NEWS

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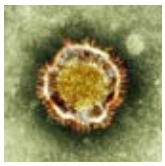


bmj.com
Novel coronavirus spreads to Tunisia

GPs vote against taking back responsibility for out of hours care

Gareth Iacobucci BMJ

UK general practitioners (GPs) have overwhelmingly rejected a call to consider taking back responsibility for out of hours medical provision, following a debate at the annual conference of local medical committees in London.

In an emergency debate announced to discuss health secretary Jeremy Hunt's proposed changes to out of hours care, representatives were asked to consider a motion accepting that GPs should take back responsibility if important guarantees were met, including all funding from the NHS 111 urgent care helpline being transferred to out of hours care, and private companies being blocked from running services.

But the motion was overwhelmingly defeated after a succession of impassioned speeches from the floor, in which most speakers expressed their opposition to altering the existing conference policy, which opposes GPs taking back responsibility for out of hours provision.

Hunt's proposals, unveiled in a speech to the King's Fund last week, set out the government's intention to make GPs more "accountable" for out of hours care.[1]

The plans, which were heavily trailed in the media, came after the health secretary had repeatedly blamed general practice for increased demand in accident and emergency departments, and hinted that he would push for changes to the 2004 GP contract—which allowed GPs to opt out of the direct provision of out of hours care.

But although Hunt's speech suggested that contractual changes for GPs could occur, he stipulated that his proposals would not mean GPs having to provide 24 hour care directly.

Those outlining their opposition to the plans included Russell Brown, chair of East Sussex local medical committee, who said: "94% of my constituents [GPs] want nothing to do with out of hours provision," and John Grenville, of Derbyshire local medical committee, who said that it was unnecessary to change existing policy, because clinical commissioning groups were already overseeing out of hours provision. "I don't think we need it. De facto, GPs are responsible for commissioning it."

Cite this as: *BMJ* 2013;346:f3469

NEWS, p 2

REUTERS/CORBIS

A man in Khobar city, Saudi Arabia, where there have been 17 deaths from novel coronavirus

WHO to probe claims that access to novel coronavirus was restricted

Clare Dyer, Owen Dyer BMJ AND MONTREAL

The World Health Organization is to investigate claims by Saudi Arabia that a Dutch laboratory's patenting of a novel coronavirus variant is hindering research into the pathogen that has claimed 23 lives in several countries.

Saudi deputy health minister Ziad Memish told the World Health Assembly last week that samples of the Middle East respiratory syndrome (MERS) coronavirus, which first emerged in his country, had been sent abroad without permission. "We are still struggling with diagnostics and the reason is that the virus was patented by scientists and is not allowed to be used for investigations by other scientists," he said.

WHO director general Margaret Chan promised to "look at the legal implications together with the Kingdom of Saudi Arabia." She added: "No IP [intellectual property] should stand in the way of you, the countries of the world, to protect your people."

Memish told the assembly that "there was a lag of three months [when] we were not aware of the discovery of the virus." MERS coronavirus was first isolated in Saudi Arabia in June 2012 by microbiologist Ali Zaki from a man who died of a mysterious respiratory illness.

Zaki sent samples of the virus to Erasmus Medical Centre in the Netherlands, where virologist Ron Fouchier sequenced it and in September identified it as a novel coronavirus strain. Zaki then notified the medical alert website ProMED that a novel virus had been identified. Meanwhile, Memish told the WHO assembly, which was held from 20 to 28 May, that "it was patented, and contracts were signed with vaccine companies and antiviral drug companies."

Zaki was later fired from his post in Saudi Arabia and has returned to work in his native Egypt. "I am happy to be fired because I did a favour for humankind," he told the Canadian Broadcasting Corporation (CBC)."

Erasmus "strongly refuted" the Saudi government's characterisation of its actions and denied signing contracts with drug companies. Albert Osterhaus, head of virology at Erasmus, told the *BMJ*: "We have patent applications submitted and that is on the sequences and the possibilities to eventually make diagnostics, vaccines, antivirals, and the like. It's quite a normal thing if you find something new to patent it. So far we have distributed the virus and also the sequences to all the laboratories that would like to be working on it for public health reasons, not only government laboratories but also university laboratories." He added, "We have not struck any deal with any company because we think it's too premature."

Public Health England said that it had developed and shared a diagnostic test for MERS coronavirus with "unprecedented" speed and had not been impeded by patenting.

Cite this as: *BMJ* 2013;346:f3464

Hunt announces plan to make GPs accountable for out of hours care

STEFAN ROUSSEAU/PA

England's health secretary Jeremy Hunt said that primary care was not working for the public

Matthew Limb LONDON

England's health secretary, Jeremy Hunt, has announced plans to overhaul primary care to improve its quality, provoking calls for clarity among doctors' leaders.

Hunt said that the move was a "more urgent" priority than improving standards in hospitals. His measures include recruiting more GPs, making them more "accountable" for out of hours care, and creating a new chief inspector of general practice within the Care Quality Commission.

Hunt said that there might be changes to the GP contract introduced by Labour in 2004, which he said had "fatally undermined the personal link between GPs and their patients."

He said, "Reclaiming the ideal of family doctoring in the 21st century means making sure clinicians are accountable for people who are unwell—whether inside or outside hospital. It means responsibility for more proactive care."

Hunt announced his plans in a speech at the third annual NHS leadership and management summit held by the health think tank the King's Fund in London on 23 May. He said that primary care was not meeting the challenges society faced, was of variable quality, and didn't "work for the public."

The NHS Alliance, which represents primary care professionals and organisations, said that Hunt's plans to make GPs accountable were unclear. David Jenner, for the NHS Alliance's general practice network, said, "If we are to recruit and retain skilled GPs in the profession, Mr Hunt urgently needs to clarify whether he means that GPs will be accountable for commissioning out of hours services, rather than directly providing them through their GP contracts."

Cite this as: *BMJ* 2013;346:f3432

Doctors' leader calls on Hunt to stop using GPs as scapegoats

PAUL FAITH/PA

GP committee chairman Laurence Buckman accused Jeremy Hunt of "spouting rubbish"

Gareth Iacobucci BMJ

The chairman of the BMA's General Practitioners Committee has called on the government to end its attacks on the profession and to stop blaming GPs for the ongoing pressure on hospitals' accident and emergency departments.

In a defiant keynote speech to GPs at the annual conference of local medical committees in London, Laurence Buckman accused the health secretary for England, Jeremy Hunt, of "spouting rubbish" and of using the NHS as a "political weapon" at a time when "the future of the health service is under real threat."

In a fierce response to recent criticism from the health secretary, who has blamed recent pressure on emergency departments on the 2004 GP contract, which allowed GPs to opt out of the direct provision of out of hours care, Buckman insisted that other factors such as reductions in hospital bed numbers, staff shortages, and the "botched introduction" of the NHS 111 urgent care helpline were the real root of the problem.

GPs have faced a series of hostile headlines in the past few weeks, as the government stepped up its rhetoric. But Buckman urged Hunt to stop "political point scoring" and using GPs as scapegoats. He told assembled colleagues, "As we have done over the last 65 years, doctors, nurses, and other NHS staff can work together to find a way through the current challenges... But not if the government insists on denigrating us and using the NHS as a political weapon, as it increasingly has been doing in recent months."

Cite this as: *BMJ* 2013;346:f3419

Implementation of NHS 111 has harmed patients, admits safety chief

Matthew Limb BIRMINGHAM

Patients are likely to have been harmed by implementation of the new NHS 111 urgent care telephone system, a government expert on the safety of patients has admitted.

Mike Durkin, director of patient safety for NHS England, said that data on potentially serious incidents were being collected but that it was not yet known whether anyone was "culpable."

Durkin was speaking at the Patient Safety 2013 Congress, which opened in Birmingham on Tuesday 21 May.

The NHS 111 non-emergency advice line, which was rolled out nationally from 1 April, has come under fierce criticism from many doctors' organisations, including the BMA.[1-3]

NHS England launched an inquiry after complaints of poor quality advice, inadequate clinical support, slow response times, and inappropriate delays in treatment.

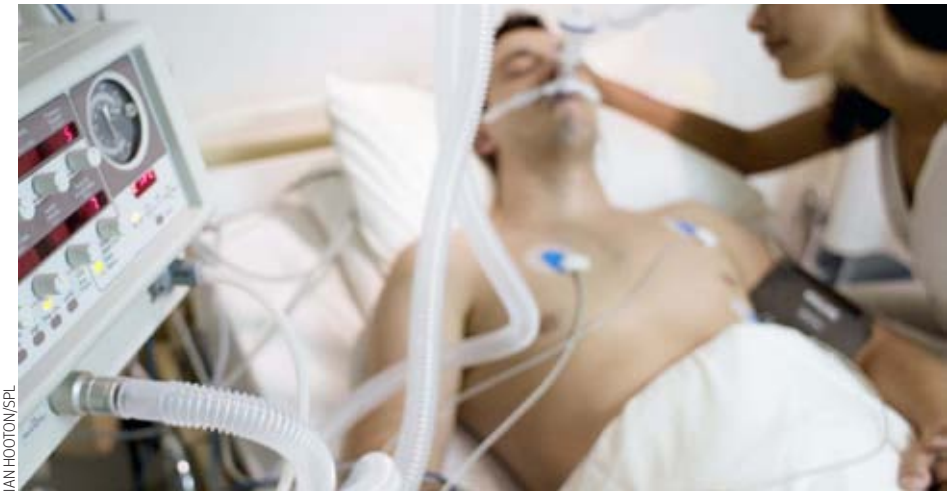
Asked whether patients could have been harmed by the faulty implementation of the service, Durkin replied, "Yes."

Durkin said that the NHS was collecting data from all parts of the system, including hospitals and ambulance services, through its "fantastic" incident reporting culture. But more data were needed from primary care and general practice to increase understanding of safety, he said.

Cite this as: *BMJ* 2013;346:f3382

A&E crisis is not a result of GPs' out of hours arrangements

The rise in demand in A&E did not occur when GPs' contracts changed, said Mike Farrar



IAN HOOTON/SPL

Government support for people who have been in intensive care is lacking, said the Intensive Care Society

Study finds critical care patients suffer long term health and financial problems

Zosia Kmietowicz BMJ

Patients who have been treated in a high dependency unit for more than two days face serious social and medical problems 12 months after their discharge, a study has found.

Nearly three quarters (73%) of 293 patients who were surveyed said that they had moderate or severe pain a year after leaving hospital, and nearly half (44%) had significant anxiety or depression. About half of the patients had some problems with mobility 12 months after discharge that they didn't have before they went to hospital.[1]

The patients had been admitted to one of 22 UK hospitals between August 2008 and February 2010 and been treated for at least 48 hours in level 3 dependency care, defined as critical care for multi-system organ failure. They completed two questionnaires about their health, social, and economic circumstances six and 12 months after being discharged. The study was carried out by the Intensive Care Aftercare Network, a group of healthcare professionals with an interest in improving the long term outlook for survivors of critical illness.

Most of the patients did not experience a change in their relationship or housing after their time in hospital, but a third (33%) reported an effect on their earning ability six months later, because they lost their job, took early retirement, switched to working part time, or took long term sick leave. Twelve months after discharge this was still the case for 28% of patients.

Critical illness also affected the earning ability of other family members, with a third (32%) of families reporting a reduction in their monthly income at 12 months.

Care needs of the patients after discharge from hospital were also found to be high. A quarter of patients (25%) needed help with activities of daily living at six months after discharge, and this proportion had fallen only slightly to 22% at 12 months.

Most of the care to these patients (80%) was provided by a family member, and in 23 cases (8%) a family member was unable to work or had to reduce their working hours 12 months after the patient came home. About a third of patients who needed care had to delve into their savings, borrow money, or sell their house to pay for care.

Commenting on the findings, Barry Williams, a member of the critical care patient liaison committee of the Intensive Care Society, said, "There is often little or no support for these people once discharged from hospital."

He urged the Department of Health for England and the UK Department for Work and Pensions to work with the society to "produce a policy to deal with the problems documented by a well designed and properly conducted survey."

Cite this as: *BMJ* 2013;346:f3451

Adrian O'Dowd LONDON

Growing pressure on hospitals' accident and emergency departments in England have not been directly caused by GPs' arrangements for out of hours care, experts have told MPs.

Speaking at the parliamentary health select committee on 21 May, expert witnesses said that many factors had contributed to the pressure on emergency departments.

The committee, holding the first evidence session of its inquiry into emergency services, asked witnesses whether they agreed with the view of the health secretary for England, Jeremy Hunt, that the main reason for rising attendances at emergency departments was changes to the GP contract in 2004 concerning out of hours work.

Mike Farrar, chief executive of the NHS Confederation, which represents organisations that commission and provide NHS services, said, "I would say the evidence of a direct correlation between GP out of hours care contractually being the requirement of GPs and the A&E [accident and emergency department] performance isn't necessarily proven by statistics."

After the meeting, Farrar added, "With specific regards to the contractual arrangements for GP out of hours care, we do not see a correlation between the changes to the 2004 GP contract and the NHS four hour waiting standard for A&E departments.

"In fact, for the vast majority of the last decade A&E waiting time standards have been improving. It is in recent years where the pressures have started to bite, and there have not been any discernible structural changes to out of hours GP contracts during that time."

"For the vast majority of the last decade A&E waiting time standards have been improving"

During the meeting Mike Clancy, president of the College of Emergency Medicine, also giving evidence, said, "The deterioration in performance [in emergency departments] hasn't corresponded [to] an alteration in the way out of hours has changed. Its contribution to the present problem is not obvious to me."

Fellow witness Patrick Cadigan, registrar of the Royal College of Physicians, said, "One of the big challenges is out of hours care, and the problem is that A&E is the recognisable brand, and that's where patients will go because they will see someone who is expert and will see them often within four hours and they will receive treatment.

"Patients will go where the lights are on. In many of the alternatives, the lights are not on after 5 o'clock in the evening or at the weekends."

MPs asked the witnesses whether they agreed with a recent view put forward by David Prior, chairman of the NHS regulator the Care Quality Commission, that pressure on emergency departments was "unsustainable and out of control."

All urgent care services had seen rises in attendances especially in the last year. Clancy said, "There are also a lack of clear alternatives to emergency departments that patients trust and want to use."

Cite this as: *BMJ* 2013;346:f3363

IN BRIEF

General practitioners asked for their views on assisted dying: The Royal College of General Practitioners has launched a consultation on whether it should change its position on assisted dying, which since 2005 has been that with good palliative care, a change in legislation is not required. The consultation will run until 9 October 2013, with a debate by the governing council expected in early 2014.

Army launches campaign for new recruits: The army has launched a recruitment drive for 10 000 new soldiers and officers. Research has shown that nine of 100 people who wanted to join the army said that they were interested in working for Army Medical Services, which provide medical support to operations, exercises, and adventurous training expeditions all over the world. The new "Step Up" campaign (www.army.mod.uk/join/StepUp) will feature new television adverts that show the potential journey that any soldier might take while following a career in the army.

More hospitals to get Schwartz rounds: The Department of Health is putting £650 000 into expanding the use of Schwartz Center Rounds to an extra 40 hospital trusts in England over the next two years. The rounds, which are currently held monthly in 15 trusts, allow staff to get together to reflect on the stresses and dilemmas in their work. Pilots have shown that the rounds improve communication between staff and patients and reduce stress.

Standard cigarette packets do not increase serving time: Using a uniform colour, size, and design on cigarette packets has not caused confusion or queues in shops as the tobacco industry predicted, a study has found.[1] Australian researchers visited small shops twice before and twice after the introduction of plain packaging in December 2012. Immediately after the new law, serving time increased by two to three seconds but returned to normal levels a week later.

Campaign launches to increase smoking cessation services in hospitals: The British Thoracic Society (www.brit-thoracic.org.uk) has launched a campaign to have a stop smoking service in every UK hospital. It has also developed a tool to enable each trust to calculate its return on investing in such a service.

Cite this as: *BMJ* 2013;346:f3466

Having your elective operation later in the week "increases the risk of dying"

Nigel Hawkes LONDON

The later in the week elective surgery takes place, the greater the chance of the patient dying, a study at Imperial College London has found.[1]

The research team found marked differences in death rates between days; deaths within 30 days of the operation were 44% higher if it occurred on a Friday rather than on a Monday (odds ratio 1.44, 95% confidence interval 1.39 to 1.50), and 82% higher if it occurred at the weekend (1.82, 1.71 to 1.94). The absolute risk of dying within 30 days was 6.7 per 1000 elective admissions.

The researchers also reviewed deaths after five higher risk operations (excision of colon or rectum, heart bypass grafting, repair of abdominal aneurysm, and excision of lung) and after high volume, low risk procedures such as hip and knee replacement. For these procedures, they found higher death rates later in the week than on Mondays, except for aneurysm repair. In the high volume, low risk group, the risk of death (2.0 per 1000 admissions) rose by 28% for operations on a Friday compared with those on a Monday.

Paul Aylin and colleagues from the Dr Foster Unit, Imperial College London, report in bmj.com that this is the first study, to their knowledge, to report a "weekday" effect in addition to the well known "weekend" effect on mortality. "The reasons behind this remain unknown but we know that serious complications are more likely to occur within the first 48 hours after an operation, and a failure to rescue a patient could be due to well known issues related to reduced locum staffing and poorer availability of services over a weekend," they add.

The data taken from hospital episode statistics covered three years, 2008-09 to 2010-11, and included all acute and specialist English hospitals. There were 4 133 346 elective admissions and 27 582 deaths within 30 days of the procedure. The results could have been affected by selection bias, but the analysis suggests that patients operated on at the weekend are for lower risk procedures, and would not account for the findings. Aylin said that although the results do suggest a poorer quality of care at the weekend, "it is difficult to draw those kinds of conclusions from routinely collected data."

Cite this as: *BMJ* 2013;346:f3485

Woman with bipolar disorder can abort her baby, judge rules

Clare Dyer BMJ

A woman with bipolar disorder has been given the go ahead to have an abortion after a Court of Protection judge ruled that she was capable of taking the decision.

The unnamed NHS trust caring for the 37 year old married woman, named only as Miss B, claimed that she had paranoid and delusional beliefs that meant she was incapable of weighing up the factors for and against a termination.

Mr Justice Holman: "There is no doubt she has the capacity to make a decision"

A psychiatrist caring for her told Mr Justice Holman that he was "100% certain" that Miss B lacked the capacity to make a decision about termination. The judge said that psychiatric evidence about capacity was normally "determinative" in the Court of Protection, but after hearing from Miss B he said that there was "no doubt" that she was capable of taking the decision.

The NHS trust brought the case to the court, which takes decisions on behalf of people who are incapable of deciding for themselves, after Miss B, whose pregnancy was originally planned, decided not to go ahead with it. The trust was backed by the woman's husband and mother, who were against the abortion.

But the judge said, "There is no doubt she has the capacity to make a decision. It would be a total affront to the autonomy of this lady to conclude that she lacks capacity to the level required to make this decision."

Miss B is in a secure mental health facility after being sectioned under the Mental Health Act for allegedly attacking her husband with a knife while he was sleeping. Her family and doctors said that she was happy about the pregnancy until she stopped her medication, which she did to protect the unborn child.

She had booked appointments in April for an abortion, but when they did not go ahead she bought pills over the internet to induce a miscarriage. She was sectioned before she could take them, and the case came to court as the 24 week deadline for a termination loomed.

GARY LEE/PHOTOSHOT

ROCHE

Poor record keeping led to £74m "waste," said Margaret Hodge

MP says choice of oseltamivir in flu pandemic was worrying

Zosia Kmietowicz BMJ

The MP Margaret Hodge has expressed dismay at the government's decision in 2009 to stockpile oseltamivir (sold as Tamiflu) in preparation for a flu pandemic despite uncertainty over the drug's effectiveness.

Hodge, who chairs the House of Commons Public Accounts Committee, said she was also appalled at the "squandering" of £74m of taxpayers' money when 6.5 million doses of oseltamivir had to be written off because of the NHS's poor record keeping on how the drug was stored. "There is simply no excuse for this waste," she said.

Hodge was responding to a memorandum from the National Audit Office written to inform members of her committee on how drugs are licensed and the reasoning behind the decision of the Department of Health for England to stockpile oseltamivir for the treatment of pandemic flu.[1]

The committee is to hold a hearing on clinical trials and oseltamivir on 17 June, at which it will cross examine, among others, Sally Davies, England's chief medical officer since 2010.

The National Audit Office, which scrutinises public spending, said that there was a "general consensus" that oseltamivir reduced the duration of flu symptoms but less consensus that it reduced complications, hospitalisations, and deaths.

It said that the government spent £560m on antivirals between 2006-7 and 2012-13: £424m on oseltamivir and £136m on zanamivir (Relenza).

Of the 40 million doses of oseltamivir purchased, 2.4 million were consumed, mainly during the 2009-10 pandemic. A further 10 million were written off, 6.5 million of them (worth £74m) before their shelf life was reached because it was unsure how they were stored.

Hodge described the decision to purchase oseltamivir at such a great cost, "despite there being question marks over the effectiveness of the drug," as "extremely worrying." The poor record keeping over storage of oseltamivir was "a shocking example of incompetence," she added.

The audit office said that when the health department decided what drugs to stockpile for use in a pandemic it should "concentrate on building up knowledge about the added value of stockpiling through reducing complications and deaths, if necessary by commissioning additional independent research."

And NHS England and Public Health England should ensure that there were robust procedures in place during a pandemic to "reduce unnecessary write-offs."

Its memorandum explained how the Medicines and Healthcare Products Regulatory Agency and the European Medicines Agency did not ask manufacturers for patient level data to conduct their own analyses when considering licensing a drug because they lacked the capacity to do so—unlike the Food and Drug Administration in the United States.

Cite this as: *BMJ* 2013;346:f3371

The woman told the judge that she planned to divorce her husband, whom she had married partly because "he was undocumented and had no right to be in the country." She did not believe that she would be well enough to look after the baby as a single mother and was frightened that if she had the baby her foreign husband would send it abroad to live with his family.

Asked what she would do if she were forced to go on with the pregnancy to term, she replied, "I would seek to kill myself and the baby."

The judge said, "She is a lady of considerable intelligence, is well educated, including having a degree, and was previously working in a demanding professional job. She's articulate, can clearly engage with her lawyers and the legal process, and can express perfectly what she wants to achieve.

"I cannot agree that she is lacking capacity to make such a decision."

By the time the judge delivered his ruling, Miss B's pregnancy had almost reached 24 weeks' gestation, the upper time limit set for abortions in England, Wales, and Scotland.

But in exceptional cases an abortion may be performed later. This could include cases where suicide was a real risk.

Cite this as: *BMJ* 2013;346:f3387

Study links iodine deficiency in pregnancy with lower IQ in kids

Lola Loewenthal LONDON

A study of nearly 1000 pregnant women from the United Kingdom has found that two thirds were deficient in iodine and that this deficiency was associated with a lower IQ and poorer reading ability in their children.[1]

The *Lancet* study used stored urine samples and data from the Avon Longitudinal Study of Parents and Children (ALSPAC), also known as "the children of the 90s cohort."

Iodine concentrations were measured in 958 urine samples taken in the first trimester of pregnancy and correlated with the IQ of the children when they were 8 years old and with their reading ability at 9 years old.

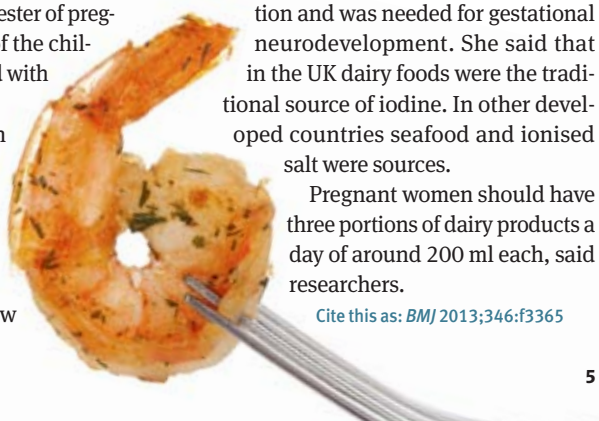
The World Health Organization says that women who have urinary iodine concentrations below 150 micrograms per litre of urine have a deficiency.[2] This was the case in 67% of the women in the study.

Children whose mothers had low urinary iodine concentrations had lower scores on verbal IQ (odds ratio 1.6 (95% confidence interval 1.1 to 2.3)), reading accuracy (1.7 (1.2 to 2.5)), and reading comprehension (1.5 (1.1 to 2.2)) than did children of mothers with normal iodine concentrations.

Speaking at a press briefing on the study on 21 May, Margaret Rayman, professor of nutritional medicine at the University of Surrey and one of the study's authors, said that iodine was a crucial component in thyroid hormone production and was needed for gestational neurodevelopment. She said that in the UK dairy foods were the traditional source of iodine. In other developed countries seafood and ionised salt were sources.

Pregnant women should have three portions of dairy products a day of around 200 ml each, said researchers.

Cite this as: *BMJ* 2013;346:f3365



UKRAFOTO UKRAINIAN NEWS/DEMOTI/PA

In April people with hepatitis C were among those who took part in a theatrical hanging in Kiev to demand treatment. A scheme was approved soon afterwards

Spend more on treating hepatitis C, say campaigners

Zosia Kmietowicz BMJ

Governments around the world are being called on to redirect resources away from the "war on drugs" and into public health schemes for preventing and treating hepatitis C infection.

In a report published on 30 May the Global Commission on Drug Policy, a panel of 22 political and cultural leaders, estimated that 10 million of the 16 million people who inject drugs around the world are infected with hepatitis C.[1]

Research has consistently shown that harsh drug laws forced drug users away from public health services and into hidden environments where the risk of infection with hepatitis C and HIV became markedly raised.

The report described the billions of dollars spent each year on arresting and punishing drug users as "a gross misallocation of limited resources." Because of such policies, very few countries had reported significant declines in new infections of hepatitis C among drug users.

The money would be better spent on harm reduction services, such as the provision of sterile needles and syringes and opioid substitution therapy, as well as treatment schemes, it said.

Hepatitis C is more than three times as common as HIV in this population, said the report. In some of the countries with the harshest drug policies over 90% of people who inject drugs have hepatitis C, with the highest numbers reported in China (1.6 million infected people), the Russian Federation (1.3 million people), and the United States (1.5 million people).

"Hepatitis C has to be one of the most grossly miscalculated diseases by governments on the planet," said one of the commissioners, Michel Kazatchkine, who is also the UN secretary general's special envoy on HIV and AIDS in Eastern Europe and Central Asia. "It is a disgrace that barely a handful of countries can actually show significant declines in new infections of hepatitis C among people who inject drugs," he said.

The report also highlighted the fact that hepatitis C had not had the publicity that HIV had attracted, which had helped to reduce the price of antiretrovirals around the world. Drug treatment of hepatitis C with pegylated interferon is patented by the drug companies Roche and Merck and in different countries costs between $2000 (£1320; €1540) and $20 000 for a course of treatment. Costs are likely to come down with the expiry of patents in 2-4 years' time, and the World Health Organization has recently called for drugs used to treat hepatitis C to be included in lists of essential treatments.

However, the report said that in the meantime countries could negotiate price reductions with manufacturers. It gave the example of Ukraine, where one million people have hepatitis C, including 90% of injecting drug users. Pressure from civil society groups there, such as the International HIV/AIDS Alliance in Ukraine, led to an agreement with the Global Fund to Fight AIDS, Tuberculosis and Malaria to fund treatment of injecting drug users, to be delivered alongside opioid substitution therapy and antiretroviral therapy. Drug companies have agreed to halve the price of drugs for the deal.

The Global Commission on Drug Policy campaigns to promote an evidence based global discussion on effective ways to reduce the harms caused by drugs to people and societies. Its commissioners include Kofi Annan, former secretary general of the United Nations.

Cite this as: *BMJ* 2013;346:f3428

Nicholson to step down as chief executive of NHS England by March 2014

Nigel Hawkes LONDON

David Nicholson, the chief executive of the NHS in England, has announced his intention to step down by March 2014 at the latest, when he will have completed seven and a half years in the top job.

He may go sooner if a successor has been chosen and the chairman of NHS England, Malcolm Grant, thinks that an earlier change would be in the best interests of the service. Nicholson has been credited with maintaining control of the service at a time of upheaval during the introduction of Andrew Lansley's reorganisations but has also been criticised for his top-down management style.

His involvement in the Mid Staffordshire NHS Foundation Trust scandal was indirect but, critics claim, significant, because his insistence on meeting financial targets took managers' minds off the central task of providing care.

Julie Bailey, a leading Mid Staffordshire campaigner, said that it was "time to celebrate," while Roy Lilley, an outspoken blogger on NHS management issues, said that Nicholson should have gone before Lansley's changes, when he would have been remembered as the man who made waiting times disappear. "Instead he will be remembered in the same breath as patients drinking from flower vases," Lilley wrote, a reference to patients' maltreatment at Mid Staffordshire.

Since the publication of the second report into Mid Staffordshire by Robert Francis QC, Nicholson has been the subject of sustained attack from the *Daily Mail* but has retained the support of the government.

Jeremy Hunt, health secretary for England, paid tribute to his calmness and focus, crediting him with falling waiting times, lower rates of hospital infections, and fewer mixed sex wards. Mike Farrar, the chief executive of the NHS Confederation, which represents organisations that commission and provide NHS services, said that under Nicholson access to treatment had improved more quickly than in almost any similar health system.

Cite this as: *BMJ* 2013;346:f3364