Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

CMO's UPDATE 31

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IMPORTANT INFORMATION FOR DOCTORS FROM THE CHIEF MEDICAL OFFICER AUGUST 2007

CMO's Annual Report

This year's Report was published in a magazine format. The aim is to bring the Report to the attention of as many homes and members of the public as possible. (Approximately 200,000 copies will be distributed by three newspapers).

The health of the public of Northern Ireland is improving but these health gains are not experienced by all. There is still much work to be done to improve the health of those living in the most disadvantaged areas.

Changing the lifestyles being adopted by many in society is a major challenge: in particular reversing the trends in obesity, reducing further the numbers who smoke, getting people to have a more responsible approach to alcohol consumption and tackling the increasing numbers who are acquiring sexually transmitted infections.

Some of the key facts noted in this years report are:

- **Over 20% of our primary one children are overweight or obese.**
  Two-thirds of men and over half of women are overweight or obese.
  Obesity is estimated to cause around 450 deaths per year.
- **350, 000 people smoke in Northern Ireland.**
  Smoking is responsible for approximately 2,300 deaths here each year.
- **Half of men and one-third of women admitted to at least one binge drinking session in the last week.**
  There are between 15,000 and 20,000 problem drinkers in Northern Ireland.
- **STIs are rising at a dramatic rate - 100% increase in 10 years.**
  Just under 13,000 diagnoses of STIs made in Northern Ireland in 2005.
- **291 deaths were recorded as suicide in 2006.**
  Suicide is now widely recognised as the third biggest cause of "years of lives lost" after cardiovascular disease and cancer.
- **Men living in the 20% most deprived wards die 4 years earlier than the Northern Ireland average.**
- **The Traveller community life expectancy is 15 years less than the NI average.**

Prescribing and supply arrangements for specialist medicines in NI:

THE RED AMBER LIST

Potential difficulties can arise in the transfer of care of patients from hospitals to the community when the prescribing of highly specialised medicines is involved.

Following the work of a review group with representatives from the Department of Health, Social Services and Public Safety (known as the Regional Group on Specialist Medicines), the implementation of a system to manage the prescribing and supply of specialist medicines has been agreed and specialist medicines are being categorised using a red and amber 'traffic light' system.

Red List Drugs: prescribing responsibility should remain with the consultant or specialist clinician and the supply organised via the hospital pharmacy.

Amber List Drugs: prescribing responsibility should be transferred from secondary to primary care with the agreement of the patient's GP and when shared care arrangements have been established.

Implementation of the red/amber list is facilitated by The Interface Pharmacist Network Specialist Medicines (IPNSM), and helps to ensure:

- Safer systems, with the responsibility for prescribing specialised medicines lying with the most appropriate practitioner.
- Better communication between primary and secondary care leading to better working relationships and enhanced patient care.
- Consistency in approach across Northern Ireland.

If you are prescribing specialist medicines, the Red Amber list will be relevant to you.

Further Information

To view the Red Amber list, regional Shared Care Guidelines, and the contact details of the IPNSM visit http://www.ipnsm.hscni.net/

BLOODSPOT SCREENING –

UK Data Collection and Performance Analysis Report 2005/06

For many years screening for phenylketonuria (PKU), congenital hypothyroidism (CHT) and cystic fibrosis (CF) has been offered to parents of newborn babies. Hundreds of people have now benefited from early diagnosis and intervention with significant life-long disability being prevented or substantially reduced.

The UK Newborn Screening Programme Centre (UKNSPC) was established in 2002 with the objective of assuring high quality screening services for babies and their parents. In December 2004 the UKNSPC launched standards for the bloodspot screening programme. For the last 2 years the Programme Centre has collected data from England, Wales and Northern Ireland to measure performance against these standards. (Standards in Scotland are slightly different).

The 2005/06 Data Collection and Performance Analysis Report was published earlier this year. It shows that Northern Ireland is the best performing region against each of the measurable standards. This high level of performance is undoubtedly due to the commitment and collaborative working of the many staff who provide a range of services. It reflects high standards of professional practice and quality management arrangements in Northern Ireland.

Further Information

The standards and a copy of the report can be accessed at www.newbornscreening-bloodspot.org.uk

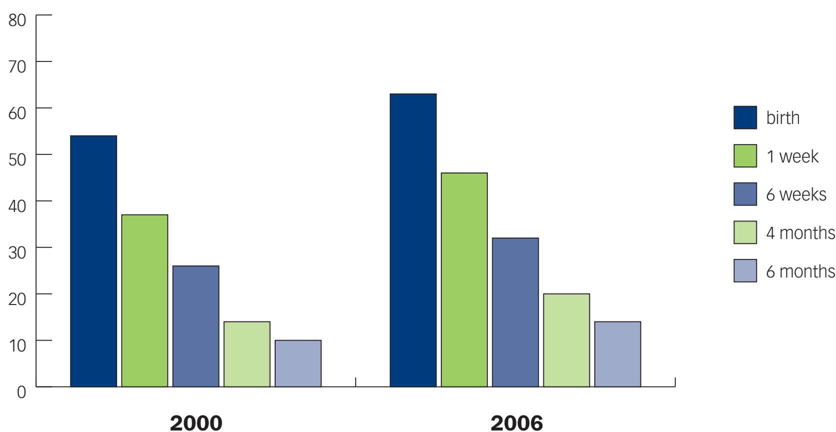
BREASTFEEDING
and Public Health

The importance of breastfeeding in relation to health is now increasingly recognised. Breastfeeding reduces the risk of gastroenteritis, ear, chest and urinary infections. Type 1 and Type 2 childhood diabetes and obesity are reduced and children also benefit from a lower diastolic blood pressure and reduced cholesterol levels. Mothers who breastfeed beyond the first few months have a reduced risk of breast cancer, ovarian cancer and Type 2 diabetes. It is therefore recommended that babies should be exclusively breastfed for the first six months, with continued breastfeeding after solids are introduced.

Recently published figures show that in Northern Ireland the prevalence of breastfeeding in babies up to the age of 9 months has increased. According to the UK Infant Feeding Survey 2005 the incidence of breastfeeding has increased from 54% in 2000 to 63% in 2005. Despite this positive upward trend, many mothers stop breastfeeding in the first few weeks. The main reason for this is concern about low milk supply. Almost all women can physically produce enough milk to fully breastfeed, but many doubt this ability and stop because of perceived milk insufficiency.

There are many local and regional initiatives underway to promote breastfeeding and improve the support provided to breastfeeding families. Examples include: implementing UNICEF UK Baby Friendly Initiative best practice standards for breastfeeding in hospital and community settings; strengthening mother-to-mother support through breastfeeding groups and peer support programmes; and encouraging social acceptance of breastfeeding through the ongoing public information campaign for breastfeeding.

Prevalence of breastfeeding in Northern Ireland (UK Infant Feeding Survey 2005)



Further Information

Further information about breastfeeding can be seen on the HPA website
www.breastfedbabies.org

For more information on regional and local breastfeeding initiatives contact
Janet Calvert, Regional Breastfeeding Coordinator
j.calvert@hpani.org.uk
028 90311611

EMAS
Employment Medical Advisory Service
Health
ADVICE
Work
hseni
CONTROLLING RISK TOGETHER
Working for Health
our work
our health
our lives
Medical Advice for all Workplaces

Primary Care Role in
OCCUPATIONAL HEALTH

General Practitioners have a key role in the identification and management of ill health caused or contributed to by work. They are also directly involved in decisions relating to sickness absence, rehabilitation and return to work.

In early 2007 the Health and Safety Executive for Northern Ireland (HSENI) explored with GPs including representatives of the RCGP and the BMA their occupational health needs. A number of objectives have been agreed in areas such as training, awareness raising and the interface between GPs and employers.

As a first step all general practices will be provided with information on HSENI's Employment Medical Advisory Service and with copies of the associated advisory leaflet. Further joint work is planned for the coming year.

EMAS welcomes requests for advice from GPs as well as from their patients. Its leaflet can be downloaded from
http://www.hseni.gov.uk/emas_leaflet.pdf

Further Information

Further information can be obtained from:
Dr D Skan, Employment Medical Advisory Service, Avenue House, 42-44 Rosemary Street, Belfast, BT1 1QE tel: 028 90 408004, email: emasmail@detini.gov.uk .

INCAPACITY BENEFITS
IB113 medical reports

GPs are requested by the Social Security Agency to complete IB113 medical reports on patients claiming Incapacity Benefit. These reports form an important part of the evidence considered by doctors advising the Agency and by the Agency's Decision-Makers in reaching their decision on benefit entitlement.

GPs should complete the report as fully as they are able from the information which is currently available to them. The doctor does not need to arrange a consultation or medical examination of their patient.

A fully completed promptly returned report may:

1. avoid the need for your patient to undergo a medial examination;

2. help the Social Security Agency to give your patient a prompt decision on their entitlement to benefit;

3. reduce the number of requests for reports in the event of an appeal as you will already have provided the relevant clinical information required to inform the initial decision on the claim.

The provision of poorly completed reports (including the enclosure of brief computer printouts) or the non return of reports is unhelpful and is unlikely to be in the best interests of your patients.

Doctors are obliged to complete these reports under their terms and conditions of service. The report should be returned within a reasonable timescale (10 working days) and address the questions asked. An exercise carried out by the Social Security Agency showed that 30% of reports are not returned and a further 25% returned late. This non return/late return can result in your patients being called for unnecessary examinations.

The Social Security Agency thanks GPs for their assistance in the past in these matters and trust that this will continue.

Further Information

For further information contact:
Medical Support Services
Royston House, Upper Queen Street
Belfast BT1 6FX
028 9054 2131

ASBESTOS RELATED DISEASES
in Northern Ireland: 2001-2006

Asbestos-related diseases are the single most common cause of preventable work-related deaths in Northern Ireland. In 2006 there were 76 deaths caused or contributed to by asbestos-related diseases of which in 47 mesothelioma was the primary cause and six in which asbestosis was the primary cause (Tables 1 and 2). It is estimated that there are equal numbers of deaths caused by asbestos-related lung cancer as there are mesothelioma deaths hence the estimated total number of deaths related to asbestos exposure in Northern Ireland in 2006 is 126.

Asbestos- related diseases typically have extremely long latent intervals with deaths now reflecting exposure to asbestos 30-50 years ago.

Information on asbestos is available from the Asbestos Advisory Service of the Health and Safety Executive for Northern Ireland - http://www.hseni.gov.uk .

Table 1. Total asbestos–related deaths in Northern Ireland: 2001-2006

Primary/secondary cause				
Registration Year	Mesothelioma without asbestosis	Asbestosis* without mesothelioma	Mesothelioma and asbestosis*	All primary or secondary cause
2001	55	18	3	**76**
2002	41	32	1	**74**
2003	47	23	2	**72**
2004	53	38	1	**92**
2005	38	19	2	**59**
2006**	45	26	5	**76**

* For certain years these figures also include a small number of other asbestos related chest diseases and pulmonary fibrosis where there was coexisting asbestos exposure

** Figures supplied by GRO and are provisional

Further Information

Further information can be obtained from:

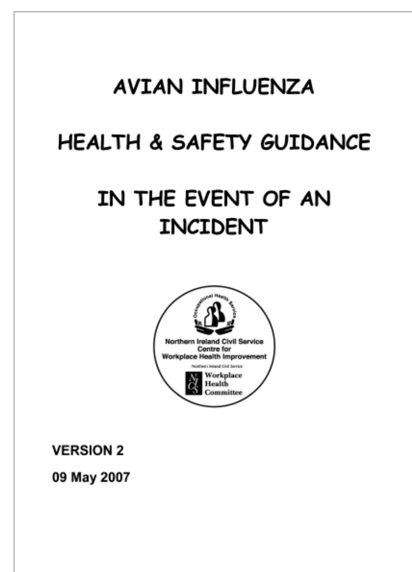
Dr D Skan, Employment Medical Advisory Service, Avenue House, 42-44 Rosemary Street, Belfast, BT1 1QE tel: 028 90 408004, email: emasmail@detini.gov.uk .

AVIAN INFLUENZA –
Health & Safety Guidance

The NI Civil Service OHS has recently updated it's guidance on the health and safety aspects of dealing with an incident of Avian Influenza. Whilst primarily aimed at staff from the Department of Agriculture and Rural Development, it will be of wider interest to those who have an involvement or interest in contingency planning for an outbreak of bird flu.

The guidance covers identification of hazard and risk; route of infection; control measures; fitness for work and surveillance of employees.

The document can be accessed on the following website: http://www.nicsohs.gov.uk.



Further Information

Further information on avian influenza can be found at:

http://www.dhsspsni.gov.uk/index/phealth/php/infectious_diseases/avianflu.htm.

REDUCING THE RISK OF HYPONATRAEMIA

when administrating intravenous infusions to children

The National Patient Safety Agency (NPSA) has issued advice to the NHS on how to reduce the risks associated with administering infusions to children. The recommendations made in the NPSA Patient Safety Alert relate to paediatric patients from one month to 16 years old.

A number of resources have been developed by NPSA to support implementation of the Alert. All materials are available on www.npsa.nhs.uk/health/alerts. These include:

A **guideline template** to assist with the production of local clinical guidelines;

A **prescription template** providing ideas on how local prescriptions for intravenous fluids can be improved;

An **e-learning module** for clinical staff prescribing paediatric infusion therapy;

A **practice competence statement** for the prescribing and monitoring of intravenous infusions;

An **audit checklist** to assist organisations with an annual audit process to ensure that the recommendations are embedded and maintained within practice; and

A **patient briefing**.

NHS
National Patient Safety Agency

Patient safety alert 22

Alert

28 March 2007

Immediate action	☐
Action	☑
Update	☐
Information request	☐

Ref: NPSA/2007/22

Reducing the risk of hyponatraemia when administering intravenous infusions to children

The National Patient Safety Agency (NPSA) is issuing advice to healthcare organisations on how to minimise the risks associated with administering infusions to children.

The development of fluid-induced hyponatraemia in the previously well child undergoing elective surgery or with mild illness may not be well recognised by clinicians. To date, the NPSA's National Reporting and Learning System (NRLS) has received only one incident report (that resulted in no harm), but it is likely that incidents have gone unreported in the UK.

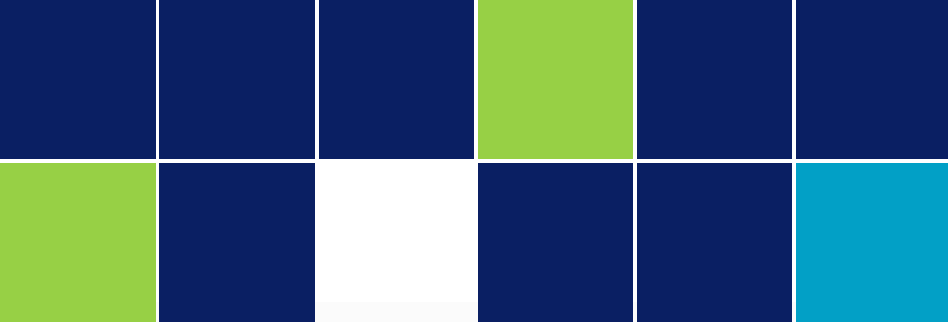
Since 2000, there have been four child deaths (and one near miss) following neurological injury from hospital-acquired hyponatraemia (see definition on page 7) reported in the UK.[1-3] International literature cites more than 50 cases of serious injury or child death from the same cause, and associated with the administration of hypotonic infusions.[4]

Action for the NHS and the independent sector

The NPSA recommends that NHS and independent sector organisations in England and Wales take the following actions by 30 September 2007 to minimise the risk of hyponatraemia in children:

1. Remove sodium chloride 0.18% with glucose 4% intravenous infusions from stock and general use in areas that treat children. Suitable alternatives must be available. Restrict availability of these intravenous infusions to critical care and specialist wards such as renal, liver and cardiac units.
2. Produce and disseminate clinical guidelines for the fluid management of paediatric patients. These should give clear recommendations for fluid selection, and clinical and laboratory monitoring.
3. Provide adequate training and supervision for all staff involved in the prescribing, administering and monitoring of intravenous infusions for children.
4. Reinforce safer practice by reviewing and improving the design of existing intravenous fluid prescriptions and fluid balance charts for children.
5. Promote the reporting of hospital-acquired hyponatraemia incidents via local risk management reporting systems. Implement an audit programme to ensure NPSA recommendations and local procedures are being adhered to.

The Northern Ireland Regional Paediatric Fluid Therapy Working Group and the NI Medicines Governance Team were part of the NPSA external reference group, the Department has asked both of these groups to work collaboratively to produce an intravenous fluid clinical guideline in accordance with NPSA guidance, by **31 July 2007**. This will then be disseminated to each HSC Trust for local implementation and monitoring.



vCJD AND MEDICAL AND DENTAL INSTRUMENTS

Since 1996 there have been 165 cases of vCJD in the UK. Several measures have been introduced since then to reduce the spread due to healthcare treatment. In the last year further measures have been introduced.

Instruments used in ophthalmic or neurological surgery

NICE produced guidance in 2006 to further reduce any risk of iatrogenic spread of CJD via surgical instruments and endoscopes. The recommendations relate to those instruments, which have or may have come into contact with high risk tissues defined primarily as brain and the posterior eye. In April 2007 the Chief Medical Officer issued a letter advising that all Trusts should review current practice on and identification, decontamination and tracking of instruments used for high risk tissues.

Dental endodontic files and reamers

There are approximately 1 million NHS endodontic treatments undertaken every year in England and Wales, 125,000 in Scotland and 50,000 in Northern Ireland. There is no current evidence of vCJD being transmitted by any form of dentistry. In view of the microbiological evidence which shows that endodontic reamers and files cannot be reliably decontaminated it is advised that these instruments be treated as single use and disposed of appropriately after each patient. This should be done whether or not the instruments are labelled as single use. **In April 2007 the Chief Medical Officer and Chief Dental Officer issued a joint letter advising that all dentists must ensure that endodontic files and reamers are treated as single use instruments.**

Assessment to be carried out on patients, before certain surgery and endoscopy procedures, to identify patients with, or at risk of, CJD.

The advisory committee on dangerous pathogens (ACDP) recommended assessment to be carried out on patients before surgical and endoscopic procedures, that may involve contact with tissues with high or medium level infectivity, to identify those with, or at risk of, CJD. **In August 2006 the Chief Medical Officer issued a letter advising that all Trusts should develop policies and procedures for assessing patients before specified procedures.**

Reducing the risks from fresh frozen plasma (FFP)

As a precaution against the theoretical possibility of vCJD transmission in humans through blood and blood components and in line with recommendations made by the Advisory Committee on Microbiological Safety of Blood and Tissues and Organs (MSBTO), all children up to (but not including) 16 years of age by the end of 2005 will be treated using imported FFP, which is treated with Methylene Blue (MB) as a pathogen reduction step.

Patients with thrombotic thrombocytopenic purpura (TTP) have high donor exposure and should be treated with non-UK, virus-treated plasma. Because there is limited experience of treating TTP with MBFFP, it is recommended that Solvent Detergent treated FFP (SDFFP) is used. **In July 2006 CMO issued a circular about the use of fresh frozen plasma (FFP) in children and patients with thrombotic thrombocytopenic purpura.**

Recruitment to
SPECIALTY TRAINING

Since the previous edition of CMO Update there have been well publicised problems with the new recruitment process to specialty training. These began to emerge in late February with widespread concerns regarding the short listing element of the new process.

As a result, a revised process was agreed upon locally and announced in early April. Effectively, this dispensed with short listing and ensured an interview for all those candidates who fulfilled the basic eligibility criteria. This led to an additional thousand interviews, creating a significant additional burden for local consultants and staff at the Northern Ireland Medical and Dental Training Agency.

The extended round of interviews was concluded at the end of May and the process of offering appointments is nearing completion at the time of going to press.

Other concerns over the new process have emerged from various sources. Chief among the concerns expressed has been the apparent imbalance between the number of applicants and posts available and the potential for those who are unsuccessful in gaining appointment to a specialty training programme being permanently excluded from specialist training.
To address these and other issues, the Minister for Health, Social Services and Public Safety, Michael McGimpsey, announced a review of the recruitment process on the 22nd May. Professor Randal Hayes is leading the review. Whilst concentrating on providing a solution to local problems, Professor Hayes' review will take account of the developments more widely.

Of particular relevance in this respect, is a similar exercise being conducted by Professor Sir John Tooke, called the MMC inquiry (Details at www.mmcinquiry.org.uk).

NORTHERN IRELAND HEALTH ECONOMICS GROUP

Annual Conference

The Economics of Chronic Conditions

Friday 19th October 2007

Dunadry Hotel

A panel of experts has been assembled including Professor Hugh Gravelle (University of York), Professor Jennifer Dixon (Kings Fund), Dr Andrew Walker, (University of Glasgow), Professor Martin Knapp (LSE), Professor Charles Normand (Trinity College Dublin), Professor Carolyn Summerbell (University of Teeside) and Dr Anna Gavin (Northern Ireland Cancer Registry).

They will examine a range of chronic conditions including those related to obesity, respiratory disease, mental health and cancer as well as overarching issues such as reimbursement and incentives and overall system design. An introductory address will be provided by Dr Michael McBride, Chief Medical Officer.

Further Information

Further information can be obtained by contacting:
Ciaran O'Neill
Chairman, NIHEG, School of Medicine and Dentistry
Queens University Belfast BT12 6BP
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