed trust wanted a declaration that it need not give David James, a 68 year old former musician, cardiopulmonary resuscitation, renal replacement treatment, or invasive support for chronic low blood pressure in an attempt to keep him alive.

But at the Court of Protection Mr Justice Peter Jackson refused the declaration, which was strongly opposed by James's family. The judge said, "Although Mr James's condition is in many respects grim, I am not persuaded that treatment would be futile or overly burdensome or that there is no prospect of recovery.

"Although the burdens of treatment are very great indeed, they have to be weighed against the benefits of a continued existence." He added that recovery did not mean a return to full health but the resumption of a quality of life that James would consider worthwhile.

The judge said that doctors had undervalued the limited quality of life that the patient could still enjoy. He also noted that James's medical condition was "fluctuating," adding that it would not be right to validate in advance the withholding of the treatments in all circumstances.

James, a well known guitarist in Liverpool, survived colon cancer 11 years ago. He walked into hospital last May with constipation but contracted pneumonia and had a stroke that left him with brain damage. He has also sustained kidney damage and had a cardiac arrest and is dependent on a ventilator.

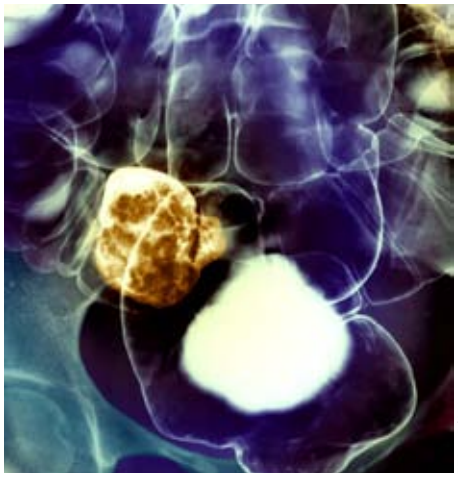
Doctors told the court that he was prone to septic episodes that made further brain damage likely and irreversible.

The head of the team treating him at the trust, which cannot be named for legal reasons, told the judge that James was in a minimally conscious state. An independent doctor confirmed the diagnosis and estimated his chance of leaving hospital as less than 1%.

The official solicitor for England and Wales, acting for the patient, agreed with the trust that treatment would be disproportionate.

The judge refused the trust permission to appeal, but it can still ask the Court of Appeal to hear the case. The trust said that it was reviewing the judgment and considering the next steps.

Cite this as: *BMJ* 2012;345:e8404



ZEPHYR/SPL

Six trusts are going to invite people aged over 55 to be screened for bowel cancer (above)

NHS is to pilot new screening tests for bowel and cervical cancer

Nigel Hawkes LONDON

New cancer screening tests are to be piloted in the NHS in England, the health secretary announced this week at the Britain against Cancer conference in London.

Condemning the variation in outcomes among people who develop bowel cancer, with five year survival from bowel cancer ranging from 68% of patients in the best areas to 40% in the worst, Jeremy Hunt said, "This cannot be right."

He announced that pilot schemes using flexible sigmoidoscopy to screen for bowel cancer would be launched next March by trusts in six areas: Norwich, south Tyneside, northwest London, Surrey, west Kent, and Wolverhampton. All people aged over 55 would be invited.

Deborah Alsina, chief executive of the charity Bowel Cancer UK, welcomed the announcement. She said, "This simple test can help to prevent bowel cancer from developing and can also help detect cancer at an early stage. Early diagnosis is vital if we are to save lives from bowel cancer. We strongly recommend people take part in the programme when it becomes available in their area."

Hunt also announced changes to screening for cervical cancer. Some areas will pilot the introduction of tests that detect the presence of human papillomavirus (HPV), the cause of the great majority of cases. Under the existing cervical smear screening programme women over the age of 25 are tested every three years, but the more sensitive HPV test means that screening could take place every 6-10 years.

The test will be piloted in Liverpool, Manchester, northwest London, Bristol, Sheffield, and Norwich. The bowel screening pilot is expected to cost £2m (€2.5m; $3.2m), the HPV pilot £1.2m.

Research published in the *British Journal of Cancer* earlier this year showed that testing for HPV, followed by a smear test in women who tested positive, was the most effective approach.[1] Using this combination approach would mean that only women at the highest risk would be referred for further testing, reducing unnecessary examinations.

Hunt spoke to a sceptical audience, which in a vote earlier in the day had shown little enthusiasm for the changes—three quarters saying that they would not lead to better cancer outcomes. Hunt said that his ambition was to make the country "among the best places in Europe" for treatment of cancer, heart disease, respiratory disease, and liver disease.

Labour's shadow health secretary, Andy Burnham, speaking earlier in the day, said he regretted that the government had failed to build on the progress made by Labour in tackling cancer. "Cancer networks, which were instrumental in driving improvements, now face reduced funding," he said.

Cite this as: *BMJ* 2012;345:e8455

Chancellor unveils "son of PFI" to build next wave of hospitals

The first revamped PFI scheme will be for a new hospital in Smethwick, shown above in a computer generated image

Ingrid Torjesen LONDON

A new wave of hospitals will be built under a revamped version of the discredited private finance initiative (PFI) scheme, the chancellor of the exchequer, George Osborne, announced to the House of Commons in his autumn statement.

In a document published the same day outlining how the new public-private partnerships, to be known as PFI2, would work, the Treasury admitted that the existing PFI scheme had "become tarnished by its waste, inflexibility and lack of transparency."[1]

Audit finds 24 000 premature deaths in 2010-11 among people with diabetes in England and Wales

Zosia Kmietowicz BMJ

An audit of nearly two million people with diabetes in England and Wales has found that in 2010-11 about 45 000 of them had heart failure, 17 700 (65%) more than the number that would be expected in the general population (27 300).[1]

However, the risk of heart failure varied widely across England and Wales. After standardisation to minimise differences in local populations, such as age and sex, the risk of heart failure in patients with diabetes in Havering was 27% more than the general population, while in Kensington and Chelsea it was 164% higher.

The national diabetes audit of diabetes related complications and mortality quantified the risks of cardiovascular complications among people with diabetes. It included 85% of people with diabetes in England and 54% in Wales—just under two million people whose complications were recorded between 1 April 2010 and 31 March 2011. It was carried out by the NHS Health and Social Care Information Centre in partnership with the charity Diabetes UK.

It found that 14 500 people with diabetes had a heart attack in 2010-11, 48% more than the 9800 expected cases. There were also an excess of 3600 strokes among people with diabetes (25% more than expected) and 5800 more cases of people needing renal replacement therapy (114% more than expected).

In 2010-11 around 3000 people with diabetes needed a minor amputation, which was 331% more than the 700 cases expected, while major amputations were 210% more common than expected (1700 cases, rather than the 600).

Overall, people with diabetes were found to have a 40% higher risk of death than the general population in 2011, with the highest risk among women and patients with type 1 diabetes.

1EXPOSURE/ALAMY

More should be spent on preventing complications, such as amputations, said Barbara Young

The audit estimated that were 22 200 excess deaths in England and 1900 in Wales among people with diabetes, with wide geographical variations.

Barbara Young, chief executive of Diabetes UK, said that too many people with diabetes were dying from the complications of stroke, heart disease, and kidney disease. Altogether 80% of the £10bn that the NHS spends on diabetes goes on treating complications. Young called on the government and NHS to prioritise care of people with diabetes to reduce premature deaths in the UK.

She added, "The finding that people with diabetes are almost 50% more likely to have a heart attack is shocking, and this is one of the main reasons many thousands of people with the condition are dying before their time.

"It is a tragedy that a large proportion of these thousands of extra heart attacks could have been prevented simply through better education, treatment, and care."

The charity said that at the moment just 41% of people with diabetes were meeting the recommended cholesterol levels and that 10% were not getting the annual cholesterol check recommended by the National Institute for Health and Clinical Excellence.

Young added, "We want everyone with diabetes to get their cholesterol, blood pressure, and blood glucose checked once a year and for this to be the start of a process of supporting the person to achieve healthy levels of these. Unless this happens, people with diabetes will continue to be at much greater risk of heart attacks."

Cite this as: *BMJ* 2012;345:e8406

Costly and inflexible PFI deals that tied trusts to expensive and inflexible contracts for many years have been blamed for the financial instability of at least 20 trusts.[2]

Osborne told MPs that the public sector had been "ripped off" by PFI schemes in the past. "The big difference is that from now on, instead of the public sector bearing the risk and getting none of the reward . . . it will share in the upside as well."

"Soft" services such as cleaning and catering will be removed from all future PFI contracts, and trusts will have discretion over the inclusion of certain minor maintenance activities, such as redecorating. Some trusts in existing PFIs have been locked into maintenance contracts where it reportedly cost £300 (€370; $480) to change a light bulb.[3]

Under the old PFI schemes private companies could inject equity of just 10%, with the remaining funds being raised from debt or bonds. But the Treasury said that in future this bar would be raised to 20-25% to reduce the proportion that had to be raised, often from banks. The government also intends to act as a minority equity co-investor in future projects, giving it a share of profits.

The chancellor said that most government departments would have to find an additional 1% in savings next year and 2% in 2014-15 to provide the government with a £5bn stake to invest. On top of this, the government was ready to provide guarantees for an additional £40bn. The first PFI2 scheme in the health sector will be a £380m hospital in Smethwick in the West Midlands.

To cut down on the windfall profits from equity, the government wants to reduce the number and size of secondary market transactions, by encouraging new types of long term investor, such as pension funds, to take a stake.

North Tees and Hartlepool Hospitals Foundation NHS Trust is already in talks with two pension funds over a £298m PFI deal,[4] but historically this type of investor has tended to shy away because of the time, risk, and cost of bidding for PFI projects.

Cite this as: *BMJ* 2012;345:e8334

KOTA KAWASAKI/AP/PA

Shinya Yamanaka (left) and John Gurdon answer questions at a press briefing in Stockholm this month

Scientist sues Nobel assembly for awarding prize to "wrong" people

Clare Dyer BMJ

The body that awards the Nobel prize for physiology or medicine is being sued for defamation by a researcher who alleges that the two scientists awarded this year's prize have been wrongly credited with work he did a decade before.

Rongxiang Xu, a Chinese scientist working in California, filed the lawsuit at the Superior Court of California, Orange County.

This year's prize has gone to John Gurdon, of the Gurdon Institute at Cambridge University, and Shinya Yamanaka, of Kyoto University.[1] They share the $1.2m (£0.7m) award for discoveries showing that mature cells can be reprogrammed to become pluripotent, with the ability to grow into different tissues in the body.

In announcing the prize in October the Nobel jury said, "Their findings have revolutionised our understanding of how cells and organisms develop" and "created new opportunities to study diseases and develop methods for diagnosis and therapy."

In a statement announcing the lawsuit Xu described himself as the founder of "human body regenerative restoration science" and said that he had discovered "regenerative" cells in 1984 while studying treatments that have benefited 20 million burns victims in 73 countries.

The Nobel Assembly at the Karolinska Institute in Sweden, which chooses the laureates in physiology or medicine, said in a statement, "We have not yet received any such lawsuit and have not, therefore, been able to assess it in detail. The name of the plaintiff has never been put forward to us previously.

"The prize has been very well received and has obtained massive support by the international scientific community."

Xu said in his statement, "My main priority for filing this suit was to clarify the academy's mistaken and misleading statements for the preservation of humanity and future generations."

The Nobel Assembly's announcement last October cited Gurdon's experiment with a frog as far back as 1962 and Yamanaka's discovery in 2006 that mature cells in mice could be reprogrammed to become pluripotent stem cells, immature cells that are able to develop into all types of cells in the body.

The Nobel laureates were presented with their award in Stockholm on 10 December.

Cite this as: *BMJ* 2012;345:e8414

Health information is too complex, study shows

Susan Mayor LONDON

Nearly half of adults in England are unable to understand standard health information material—such as instructions on how to calculate the dosage of paracetamol for a child—well enough to act on it, indicate results from a study reported this week.

Researchers extrapolated results for levels of literacy and numeracy collected in interviews with more than 6000 people aged 16-65 years to assess understanding of 64 items of information on health and safety. The data came from a representative sample taking part in the Skills for Life survey,[1] conducted by the Department for Business, Innovation and Skills. They were applied to a range of materials used to promote health and manage illness, including health screening leaflets and letters from GPs.

The results showed that 43% of people would be unable to understand and act on the information. This figure was based on the proportion of people whose literacy and numeracy scores were below that required for the material.

Cite this as: *BMJ* 2012;345:e8364

Royal commission should be set up to look at UK drug policy, MPs say

Gareth Iacobucci BMJ

MPs have called for a royal commission to examine and deal with failings in UK drug policy, in their first report into the issue in a decade.

The Home Affairs Committee has published detailed findings from a year long inquiry. It supports the direction that the government set out in its 2010 drug strategy[1] but calls for additional measures to tackle the UK's drugs problem.

As a key priority the report identifies the need to "break the cycle" of drug addiction, pinpointing improved treatment in prisons and society as whole, early intervention, and better education and preventive work as key areas to focus on.

The committee said that it was "disturbed" that almost a quarter of prisoners found it easy to get drugs in prison and called for an increase in "regular random drug tests based on suspicion" to combat this.

It expressed concern that drug rehabilitation in prisons was being undermined by "the lack of support for offenders on release" and that the government's recovery programme failed to take into account addiction to prescribed drugs. The report recommends mandatory drug testing on arrival and release from prison.

The prime minister rejected the call for a royal commission. "I don't support decriminalisation," said David Cameron. "We have a policy which actually is working in Britain. Drugs use is coming down, the emphasis on treatment is absolutely right, and we need to continue with that to make sure we can really make a difference. Also, we need to do more to keep drugs out of our prisons."

MPs welcomed the fall in numbers of heroin and crack cocaine users and the increased numbers undergoing treatment but said that they were concerned that retaining addicts in treatment was hindering attempts at recovery.

The report calls for drug misusers to be offered more flexible tailored treatment plans to suit their recovery needs, and it highlights the relative cost effectiveness of residential rehabilitation and the use of buprenorphine as an alternative to methadone as two currently underused methods of treatment.

Better housing, training, and employment support are identified as prerequisites to promoting better integration of addicts back into society, while the report also urges the government to consider introducing league tables of health and wellbeing boards' performance on the provision of local drug treatment.

Cite this as: *BMJ* 2012;345:e8403